

Evidence of **COVERAGE**

Effective January 1, 2010 – December 31, 2010

Insured by: PacifiCare of Oregon, Inc.
PacifiCare of Washington, Inc.

AARP® MedicareComplete® Retiree Plan (HMO) from SecureHorizons
SecureHorizons® MedicareComplete® Retiree Plan (HMO)

Oregon and Washington

H3805, H5005

Introduction to the AARP® MedicareComplete® Retiree Plan (HMO) from SecureHorizons and the SecureHorizons® MedicareComplete® Retiree Plan (HMO)

From listening to and learning from health care consumers like yourself, SecureHorizons® health plans has developed and brought to the market a powerful and unique health coverage option for seniors and other eligible Medicare beneficiaries – AARP® MedicareComplete® Retiree Plan (HMO) from SecureHorizons and the SecureHorizons® MedicareComplete® Retiree Plan (HMO). The Plan offers coverage that is designed to help you live a better, more complete life now and in the coming years. By providing you with a more comprehensive range of health care benefits than you get with Original Medicare, SecureHorizons aims to help you prevent and manage illness and improve your overall health and well-being.

As you read your Plan materials, you will learn important details about the benefits that this Plan has been designed to offer you. If you have a question at any point while you are reading this information, please call us at one of the phone numbers listed on the back cover. A representative will be happy to assist you and answer any questions you may have.

Thank you for your interest in the Plan. We look forward to providing you with your health coverage.

This Plan is offered by PacifiCare of Oregon, Inc. and PacifiCare of Washington, Inc., referred throughout the Evidence of Coverage and other Plan materials as “we”, “us” or “our”. AARP® MedicareComplete® Retiree Plan (HMO) from SecureHorizons and the SecureHorizons® MedicareComplete® Retiree Plan (HMO) are referred to as “Plan or “our Plan”. Our organization contracts with the Federal government.

When the Agreement is purchased by the Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Table of Contents

Welcome to the AARP® MedicareComplete® Retiree Plan (HMO) from SecureHorizons and the SecureHorizons® MedicareComplete® Retiree Plan (HMO)	1
Call Us When You Need Information.....	2
Updating Your Enrollment Records.....	2
We Are Interested in Your Comments.....	3
How to Submit a Claim	3
Section 1 – Health Care Terms.....	4
Section 2 – Eligibility, Enrollment Periods and Effective Date	16
Are You Eligible to Enroll in the Plan?.....	16
When You May Enroll in the Plan	17
Medicare Part D Late Enrollment Penalty.....	19
Creditable Coverage.....	20
Your Enrollment Request Form.....	21
When Your Plan Coverage Begins	21
Our Liability upon Your Initial Enrollment.....	21
About Your Medicare Supplement (Medigap) Policy	22
Section 3 – Member Rights and Responsibilities	27
Section 4 – How Your Coverage Works	32
Your Member ID Card.....	32
How the Lock-In Feature Works for You and UnitedHealthcare.....	32
Section 5 – Working with Your Contracted Medical Providers	33
Your Primary Care Physician.....	33
Physician-Patient Relationship	33
Changing your Primary Care Physician.....	33
Provider Terminations.....	35
How to Schedule an Appointment with Your Primary Care Physician.....	35
How to Receive Care After Hours.....	35
How to Receive Covered Services from a Specialist	35
Standing Referrals to Specialists	36
Extended Referral for Coordination of Care by a Specialist	36
Access to OB/GYN Physician Services and Women's Routine and Preventive Health Care Services	36
Monitoring Services for Anticoagulation Medications	37
Continuity of Care for Members with Terminating Physicians.....	37
Access to Your Medical Records and Files.....	38
Utilization Review	38
Second Medical Opinions	39
Prior Authorization.....	39
Hospitalization	40

Hospitalist	41
Skilled Nursing Facility (SNF) Care	41
Prosthetic Devices, Orthotic Appliances and Durable Medical Equipment and Supplies.....	41
Ambulance	42
Home Health Agency Care Services	42
Hospice.....	43
Clinical Trials	44
Religious Non-medical Health Care Institutions (RNHCIs) Care.....	44
Organ Transplants	44
How To Access Your Behavioral Health Benefit	48
Section 6 – How You Get Prescription Drugs	49
What Do You Pay For Covered Drugs?	49
If You Have Medicare And Medicaid	49
What Drugs Are Covered By This Plan?.....	49
What Is a Formulary?.....	49
How Do You Find Out What Drugs Are on the Formulary?.....	49
What Are Drug Tiers?.....	49
Can the Formulary Change?.....	50
What if Your Drug Isn't on the Formulary?.....	50
Transition Policy	51
Drug Management Programs	52
Utilization Management.....	52
Drug Utilization Review	53
Medication Therapy Management Programs	53
How Does Your Enrollment in This Plan Affect Coverage For the Drugs Covered Under Medicare Part A or Part B?	53
Using Network Pharmacies to Get Your Prescription Drugs.....	54
What if a Pharmacy is no Longer a Network Pharmacy?	54
How Do You Fill a Prescription at a Network Pharmacy?.....	54
Our Plan's Network Mail-Order-Pharmacy Service	54
How To Fill a Prescription Through Our Network Mail-Order-Pharmacy Service	55
How Do You Fill Prescriptions Outside the Network?	56
How Do You Submit a Paper Claim?.....	56
How Does Your Prescription Drug Coverage Work if You Go to a Hospital or Skilled Nursing Facility?	58
Long-Term Care (LTC) Pharmacies	58
Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies.....	58
Home Infusion Pharmacies	58
Some Vaccines and Drugs May be Administered in Your Doctor's Office.....	58
How is Your Out-of-Pocket Cost Calculated?.....	60
What Type of Prescription Drug Payments Count Toward Your Out-of-Pocket Costs?	60

What Type of Prescription Drug Payments Will Not Count Toward Your Out-of-Pocket Costs?.....	61
Who Can Pay For Your Prescription Drugs, And How Do These Payments Apply to Your Out-of-Pocket Costs?.....	61
Part D Explanation of Benefits.....	62
What is the Explanation of Benefits?.....	62
What Information is Included in the Explanation of Benefits?.....	62
What Extra Help is Available to Help Pay My Plan Costs?	63
Do You Qualify For Extra Help?.....	63
How Do Costs Change When You Qualify For Extra Help?.....	63
What If You Believe You Have Qualified For Extra Help and You Believe That You Are Paying an Incorrect Copayment Amount?.....	63
Section 7 – Emergency and Urgently Needed Services	65
What is an Emergency Medical Condition?.....	65
What To Do in an Emergency.....	65
Post-Stabilization Care	66
When You Need Urgent Care and You Are Out of Your Service Area.....	67
When You Need Urgent Care and You Are In Your Service Area.....	67
Reimbursement for Services Paid by Member	68
Right to Appeal.....	68
Section 8 – Premiums and Payments.....	69
What Happens if You Do Not Pay Your Health Plan Premiums?.....	70
Your Premium Payment Options (if applicable).....	70
Changes in Health Plan Premiums	70
Section 9 – Optional Supplemental Plans (if applicable to your plan)	72
Adding Optional Supplemental benefits to your Plan	72
Enrolling in an Optional Supplemental Plan.....	72
Disenrolling from an Optional Supplemental Plan	72
Refund of Premium	72
Section 10 – What to do if You Have a Problem or Complaint (Coverage Decisions, Appeals, Complaints)	73
What to do if you have a problem or concern - Please call us first.....	73
You can get help from government organizations that are not connected with our plan.....	74
To deal with your problem, which process should you use? Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?.....	74
A guide to the basics of coverage decisions and appeals.....	74
Your medical care: How to ask for a coverage decision or make an appeal.....	76
Step-by-step how to ask for a coverage decision (how to ask our plan to provide the medical care coverage you want).....	77
Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan).....	79

Step-by-step: How to make a Level 2 Appeal.....	81
What if you are asking our plan to pay you for our share of a bill you have received for medical care?	83
How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.....	92
Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date	94
Step-by-Step: How to make a Level 2 Appeal to change your hospital discharge date.....	96
What if you miss the deadline for making your Level 1 Appeal to change your hospital discharge date?	97
How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon?	99
Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.....	100
Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.....	102
What if you miss the deadline for making your Level 1 Appeal to have our plan cover your care for a longer time?.....	103
Taking your Appeal to Level 3 and beyond (Levels of Appeal 3, 4 and 5).....	105
How to make a complaint about quality of care, waiting times, customer service, or other concerns	106
Step-by-step: Making a complaint (filing a grievance).....	108
You can also make complaints about quality of care to the Quality Improvement Organization.....	110
Section 11 – Disenrollment from the Plan	115
Voluntary Disenrollment.....	115
The Effective Date of Your Disenrollment	115
Moves or an Extended Absence from the Service Area.....	118
What happens if the Plan leaves the Medicare Program or leaves the Service Area where you live?	118
Coverage that ends during an inpatient Hospital Stay.....	119
Involuntary Disenrollment.....	119
We cannot Disenroll you due to your health.....	120
Section 12 – Coordinating Other Benefits You May Have	121
Who Pays First?.....	121
Section 13 – Advance Directives: Making Your Health Care Wishes Known	123
Section 14 – General Provisions	124
Notice about governing law	124
Notice about nondiscrimination	124
Your Financial Liability as a Plan Member	124
Member Liability.....	124
Third Party Liability and Subrogation	125
Reimbursement of Third Party Medical Expenses.....	126
Non Duplication of Benefits With Automobile, Accident or Liability Coverage	126

Acts Beyond Our Control	126
Contracting Medical Providers and Network Hospitals Are Independent Contractors.....	127
Our Contracting Arrangements.....	127
How Our Network Providers are Compensated.....	127
Technology Assessment	128
Section 15 - Notices	129
Member Statements	129
Information Upon Request	129
Internal Protection of Information within UnitedHealth Group.....	129
How You Can Fight Healthcare Fraud	129
Section 16 - The Geographic Service Area For Our Plan	131
Section 17 - HEALTH PLAN NOTICES OF PRIVACY PRACTICES.....	132

Welcome to the AARP® MedicareComplete® Retiree Plan (HMO) from SecureHorizons and the SecureHorizons® MedicareComplete® Retiree Plan (HMO)

This Evidence of Coverage, along with the Retiree Benefits Summary and Insert, contains the terms and conditions of coverage, and explains the rights and responsibilities you have as a Member of the Plan. These documents also explain our responsibilities to you. All applicants have a right to view these documents prior to enrollment, and this information should be read completely and carefully. Your Member contract for the Plan consists of this Evidence of Coverage, the Retiree Benefits Summary and Insert, Formulary (if applicable), Riders (including optional supplemental benefit brochures if applicable to your plan), your Enrollment Request Form and any current or future amendments.

This Evidence of Coverage and your Retiree Benefits Summary and Insert contain important information. These documents will be mailed to you annually and will replace all prior Evidence of Coverage and Retiree Benefits Summary and Insert documents. Please keep them in a safe place, available for quick reference. If you have special needs, this document may be available in other formats upon request.

How We Work With CMS

We have entered into a contract with the Centers for Medicare & Medicaid Services (CMS), the federal governmental agency that administers Medicare. The contract with CMS authorizes us to arrange for comprehensive health services and Prescription Drug Coverage for individuals who are entitled to Medicare benefits and who choose to enroll in the Plan. When you join the Plan, you usually do not pay Medicare deductibles and Coinsurance charges, but instead you may pay Health Plan Premiums (if applicable), Copayments and Coinsurance. The Plan covers all health services and supplies and/or drug coverage offered by Medicare, plus additional services not covered by Medicare. We are also licensed by the State Department of Insurance.

How the Contract With CMS Works

We have signed contracts with CMS agreeing to cover you for one calendar year (or plan year, if applicable) at a time. The Plan costs and benefits may change from year to year, and we will notify you before any changes are made. In general, your benefits will not change during the calendar year (or plan year, if applicable). (Your Plan Sponsor may modify your benefits mid-year during the calendar year (or plan year, if applicable), with written notice.) In addition, either CMS or we may choose not to renew all or a portion of the contract. If the contract is not renewed, your Medicare coverage will be switched to Original Medicare, unless you decide to choose another Medicare Advantage plan. If either CMS or we decide not to renew the contract at the end of the year, you will receive a letter at least ninety (90) days before the end of the contract. If CMS ends the contract in the middle of the year, you will receive a letter at least thirty (30) days before the end of the contract. In either situation, the letter will explain your options for health care and/or Medicare prescription drug coverage in your area and provide information about your right to obtain Medicare supplemental insurance coverage.

The Importance of Using Contracted Providers

By enrolling in the Plan, you have agreed to receive your health care services from Contracted Medical Providers and facilities. You are required to follow all plan rules outlined in this Evidence of Coverage, your Retiree Benefits Summary and Insert and other Plan documents.

If you need Emergency Services (anywhere in the world) or Urgently Needed Services (generally, outside the area served under the Plan), those services will be covered. However, **neither UnitedHealthcare nor Medicare will pay for services you receive from Non-Contracted Providers outside of this Service Area, except for Emergency Services, Urgently Needed Services and out-of-area renal dialysis or post-stabilization services.**

Call Us When You Need Information

In addition to arranging health care services and/or Medicare prescription drug coverage, we strive to provide the information you need about the Plan when you need it.

We have specially trained representatives who can answer your questions about:

- Covered Services
- Making address or telephone number changes
- Primary Care Physician selection and changes
- Enrollment or Disenrollment
- Appeal and Grievance complaint rights
- Medical and/or prescription drug coverage when you are traveling
- The quality of care you are receiving
- Certain information concerning your physician
- Claims
- Any other questions or concerns regarding the Plan

Our phone numbers are listed on the back cover for your easy reference.

Important Information

We will send you the Questionnaire for Beneficiaries with Medicare Prescription Drug Coverage (Part D) survey so that we can know what other health and/or drug coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional health and/or drug coverage, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health and/or prescription drug coverage, please call Customer Service to update your membership records.

Updating Your Enrollment Records

Your enrollment record contains information from your Enrollment Request Form, including your address and telephone number, as well as your specific benefit plan and/or Medicare prescription drug coverage, and Primary Care Physician you selected upon enrollment. These records are very important, because they identify you as an eligible Plan Member and determine where and if you are eligible to receive Covered Services.

Please report any changes in name, address or phone number to Customer Service immediately. You must also report any changes in health insurance coverage you have from

Questions? Call our Sales or Customer Service Departments listed on the back cover.

your employer or your spouse's employer. Additionally, you must report any liability claims (such as claims against another driver in an auto accident), eligibility under Workers' Compensation or Medicaid.

We Are Interested in Your Comments

Our goal is to arrange the Covered Services you need to stay as healthy and active as you can. We are interested in your comments. From time to time, we will ask for your thoughts on the Plan through voluntary Member satisfaction surveys. These surveys help us measure both the performance of our Plan Contracted Medical Providers, as well as our ability to assist you with your health care and/or Medicare prescription drug coverage concerns.

How to Submit a Claim

All Covered Services obtained from a Contracted Medical Provider will be billed directly to the plan. However, if you receive a bill for a Covered Service or Emergency Service you received from a Non-Contracted Medical Provider, please send the claim (keep a copy for your records) for determination of coverage to:

For Oregon:
UnitedHealthcare
Claims Department
P.O. Box 30974
Salt Lake City, UT 84130-0976

For Washington:
UnitedHealthcare
Claims Department
P.O. Box 30976
Salt Lake City, UT 84130-0976

You are responsible for paying any applicable Copayments or Coinsurance amounts directly to the Provider at the time of service. If you have any questions about any claims, please call Customer Service.

Section 1 – Health Care Terms

The following definitions apply to this Evidence of Coverage:

Acute Care – Treatment for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma or during recovery from surgery. Acute Care is usually received in a Hospital from specialized personnel using complex and sophisticated technical equipment and materials. This pattern of care is often necessary for a short time, unlike chronic care, where no significant improvement can be expected.

Ambulance Services – Those Covered Services provided within the United States, its territories and in certain border areas of Canada and Mexico according to Medicare coverage guidelines dispatched through calling 911 in an Emergency.

Appeal – The type of complaint you make when you want a reconsideration of a decision (determination) that was made regarding a service and/or prescription drugs or what we will pay for a service and/or prescription drugs. You may file an Appeal in the following instances:

- If we refuse to cover or pay for services and/or prescription drugs you think we should cover
- If we or one of the Contracted Medical Providers refuses to provide a service and/or prescription drugs you think should be covered
- If we or one of the Contracted Medical Providers reduces or cuts back on services and/or prescription drugs you have been receiving
- If you think that we are stopping your coverage too soon

Basic Benefits – All health care services that are covered under the Medicare Part A and Part B programs (except Hospice services, which are covered by Medicare), additional services that we use Medicare funds to cover, and other services for which you may be required to pay a Health Plan Premium (if applicable). All Members of the Plan receive all Basic Benefits.

Benefit Period – A Benefit Period is a way of measuring your use of services under Medicare Part A. A Benefit Period begins with the first day of a Medicare-covered inpatient Hospital or Skilled Nursing Facility Stay, and ends with the close of a period of sixty (60) consecutive days, during which you were neither an inpatient of a Hospital or of a Skilled Nursing Facility.

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

Catastrophic Coverage – The phase in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – Federal agency responsible for administering Medicare.

Coinsurance – The percentage of the cost a Member is required to pay for a Covered Service. Coinsurance is based upon Medicare Allowable Cost (MAC) or, for services not included in MAC, Coinsurance is based upon UnitedHealthcare's contractually negotiated rates.

Confinement and “Confined” – An uninterrupted stay following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on a Medicare Part A inpatient basis.

Contracted – Used to describe a provider of health services (such as a Physician, Hospital, Home Health Agency, pharmacy, Skilled Nursing Facility, Mental Health/Substance Abuse Designee, or Inpatient Rehabilitation Facility) that has entered into a written agreement with us to provide Covered Services to Members. The Contracted status of individual Physicians and other providers may change from time to time.

Contracted Medical Groups/Independent Physicians Associations (IPAs) –

Contracted Medical Groups – Physicians organized as a legal entity for the purpose of providing medical care. The Contracted Medical Group has an agreement with us to provide medical services to Members.

Independent Physicians Associations (IPAs) – Organizations or affiliated groups of physicians that deliver or arrange for the delivery of health services and function as Contracted Medical Groups, with physicians practicing out of their own independent medical offices.

Contracted Medical Provider – A health professional, a supplier of health items or a health care facility having an agreement with us or a Contracted Medical Group/IPA, to provide or coordinate medical services to Members. Contracted Medical Providers are independent contractors and are not the employees or agents of UnitedHealthcare.

Contracted Provider – A health professional or a supplier of health items (such as a dentist, optometrist or chiropractor) having an agreement with us to provide or coordinate Covered Services to Members. Contracted Medical Providers are independent contractors and are not the employees or agents of UnitedHealthcare.

Contracted Specialist – Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare), who has an agreement with us to provide health care services to Members for a specific disease, condition or body part.

Coordinated Care Plans – Medicare Advantage Plans that use a network of Providers, which are under contract or arrangement with a Medicare Advantage Organization or its Contracted Medical Groups/IPAs, to provide covered benefits. The Plan is a Coordinated Care Plan.

Copayment – The fee you pay at the time of medical services in accordance with your Plan.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs or services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs or services are covered; (2) any fixed “copayment” amounts that a plan may require be paid when specific drugs or services are received; or (3) any “coinsurance” amount that must be paid as a percentage of the total amount paid for a drug or service.

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

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

Covered Service(s) – Those health services, including services, supplies, or pharmaceutical products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Member, Physician, facility or any other person.
- Described in this Evidence of Coverage and the Retiree Benefits Summary and Insert.
- Not otherwise excluded in this Evidence of Coverage or in the Retiree Benefits Summary and Insert.

In applying the above definition, “scientific evidence” and “prevailing medical standards” shall have the following meanings:

- “Scientific evidence” means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- “Prevailing medical standards and clinical guidelines” means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Plan covers all services and supplies offered by Medicare, plus additional services and supplies not covered by Medicare.

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare’s prescription drug coverage.

Custodial Care – Services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, using the toilet, bathing, dressing, feeding, and preparation of special diets and supervision of the administration of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is not a Covered Service.

Customer Service – A department dedicated to answering your questions concerning (but not limited to) your membership, Covered Services, Grievances and Appeals.

Deductible – The amount you must pay for the health care services or drugs you receive before our Plan begins to pay its share of your covered services or drugs.

Designated Transplant Facility – A Hospital, named as such by us and certified by Medicare for transplant procedures, that has entered into an agreement with us or on our behalf under this Plan to provide medically appropriate health services for transplants that are Covered Services. A Designated Transplant Facility may or may not be located within the Service Area.

Disenroll or Disenrollment – The process of ending your membership in the Plan. Disenrollment may be voluntary or involuntary.

Durable Medical Equipment (DME) – Equipment that can withstand repeated use and is not disposable; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home (the definition of home as determined by Medicare coverage guidelines). To be covered, Durable Medical Equipment must be prescribed by a Contracted Medical Provider for use in your home, such as oxygen equipment, wheelchairs, hospital beds and other items that are determined to be covered in accordance with Medicare law, regulations and guidelines. Routine DME will not be covered when the Member has exhausted the one hundred (100) days Skilled Nursing Facility benefits and remains in an institution or distinct part of an institution meeting the basic requirements of a Hospital or Skilled Nursing Facility. The decision to rent or purchase a DME item is determined by your Primary Care Physician, Contracted Medical Provider or us.

Effective Date – The date your Plan coverage begins. You receive written notification of your Effective Date from us.

Eligible Expenses – Fees for Covered Services that are either: (a) for Contracted Physicians and other Contracted providers, the contracted rate or if none, the Medicare allowable charge; or (b) for non-Contracted Physicians and other non-Contracted providers, (i) for those who accept assignment, the lesser of the Medicare allowable charge or the Physician's or provider's billed charges, or (ii) for those who do not accept assignment, the lesser of the Medicare limiting charge or the Physician's or provider's billed charges. All Eligible Expenses must be for Covered Services under this Evidence of Coverage and incurred while this Evidence of Coverage is in effect.

Emergency Medical Condition – An Emergency Medical Condition is a medical condition recognizable by symptoms serious enough (including severe pain, serious injury) that a person with an average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in: 1) placing your health at serious risk 2) serious harm to bodily functions; 3) serious dysfunction of any bodily organ or part; 4) In the case of a pregnant woman, an Emergency Medical Condition exists if the pregnant woman is in Active Labor, meaning labor at a time in which either of the following would occur: a) there is not enough time to safely transfer the pregnant woman to another hospital before delivery; or b) a transfer may pose a threat to the health and safety of the pregnant woman or the unborn child.

Emergency Services – Covered Services that are 1) furnished by a Provider qualified to furnish Emergency Services and 2) needed to evaluate or stabilize a medical emergency. (See the definition of Emergency Medical Condition.)

Enrollment Request Form – The enrollment form a Medicare beneficiary or legal representative must complete (with your signature and date) in order to be enrolled as a Member of the Plan. This form is submitted to CMS for approval.

Evidence of Coverage – A document that explains Covered Services and defines your rights and responsibilities as a Member, and those of UnitedHealthcare.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Exclusion or Excluded – Items or services that are not covered under this Evidence of Coverage and the Retiree Benefits Summary and Insert. Benefit specific Exclusions are disclosed in the Retiree Benefits Summary and Insert. You are responsible for paying for excluded items or services.

Experimental and Investigational Services and Items – May include any procedure, study, test, drug, equipment or facility still undergoing study and for which there is not FDA and CMS approval. Any interpretation for specific cases must rely on and be consistent with Medicare Rules, Statutes, Federal Regulations, CMS Program Manuals, and other publications by CMS that are in place (including all CMS National Coverage Decisions) at the time the services are provided and that apply to the specific procedure, drug, or item requested.

Formulary – A list of covered drugs provided by the Plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance – A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 10 for more information about grievances.

Health Plan Premium – The monthly payment to UnitedHealthcare, *if applicable*, along with the Medicare Part B Premium and Medicare Part A Premium, paid to Medicare, *if applicable*, that entitle you to the Covered Services outlined in this Evidence of Coverage. Plans that offer Medicare Part D prescription drug coverage may also have a Medicare Part D Premium.

Home Health Agency – A Medicare-certified agency, which provides intermittent Skilled Nursing Care and other medically necessary therapeutic services in your home, when you are confined to your home, and when authorized by your Primary Care Physician or Contracted Medical Provider.

Hospice – An organization or agency certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital – A Medicare-certified institution licensed by the State, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “Hospital” does not include a convalescent nursing home, rest facility, or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Hospital Stay – A Hospital Stay commences on the first day of Covered Services in an Acute Care Hospital. A Hospital Stay ends when the Member is either discharged from the Hospital or transferred to another level of care, for example, home health care or Skilled Nursing Facility. If a Member subsequently transfers from an Acute Care Hospital to a Skilled Nursing Facility; a Skilled Nursing Facility to an Acute Care Hospital; or Home Health Agency to an acute or Skilled Nursing Facility, another applicable Copayment period begins.

Hospitalist – When you are admitted for a medically necessary procedure or treatment at a Network Hospital, your health care may be coordinated by a physician who specializes in treating inpatients (patients in a Hospital). This allows your Primary Care Physician or Contracted Medical Provider to continue to see other patients in his or her office, while you are hospitalized.

Independent Review Entity – An entity under contract with CMS which reviews Appeals by members of Medicare Advantage plans, including this Plan.

Initial Coverage Limit – The maximum limit of Medicare Part D coverage under the initial coverage period (if applicable to your plan).

Initial Coverage Period – This is the period before your total Medicare Part D drug expenses, have reached the Coverage Gap phase of your Medicare Part D prescription drug benefit (if applicable to your plan), including amounts you've paid and what our Plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

Lock-In Feature – An arrangement under which all Covered Services, with the exception of Emergency Services, Urgently Needed Services, out-of-area and routine travel renal dialysis or post-stabilization services, must be provided by your Contracted Medical Provider or your Primary Care Physician. If you receive services from a Non-Contracted Medical Provider or Facility, or a Contracted Medical Provider such as a Specialist, without approval from us or a Contracted Medical Provider (in accordance with the terms of this Evidence of Coverage), neither UnitedHealthcare nor Medicare will pay for that care. There are very limited exceptions to this rule.

Medicaid – A joint federal/State medical assistance program established by Title XIX of the Social Security Act. Some Medicare beneficiaries are also eligible for Medicaid. Unlike Medicare, Medicaid can cover long-term care, such as Custodial Care. Medicaid can cover all or part of your Medicare premiums and/or deductibles and Coinsurance, if your income and resources fall below specific levels. You may inquire about Medicaid and related programs – Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary, Qualified Disabled Working Individual and Qualified Individual – at your local Department of Human Service.

Medical Director – A licensed physician who is an employee of UnitedHealthcare and is responsible for monitoring and overseeing the quality of care to Plan Members.

Medically Necessary or Medical Necessity – A health intervention will be covered under the Plan if it is an otherwise Covered Service, not an Excluded service, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity. An intervention is Medically Necessary if, as recommended by the treating physician and determined by the Medical Director of UnitedHealthcare, it is all of the following:

- (a) A health intervention for the purpose of treating a medical condition;
- (b) The most appropriate supply or level of service, considering potential benefits and harms to the Member;
- (c) Known to be effective in treating the medical condition. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
- (d) If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner, which may be provided safely and effectively to the Member.

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

- (i) A **health intervention** is an item or service delivered or undertaken primarily to **treat** (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A **medical condition** is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined by the intervention itself, the medical condition and the patient indications for which it is being applied.
- (ii) **Effective** means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- (iii) **Scientific evidence** consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Such studies do not, by themselves, demonstrate a causal relationship, unless the magnitude of the effect observed exceeds anything that could be explained, either by the natural history of the medical condition, or potential experimental biases. For existing interventions, the scientific evidence should be considered first, and to the greatest extent possible, should be the basis for determination of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence, if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.
- (iv) A **new intervention** is one which is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (such as rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.
- (v) An intervention is considered **cost effective** if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition.

Medicare (Original Medicare) – The federal government health insurance program established by Title XVIII of the Social Security Act for people 65 years of age or older, certain younger people with disabilities and people with end-stage renal disease (ESRD).

Medicare Advantage Organization (MAO) – A public or private entity organized and licensed by the State as a risk-bearing entity that is certified by CMS as meeting Medicare Advantage requirements. MAOs can offer one or more Medicare Advantage Plans. PacifiCare of Oregon, Inc. and PacifiCare of Washington, Inc. is an MAO.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage (MA-PD Plan)**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply as discussed in Section 2).

“Medicare-Covered Physical Exam” – This exam includes measurement of height, weight and blood pressure, an electrocardiogram, education, counseling and referral with respect to covered screenings and preventive services. This exam does not include lab tests.

Medicare Part A – Hospital insurance benefits, including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

Medicare Part A Premium – Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. Generally, people age 65 and older may obtain premium-free Medicare Part A benefits based on their own or their spouse’s employment. If you are under 65, you may obtain premium-free Medicare Part A benefits if you have been a disabled beneficiary under Social Security or the Railroad Retirement Board **(1-800-808-0772, TTY, 1-312-751-4701)** for more than 24 months. If you do not qualify for premium-free Part A benefits, you may buy the coverage if you are at least 65 years old and meet certain requirements. Also, you may be able to buy Medicare Part A if you are disabled and lost your premium-free Part A because you are working. You may contact the Social Security Administration Office at **1-800-772-1213** toll free, (TTY the toll-free number **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday. You also may visit the Social Security Web site at www.ssa.gov.

Medicare Part B – Supplementary medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.

Medicare Part B Premium – A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Part B services. You must continue to pay this premium to Medicare to receive Covered Services, whether a Medicare Advantage Plan or Medicare covers you. If you are eligible for a Medicare Savings Program, the State may pay all or part of your Medicare Part B Premium.

Medicare Part D – A voluntary prescription drug benefit program approved by Medicare and offered to Medicare beneficiaries through Medicare Advantage Organizations, and through stand alone Prescription Drug Plans. Please refer to your Retiree Benefits Summary and Insert to determine your coverage.

Medicare Part D Premium – A monthly premium paid to Medicare Part D providers to cover Part D prescription drug coverage. Not all Medicare Advantage benefit plans that offer Medicare Part D prescription drug coverage have a Medicare Part D Premium. Not all of our plans have Medicare Part D prescription drug coverage. Please refer to your Retiree Benefits Summary and Insert to determine your coverage.

Medicare Savings Program – A program usually administered by Medicaid State agencies, which offers assistance to low income Medicare beneficiaries. This type of program includes Medicare beneficiaries who qualify as a Medicaid Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual.

Member – You, the Medicare-eligible retired employee, and your Medicare-eligible dependents who meet the eligibility requirements of your Plan Sponsor for enrollment in the Plan and whose enrollment has been confirmed by CMS, and thus is entitled to receive Covered Services.

Network – Providers, facilities and Hospitals contracted by UnitedHealthcare to deliver the Covered Services provided for in this Evidence of Coverage and the Retiree Benefits Summary and Insert.

Network Hospital – A Hospital that has a contract with UnitedHealthcare to provide services and supplies to Plan Members.

Network pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-Contracted Medical Provider or Facility – Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services, and who is neither employed, owned, operated by, nor under contract with UnitedHealthcare to deliver Covered Services to Plan Members.

Non-Contracted Specialist – Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare), who provides health care services for a specific disease, condition or body part, who is neither employed by nor under contract with UnitedHealthcare to deliver Covered Services to you. Also any duly licensed emergency room physician who provides Emergency Services to you.

Nurse Practitioner – A registered nurse who has graduated from a program which prepares registered nurses for advanced practice and who is certified as a nurse practitioner by the American Nursing Association.

Office Visit – A visit for Covered Services to your Primary Care Physician, Contracted Specialist, Nurse Practitioner, Physician’s Assistant, Psychologist, other Contracted Medical Provider, and with Prior Authorization a Non-Contracted Medical Provider.

Optional Supplemental Benefits (If applicable to your plan) – Your Plan Sponsor may have elected to offer (or endorse) these additional benefits. Refer to your Retiree Benefits Summary and Insert to determine your coverage. Non-Medicare covered benefits that may be offered beyond the benefits included in the basic Plan, which may be elected at a Member’s option. There is a Plan Premium associated with Optional Supplemental Benefits. Members of the Plan must voluntarily elect Optional Supplemental Benefits in order to receive them.

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare Plan – (“Traditional Medicare” or “Fee-for-service” Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Outpatient Mental Health Care – Covered Services include, but are not limited to, the following: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.

Outpatient Services – Ambulatory medical services received by a Member when the Member is not admitted to a Hospital or Skilled Nursing Facility.

Part C – See Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Physician Assistant – A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs (previously by the American Medical Association's Committee on Allied Health Education and Accreditation).

Plan Sponsor – Your former employer, union group or trust administrator.

Prescription Drug Plans – Medicare approved stand-alone drug plans that only cover Medicare Part D prescription drugs, not other benefits or services.

Primary Care Physician – The Contracted Medical Provider whom you choose and who is responsible for providing Covered Services while you are a Member of the Plan. Primary Care Physicians are generally physicians specializing in Internal Medicine, Family Practice or General Practice.

Prior Authorization – A system whereby a Provider must receive approval from us or your Contracted Medical Group/IPA before you, the Member, receive certain Covered Services. Among other services, all services rendered by Non-Contracted Medical Providers and Non-Contracted Specialists must have Prior Authorization, unless provided during an Emergency, or while you are temporarily out of the Service Area and need Urgent Care. Services requiring Prior Authorizations are listed in this Evidence of Coverage and in the Retiree Benefits Summary and Insert.

Prior authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Provider – Any professional person, organization, health facility, Hospital or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services.

Quality Improvement Organization (QIO) – An independent contractor paid by CMS to review medical necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. The QIO must review complaints about the quality of care given by physicians in inpatient Hospitals, outpatient Hospital facilities, Hospital emergency rooms, Skilled Nursing Facilities, Home Health Agencies, ambulatory surgical centers and Private Fee-for-Service plans.

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

Referral – A formal recommendation by your Primary Care Physician for you to receive care from a Specialist or Contracted Medical Provider.

Retiree Benefits Summary and Insert – The documents which provide the details of your particular benefit plan, including any Copayments and Coinsurance that you pay when receiving a Covered Service. In addition to your Evidence of Coverage document, the Retiree Benefits Summary and Insert explain your health care coverage.

Service Area – A geographic area approved by CMS within which a Medicare Advantage eligible individual may enroll in a particular Medicare Advantage Plan offered by us. Service Areas may contain different benefit plans that offer different benefits, Health Plan Premiums, Copayment and Coinsurance amounts.

Skilled Nursing Care – Medically Necessary services that can only be performed by, or under the supervision of, licensed nursing personnel.

Skilled Nursing Facility (SNF) – A facility that provides inpatient Skilled Nursing Care, rehabilitation services or other related health services, and is State licensed and/or certified by Medicare. The term “Skilled Nursing Facility” does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily Custodial Care, including training in routines of daily living.

Specialist – Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare), who provides health care services for a specific disease, condition or body part to whom you may be referred to by your Primary Care Physician or Contracted Medical Provider. Also, any duly licensed emergency room physician who provides Emergency Services to you. Specialists may be Contracted Specialists or Non-Contracted Specialists.

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

Time-Sensitive – A situation in which waiting for a standard decision on an authorization, request for services or an Appeal could seriously jeopardize your life, health, or your ability to recover from an illness, injury or condition.

UnitedHealthcare – Within this document, UnitedHealthcare refers to PacifiCare of Oregon, Inc. and PacifiCare of Washington, Inc. PacifiCare of Oregon, Inc. and PacifiCare of Washington, Inc. is a State corporation that is organized and licensed by the State as a risk-bearing entity and is certified by CMS as meeting Medicare Advantage requirements. PacifiCare of Oregon, Inc. and PacifiCare of Washington, Inc. is a Medicare Advantage Organization that insures the Plan. We, us and our, when used in this document, refer to PacifiCare of Oregon, Inc. and PacifiCare of Washington, Inc.

Urgently Needed Services – Covered Services provided when you are temporarily absent from the Plan Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area but your Contracted Medical Provider is temporarily unavailable or inaccessible), when such services are Medically Necessary and immediately required: 1) as a result of an unforeseen illness, injury or condition; and 2) it is not reasonable, given the circumstances, to obtain the services through your Contracted Medical Provider.

Utilization Review – A comprehensive, integrated process in which a team of health care professionals evaluates your treatment in an effort to promote the efficient use of resources and the quality of health care. Duties of the Utilization Review staff include Prior Authorization, concurrent and retrospective review of medical services.

Section 2 – Eligibility, Enrollment Periods and Effective Date

Are You Eligible to Enroll in the Plan?

To be able to enroll in the Plan:

You must be entitled to Medicare Part A and enrolled in Medicare Part B as of the Effective Date of your enrollment in the Plan.

1. You must meet the eligibility requirements of your former employer, union group or trust administrator (Plan Sponsor).
2. You must not currently have end-stage renal disease (ESRD) or receive routine kidney dialysis. However, if either of these conditions applies to you, in some instances, you may still be eligible to enroll through a Plan Sponsored Medicare Advantage (MA) health plan or as an individual. You may be newly eligible or able to continue your enrollment under the following circumstances:
 - Individuals with ESRD who age into Medicare can enroll in any Medicare Advantage plan sponsored by their Plan Sponsor regardless of prior commercial coverage affiliation (your health plan coverage prior to you becoming eligible for Medicare).
 - If a Plan Sponsor offers a Medicare Advantage plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, retirees with ESRD may select this new Medicare Advantage plan option as the Plan Sponsor's open enrollment rules allow. You should contact your Plan Sponsor to determine what their rules allow.
 - If a Plan Sponsor that has been offering a variety of coverage options consolidates its employee/retiree offerings (for example, it drops one or more plans), current enrollees of the dropped plans may be accepted into a Medicare Advantage plan that is offered by the group.
 - If a Plan Sponsor has contracted locally with a Medicare Advantage Organization (MAO) in more than one geographic area (for example, in two or more states), a retiree with ESRD who relocates permanently from one geographic location to another may remain with the Medicare Advantage Organization in the Plan Sponsor's local Medicare Advantage plan.
 - Individuals with ESRD who are affected by the contract termination, non-renewal or service area reduction of another Medicare Advantage Organization (MAO) may make one election to enroll in a Medicare Advantage plan offered by a different Medicare Advantage Organization during the appropriate election period.
 - Once enrolled in a Medicare Advantage plan, an individual with ESRD may elect other Medicare Advantage plans offered by the same Medicare Advantage Organization (within the same CMS contract) during an allowable election period. Standard Medicare Advantage eligibility rules apply.

Note: If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you **are not** considered to have ESRD and you **are** eligible to enroll in the Plan.

3. You must permanently reside in the Service Area, as defined in Section 16

4. You must complete and sign an Enrollment Request Form or make an election through your Plan Sponsor. If another person assists you in completing the Enrollment Request Form, that person must also sign the form and state his or her relationship to you.
5. You must agree to abide by the Plan rules.

If you meet the above eligibility requirements, you cannot be denied membership in the Plan on the basis of your health status, excluding end-stage renal disease as described above.

When You May Enroll in the Plan

Eligible individuals can enroll in the Plan at the following times:

- Open Enrollment – You may enroll in your Plan Sponsor’s group plan when that plan is in open enrollment. This time period is typically around the end of the calendar year but it can vary. For more information regarding your open enrollment period, please contact your Plan Sponsor.
- Special Election Period (SEP) - Special periods of time in which you can discontinue enrollment in a Medicare Advantage Plan, and change your enrollment to another Medicare Advantage Plan or return to Original Medicare. In the event of the following circumstances, a Special Election Period is warranted: the Medicare Advantage Plan in which you are enrolled is discontinued in the Service Area in which you live; you move out of the Service Area of the Medicare Advantage Plan; the Medicare Advantage Organization offering the plan violated a material provision of its contract with you; or you meet such other material conditions as CMS may provide.

*As a Member of this Plan, offered to you by your Plan Sponsor, the information below **does not** apply to you because you are allowed to make enrollment changes at times designated by your Plan Sponsor (see above). However, if you ever choose to discontinue your Plan Sponsored health care coverage, the information below (up to Medicare Part D Late Enrollment Penalty) will apply to you.*

In general, there are only certain times during the year when you can change the way you get your Medicare coverage. There are also Medicare program limits on how often you can make a change to your Medicare coverage and what types of changes you are allowed to make.

Note: Certain eligible Medicare beneficiaries such as those who are institutionalized, those who receive Medicaid, or those eligible for a Medicare Savings Program such as Medicaid Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual may enroll in an Individual Medicare Advantage plan at any time during the calendar year.

For Medicare beneficiaries who currently have Medicare coverage, the following dates are important:

From November 15 through December 31 each year, anyone with Medicare may change the way they get their Medicare coverage for an effective date of **January 1.**

Medicare beneficiaries who are enrolled in a Medicare Part D plan and who want to keep their Medicare Part D drug coverage have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage.

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in Prescription Drug Plan and return to Original Medicare coverage.
- You may leave your current Prescription Drug Plan and enroll in another Prescription Drug Plan in addition to Original Medicare.

Medicare beneficiaries who are enrolled in a Medicare Part D plan and who do **not** want to keep their Medicare Part D drug coverage have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in a “medical only” Medicare Advantage Plan without Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and return to Original Medicare.
- You may leave your current Prescription Drug Plan and continue with Original Medicare coverage.
- You may leave your current Prescription Drug Plan and enroll in a “medical only” Medicare Advantage Plan without Medicare Part D drug coverage.

Medicare beneficiaries who are not enrolled in a Medicare Part D plan and who want to enroll in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in a Prescription Drug Plan and return to Original Medicare coverage.
- You may enroll in a Prescription Drug Plan with Original Medicare coverage.
- You may leave Original Medicare and enroll in a Medicare Advantage Plan with Medicare Part D drug coverage.

From January 1 through March 31 each year, Medicare beneficiaries (including Members of one of our individual Medicare Advantage plans) have **one** chance to change the way they get their health care coverage. However, there are limits on when you may change benefit plans and the type of plan that you may join. **If you are not enrolled in a plan with Medicare Part D drug coverage, you may not use this time period to enroll in a plan with Medicare Part D drug coverage.**

Medicare beneficiaries who **are** enrolled in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in a Prescription Drug Plan and return to Original Medicare coverage.
- You may leave your current Prescription Drug Plan and enroll in a Medicare Advantage Plan with Medicare Part D drug coverage.

Medicare beneficiaries who are **not** enrolled in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in another Medicare Advantage Plan without Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and return to Original Medicare.
- If you currently have Original Medicare, you may enroll in a Medicare Advantage Plan without Medicare Part D drug coverage.

Generally, Medicare beneficiaries cannot make any other changes after March 31 each year unless they meet special exceptions, including but not limited to:

- the Medicare Advantage Plan in which the beneficiary is enrolled is discontinued in the Service Area in which the beneficiary lives.
- the beneficiary moves out of the Service Area of the Medicare Advantage Plan.
- the beneficiary meets such other material conditions as CMS may provide.
- the beneficiary has Medicaid coverage.
- the beneficiary receives assistance from a Medicare Savings Program.
- the beneficiary is in a long-term care facility such as a nursing home.

If you are a Medicare beneficiary who is newly eligible for Medicare coverage:

You may elect to enroll in a Medicare Advantage Plan when you first become entitled to both Part A and Part B of Medicare. Your enrollment period begins on the first day of the third month before the date on which you are entitled to both Part A and Part B, and ends on the last day of the third month after the date on which you become eligible for both Parts of Medicare. For example: if you are eligible for both Part A and Part B on September 1, you may enroll in the Plan as early as June 1, but not later than August 31, for a September 1 Effective Date.

Medicare Part D Late Enrollment Penalty

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your or your Plan Sponsor's monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. **However, if you qualify for extra help, you may not have to pay a penalty.**

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (the national base beneficiary premium amount varies each year and is published annually by the Centers for Medicare & Medicaid Services (CMS) in their "Medicare & You" handbook). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Customer Service to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

If you have a late enrollment penalty and you do not currently pay a monthly plan premium, call Customer Service for more information on your monthly plan premium payment options.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help

Creditable Coverage

As a Plan member, your Plan Sponsor will determine whether or not to offer you a Medicare Part D Prescription Drug Plan. Please refer to your Retiree Benefits Summary and Insert to determine your coverage. Medicare Part D prescription drug coverage is considered to be *Creditable Coverage*.

If your Plan Sponsor does not offer you Medicare Part D prescription drug coverage, but the prescription drug coverage you receive through your Plan Sponsor is at least as good as the standard Part D Medicare prescription drug coverage, it is considered to be *Creditable Coverage* and you will NOT incur a late enrollment penalty if you later decide to enroll in a standard Part D Medicare Prescription Drug Plan. Your plan administrator is responsible to notify you if your prescription drug coverage is or is not considered to be *Creditable Coverage*. If you have questions about your prescription drug coverage, please contact your Plan Sponsor.

If your prescription drug coverage is not considered to be *Creditable Coverage*, you will have to pay a penalty if you do not enroll in a Medicare Part D Drug Plan during your initial enrollment period and you do not have creditable coverage for a continuous period of 63 days or more after your initial enrollment period. See the *Medicare Part D Late Enrollment Penalty* section above for more information.

If you purchase a Medicare Part D Prescription Drug Plan on your own, it could result in the loss of your medical coverage provided through the Plan and could affect your Plan Sponsored health benefits. It is important to read the communications your Plan Sponsor (plan administrator) sends you, and consult with them before you take any action.

More detailed information about Medicare plans that offer prescription drug coverage is available in the “Medicare & You 2010” handbook. You’ll get a copy of the handbook in the mail from Medicare. You can also get more information about Medicare Prescription Drug Plan from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see the table later in this section for their telephone number)
- Call **1-800-MEDICARE (1-800-633-4227)**, (hearing impaired, **1-877-486-2048**), 24 hours a day, 7 days a week.

Your Enrollment Request Form

Once you complete and sign an Enrollment Request Form, or make an election through your Plan Sponsor, this information is submitted to CMS for verification of eligibility in the Plan. If CMS rejects your Enrollment Request Form or election through your Plan Sponsor, we will contact you for additional information or provide you with instructions for resubmitting the Enrollment Request Form or election through your Plan Sponsor.

When Your Plan Coverage Begins

The proposed Effective Date of enrollment in the Plan will be determined by your Plan Sponsor. We will send you a letter that informs you when your coverage begins. Generally, completed Enrollment Request Forms received by the end of the month will be effective the first day of the following month. For example, if we receive your completed Enrollment Request Form on January 31, your Effective Date is February 1. If we receive your completed Enrollment Request Form on February 28, your Effective Date is March 1.

From your Effective Date forward, you must receive all routine Covered Services from Contracted Medical Providers. Neither UnitedHealthcare nor Medicare will pay for services received from Non-Contracted Medical Providers, except for:

- Emergency Services anywhere in the world, unless listed as a limitation or exclusion in your Retiree Benefits Summary
- Urgently Needed Services that were not foreseeable when you left the Service Area
- Out-of-area renal dialysis services (must be received at a Medicare Certified Dialysis Facility within the United States)
- Covered Services approved by us or ordered by a Contracted Physician or other Contracted provider in accordance with the terms of this Evidence of Coverage

If you receive any medical services not covered by Medicare before your Plan coverage takes effect, you are financially responsible for those services.

Our Liability upon Your Initial Enrollment

We are responsible for the full scope of Part B services, as required by Medicare, beginning on your Effective Date. However, if your Effective Date occurs during an inpatient stay in a Hospital, we are not responsible for arranging or paying for any of the inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A). We must assume responsibility for arranging or paying for inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A) on the day following the day of discharge.

About Your Medicare Supplement (Medigap) Policy

After you receive written confirmation from us of your Effective Date, you may consider canceling any Medicare supplement (Medigap) policy you may have. If you currently have a Medigap policy with prescription drug coverage, you must inform your Medigap issuer you have enrolled in our plan. Medigap policies do not reimburse you for Health Plan Premiums, Copayments, or other amounts that Medicare Advantage Plans charge for Medicare-covered services. However, if you Disenroll from the Plan, you may **not** be able to have your Medigap policy reinstated and you **will not**, under any circumstances, be able to have your Medigap policy with prescription drugs reinstated.

Note: In certain cases, you may be guaranteed the issue (without medical underwriting or pre-existing condition exclusions) of a Medicare supplemental (Medigap) policy.

You must apply for a Medigap policy within sixty-three (63) days after your Plan coverage terminates and submit evidence of the date of your loss of coverage. For additional information regarding guaranteed Medicare supplemental policies, please call **1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048)**, 24 hours a day, 7 days a week.

Should you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed for services you receive from Non-Contracted Medical Providers. Most supplemental (Medigap) policies will not pay for any portion of such services because:

- Supplemental insurers (Medigap insurers) process their claims based on proof of an Original Medicare payment, usually in the form of an Explanation of Medicare Benefits (EOMB). However, as long as you are a Member of the Plan, Original Medicare will not process any claims for medical services that you receive.
- We have the financial responsibility for all Medicare-Covered Services you need as long as you follow Plan procedures on how to receive medical services.

Some states provide additional Medigap protections. For State specific information, please call Customer Service, your State's Department of Insurance or:

ALABAMA

Alabama Department of Senior Services
770 Washington Avenue Suite 470
Montgomery, AL 36104
1-800-243-5463
TTY 1-334-242-0995
<http://www.alabamaageline.gov/>

ARIZONA

Arizona State Health Insurance
Assistance Program
1789 W. Jefferson, Site Code 950A
Phoenix, AZ 85007
1-800-432-4040
TTY 1-602-542-6366
<https://www.azdes.gov/aaa/programs/ship>

ARKANSAS

State Health Insurance Information Program
1200 W. 3rd Street
Little Rock, AR 72201
1-800-224-6330
TTY 711
<http://insurance.arkansas.gov/seniors/homepage.htm>

CALIFORNIA

Health Insurance Counseling &
Advocacy Program
1300 National Drive, Suite 200
Sacramento, CA 95834
1-800-434-0222
TTY 1-800-735-2929
<http://www.aging.ca.gov/>

COLORADO

State Health Insurance Assistance Program,
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
1-888-696-7213
TTY 1-303-894-7880
<http://www.dora.state.co.us/insurance/senior/senior.htm>

CONNECTICUT

CHOICES
25 Sigourney Street, 10th Floor
Hartford, CT 06106
1-800-994-9422
TTY 1-800-842-4524
<http://www.ct.gov/agingservices/site/default.asp>

DELAWARE

ELDERINFO
841 Silver Lake Blvd.
Dover, DE 19904
1-800-336-9500
TTY 711
www.delawareinsurance.gov

DISTRICT OF COLUMBIA

Health Insurance Counseling Project (HICP)
2136 Pennsylvania Avenue NW
Washington, DC 20037
1-202-739-0668
TTY 1-202-973-1079
www.dcoa.dc.gov

FLORIDA

SHINE Program, Dept. of Elder Affairs
4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000
1-800-963-5337
TTY 1-800-955-8771
<http://www.floridashine.org/>

GEORGIA

Division of Aging Services
Two Peachtree Street, Suite 9385
Atlanta, GA 30303-3142
1-800-669-8387
TTY 1-404-657-1727
<http://aging.dhr.georgia.gov>

HAWAII

Sage PLUS
250 South Hotel Street, #406
Honolulu, HI 96813
1-888-875-9229
TTY 1-866-810-4379
<http://www4.hawaii.gov/ea/>

IDAHO

Senior Health Insurance Benefits Advisors (SHIBA)
700 West State Street
Boise, ID 83720-0043
1-800-247-4422
TTY 711
<http://www.doi.idaho.gov/shiba>

ILLINOIS

Senior Health Insurance Program Illinois
Division of Insurance
320 W. Washington, 4th Floor
Springfield, IL 62767-0001
1-800-548-9034
TTY 1-217-524-4872
http://www.idfpr.com/DOI/Ship/ship_help.asp

INDIANA

State Health Insurance Assistance Program
Indiana Department of Insurance
714 W. 53rd Street
Anderson, IN 46013
1-800-452-4800
TTY 711
<http://www.in.gov/idoi/2399.htm>

IOWA

Senior Health Insurance Information Program
330 Maple Street
Des Moines, IA 50319-0065
1-800-351-4664
TTY 1-800-735-2942
<http://www.shiip.state.ia.us/>

KANSAS

Senior Health Insurance Counseling for
Kansas (SHICK)
503 South Kansas Avenue New England
Building
Topeka, KS 66603-3404
1-800-860-5260
TTY 1-785-291-3167
<http://www.agingkansas.org/SHICK>

KENTUCKY

Kentucky State Health Insurance Assistance
Program
275 East Main Street 3W-F
Frankfort, KY 40621
1-877-293-7447
TTY 711
www.chfs.ky.gov/dail/ship

LOUISIANA

Senior Health Insurance Information Program
1702 N. 3rd Street
Baton Rouge, LA 70802
1-800-259-5301
TTY 711
<http://www.ldi.state.la.us/>

MAINE

Office of Elder Services
32 Blossom Lane
Augusta, ME 04333
1-800-262-2232
TTY 1-800-606-0215
<http://www.maine.gov/dhhs/oes/>

MARYLAND

Maryland Department of Aging
301 West Preston Street, Suite 1007
Baltimore, MD 21202
1-800-243-3425
TTY 1-410-767-1083
<http://www.mdoa.state.md.us/>

MASSACHUSETTS

Executive Office of Elder Affairs
One Ashburton Place, Room 517
Boston, MA 02108
1-800-243-4636
TTY 1-800-872-0166
<http://www.800ageinfo.com/>

MICHIGAN

Michigan Medicare/Medicaid
Assistance Program
6105 West St. Joseph Highway, Suite 204
Lansing, MI 48917-4850
1-800-803-7174
TTY 711
<http://www.mymmap.org>

MINNESOTA

Minnesota Board on Aging
540 Cedar Street
St. Paul, MN 55155
1-800-333-2433
TTY 1-800-627-3529
www.mnaging.org

MISSISSIPPI

Mississippi Division of Aging and Adult
Services
750 North State Street
Jackson, MS 39202
1-888-240-7539
TTY 711
www.mdhs.state.ms.us/aas_info.html

MISSOURI

Community Leaders Assisting the Insured
of MO (CLAIM), Missouri State Health
Insurance Program- Primaris
200 North Keene Street
Columbia, MO 65101
1-800-390-3330
TTY 1-800-735-2966
<http://missouriclaim.org/>

MONTANA

Montana Health Insurance
2030 11th Ave.
Helena, MT 59604-4210
1-800-551-3191
TTY 1-406-444-1421
www.dphhs.mt.gov

NEBRASKA

Nebraska Senior Health Insurance Program
(SHIP)
Terminal Building, 941 O Street, Suite 400
Lincoln, NE 68508-3639
1-800-234-7119
TTY 1-800-833-7352
www.doi.ne.gov/shiip/

NEVADA

Nevada State Health Insurance Assistance Program (SHIP)
 3100 W. Sahara Ave, Suite 110
 Las Vegas, NV 89102
 1-800-307-4444
 TTY 711
www.nvaging.net

NEW HAMPSHIRE

NH DHHS Division of Community Based Care Services Bureau of Elderly & Adult Services
 129 Pleasant Street
 Concord, NH 03301-3857
 1-866-634-9412
 TTY 1-800-735-2964
www.nh.gov/servicelink

NEW JERSEY

State Health Insurance Assistance Program (SHIP)
 P.O. Box 360
 Trenton, NJ 08625-0360
 1-800-792-8820
 TTY 711
<http://www.state.nj.us/health/senior/ship.shtml>

NEW MEXICO

NM Aging & Long Term Services Department, Benefits and Counseling Program
 2550 Cerrillos Road
 Santa Fe, NM 87505
 1-505-476-4799
 TTY 711
http://www.nmaging.state.nm.us/Benefits_Counseling_Bureau.html

NEW YORK

Health Insurance Information, Counseling and Assistance Program (HICAP)
 2 Empire State Plaza, Agency Bldg. #2, 4th Floor
 Albany, NY 12223-1251
 1-800-701-0501
 TTY 711
<http://www.hicap.state.ny.us/>

NORTH CAROLINA

Seniors Health Insurance Information Program (SHIIP)
 11 South Boylan
 Raleigh, NC 27603
 1-800-443-9354
 TTY 1-919-715-0319
<http://www.ncdoi.com/Consumer/SHIIP/SHIIP.asp>

NORTH DAKOTA

State Health Insurance Counseling Program
 600 East Boulevard, Dept 401
 Bismarck, ND 58505-0320
 1-800-247-0560
 TTY 1-800-366-6888
www.nd.gov/ndins

OHIO

Ohio Senior Health Insurance Information Program (OSHIIP)
 50 West Town Street
 Columbus, OH 43215-1067
 1-800-686-1578
 TTY 1-614-644-3745
<http://www.ohioinsurance.gov/>

OKLAHOMA

Senior Health Insurance Counseling Program (SHICP)
 2401 N.W. 23rd, Suite 28
 Oklahoma City, OK 73152
 1-800-763-2828
 TTY 711
<http://www.ohioinsurance.gov/>

OREGON

Senior Health Insurance Benefits Assistance (SHIBA)
 250 Church Street SE, Suite 200
 Salem, OR 97301-3921
 1-800-722-4134
 TTY 1-800-735-2900
<http://oregonshiba.org/>

PENNSYLVANIA

APPRISE (Health Insurance and Counseling)
 555 Walnut Street, Fifth Floor
 Harrisburg, PA 17101-1919
 1-800-783-7067
 TTY 1-717-782-2240
<http://www.aging.state.pa.us>

RHODE ISLAND

Department of Elderly Affairs
74 West Road, Second Floor
Cranston, RI 02920
1-401-462-3000
TTY 1-401-462-0740
<http://adrc.ohhs.ri.gov/>

SOUTH CAROLINA

Office on Aging
1301 Gervais Street Suite 200
Columbia, SC 29201
1-800-868-9095
TTY 711
<http://www.aging.sc.gov/>

SOUTH DAKOTA

Senior Health Information & Insurance
Education (SHIINE)
2300 W. 46th Street
Sioux Falls, SD 57105
1-800-536-8197
TTY 1-605-367-5760
www.shiine.net/

TENNESSEE

Tennessee State Health Insurance
Assistance Program (SHIP)
500 Deaderick Street, Suite 825
Nashville, TN 37243-0860
1-877-801-0044
TTY 1-615-532-3893
<http://tennessee.gov/comaging/ship.html>

TEXAS

Health Information, Counseling and Advocacy
Program (HICAP)
P.O. Box 149030, Mail Code: W350
Austin, TX 78714-9030
1-800-252-9240
TTY 1-800-735-2989
<http://www.dads.state.tx.us/>

UTAH

Health Insurance Information Program (HIIP)
120 North 200 West, Room 325
Salt Lake City, UT 84103
1-800-541-7735
TTY 711
[http://www.hsdaas.utah.gov/insurance_ programs.htm](http://www.hsdaas.utah.gov/insurance_programs.htm)

VERMONT

State Health Insurance and Assistance
Program (SHIP)
30 Washington Street
Barre, VT 05641
1-802-748-5182
TTY 711
www.medicarehelpvt.net

VIRGINIA

Virginia Insurance Counseling and Assistance
Program (VICAP)
1610 Forest Avenue, Suite 100
Richmond, VA 23229-5009
1-800-552-3402
TTY 1-800-552-3402
<http://www.vda.virginia.gov/>

WASHINGTON

Statewide Health Insurance Benefits Advisors
of Washington (SHIBA)
P.O. Box 40256
Olympia, WA 98504-0256
1-800-562-6900
TTY 1-360-586-0241
<http://www.insurance.wa.gov/shiba>

WEST VIRGINIA

Bureau of Senior Services of West Virginia
3003 Charleston Town Center Mall
Charleston, WV 25301
1-877-987-4463
TTY 711
www.wvship.org

WISCONSIN

Wisconsin State Health Insurance Assistance
Program (SHIP)
One West Wilson Street
Madison, WI 53703-2118
1-800-242-1060
TTY 1-608-267-7371
<http://www.dhfs.state.wi.us/aging/SHIP.htm>

WYOMING

Wyoming State Health Insurance Information
Program (WSHIIP)
106 W. Adams, PO Box BD
Riverton, WY 82501
1-800-856-4398
TTY 711
www.wyomingseniors.com

Questions? Call our Sales or Customer Service Departments listed on the back cover.

Section 3 – Member Rights and Responsibilities

Introduction to your rights and responsibilities:

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness:

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Customer Service. Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at **1-800-368-1019** or **TTY/TDD 1-800-537-7697**, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information:

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service.

Your right to see network providers, and get covered services, and get your prescriptions filled within a reasonable period of time:

As explained in this booklet, you will get most or all of your care from network providers, that is, from doctors and other health providers who are part of our Plan. As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. Call Customer Service to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, the chapter titled: "What to do if you have a problem or complaint" of this booklet tells what you can do.

Your right to know your treatment options and participate with practitioners in making decisions about your health care:

We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. You have the right to know your treatment options and participate in decisions about your health care. You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination. Organization determinations and coverage determinations are discussed in Section 10.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney):

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they 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* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with your State Department of Health.

Your right to get information about our Plan:

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Customer Service.

Your right to get information in other formats:

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

Your right to get information about our network pharmacies and/or providers:

You have the right to get information from us about our network pharmacies, providers and their qualifications and how we pay our doctors. To get this information, call Customer Service.

Your right to get information about your prescription drugs, Part C medical care or services, and costs:

You have the right to an explanation from us about any prescription drugs or Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve a **prescription drug or Part C medical care or service**, and how you can file an appeal to ask us to change this decision. See Section 10 for more information about filing an appeal. You also have the right to this explanation even if you obtain the **prescription drug or Part C medical care or service** from a pharmacy and/or provider not affiliated with our organization. **You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to your plan. Please review our formulary on our Web site at www.UHCRetiree.com / www.AARPMedicareComplete.com or call us at one of the phone numbers listed on the back cover.**

Your right to voice complaints or appeals about the organization or the care it provides:

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See Section 10 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Customer Service.

How to get more information about your rights:

If you have questions or concerns about your rights and protections, you can

1. Call Customer Service at the number on the back cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP).
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day, 7 days a week.

What can you do if you think you have been treated unfairly or your rights are not being respected?

You have a right to make recommendations regarding the organization's member rights and responsibilities policy. If you think you have been treated unfairly or your rights have not been respected, you may call Customer Service at the phone number on the back cover or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at **1-800-368-1019** or **TTY/TDD 1-800-537-7697**, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP. For details about this organization and how to contact it, turn to Section 2 of this booklet.

Your responsibilities as a member of our Plan include the following:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Customer Service if you have questions.
- Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care or prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the health or drug benefits that are available to you.
- **You are required to tell our Plan if you have additional health insurance or drug coverage. Call Customer Service.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your Member ID card to the provider.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your practitioner.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor’s office, hospitals, and other offices.
- Paying your plan premiums (if applicable) and coinsurance or copayment for your covered services. You must pay for services that aren’t covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, suggestions or any recommendations regarding members rights and responsibilities policy. If you do, please call Customer Service.

Section 4 – How Your Coverage Works

Your Member ID Card

Your Member ID card provides information to assist you in receiving all your Plan Covered Services and/or prescription drug coverage at network pharmacies. In nearly all instances, you will need to present your Member ID card to your Contracted Medical Provider and/or pharmacist to verify your coverage and obtain Covered Services or drugs.

Carry your Member ID card with you at all times. Although you never need to discard your Medicare card, **you must now use your Member ID card to receive Covered Services** and/or prescription drugs.

It is important for you to use only your Member ID card – **NOT** your Medicare card – for these reasons:

1. To prevent you from receiving medical services or drugs from Non-Contracted Medical Providers or out-of-network pharmacies in error.
2. In the case of a Medical Emergency, to alert Hospital staff of the need to notify your Primary Care Physician or us as soon as possible so that we are involved in the management of your care.
3. To prevent errors in billing. We pay the bills on behalf of Medicare. Medicare will not pay the bills while you are a Member of the Plan.

If you lose your Member ID card or change your address, please call Customer Service.

How the Lock-In Feature Works for You and UnitedHealthcare

As a Plan Member, all your medical benefits (except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and post-stabilization services) are provided or arranged by your Primary Care Physician, a personal physician you choose from the plan's list of Contracted Medical Providers. The day you become a Member of the Plan (your Effective Date), you are **Locked-In** to your Primary Care Physician, who will provide and coordinate all of your routine health care services. Although the Plan Provider Directory lists many Contracted Providers, once you are Locked-In, you must receive a Referral from your Primary Care Physician or Contracted Medical Group/IPA to receive services from other Plan Contracted Providers.

You may change your Primary Care Physician by calling Customer Service. (See Section 5 for information on how to change your Primary Care Physician.)

Neither UnitedHealthcare nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a Referral is required, but was not obtained from your Primary Care Physician or Contracted Medical Group/IPA, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and post-stabilization services, or when you have approval from us or when ordered by a Contracted Physician or other Contracted provider in accordance with the terms of this Evidence of Coverage.

The Lock-In feature is an important part of our contract with CMS, the governmental agency that oversees Medicare. Using the Lock-In feature, we are able to offer Medicare beneficiaries our Plan, with additional benefits that Original Medicare does not offer. Under the CMS contract, the federal government agrees to pay us a fixed monthly dollar amount for each Member. We use the monthly amount received from the federal government to contract with physicians, Hospitals and other health care Providers to arrange care for you.

Questions? Call our Sales or Customer Service Departments listed on the back cover.

Section 5 – Working with Your Contracted Medical Providers

Your Primary Care Physician

As a Member of the Plan, you must select a Primary Care Physician upon enrollment. Your relationship with your Primary Care Physician is an important one because your Primary Care Physician is responsible for the coordination of your health care and can refer you to a Contracted Specialist when necessary.

If you need assistance in choosing your Primary Care Physician, please refer to the Provider Directory for a listing of Primary Care Physicians. For a copy of the most recent Provider Directory, or to seek additional assistance, please call us at one of the phone numbers listed on the back cover, or you may consult the online Provider Directory at www.UHCRetiree.com / www.AARPMedicareComplete.com.

To promote a smooth transition of your health care when you first join the Plan, please inform us if you are currently seeing a Specialist, receiving Home Health Agency services or using Durable Medical Equipment. Please call Customer Service so that we may assist you with the transfer of care or equipment.

Once you have chosen your Primary Care Physician, we recommend that you have all your medical records transferred to his or her office. This will provide your Primary Care Physician with access to your medical history, and make him or her aware of any existing health conditions you may have.

Always ask to see your Primary Care Physician when you make an appointment. Your Primary Care Physician is now responsible for all your routine health care services, so he or she should be the first one you call with any health concerns. **When you select a Primary Care Physician, it is important to remember that this limits you to the panel of Specialists** who are affiliated with your Contracted Medical Group/IPA or Network.

Physician-Patient Relationship

You are responsible for selecting a Primary Care Physician. The physician-patient relationship shall be maintained by you and your Primary Care Physician. We are not a health care provider.

We do not prohibit or otherwise restrict a Provider, acting within the lawful scope of practice, from advising, or advocating on your behalf about:

1. Your health status, medical care or treatment options.
2. The risk, benefits, and consequences of treatment or non-treatment.
3. The opportunity for you to refuse treatment and to express preferences about future treatment decisions.

Changing your Primary Care Physician

If you want to change your Primary Care Physician within your Contracted Medical Group/IPA, you must call Customer Service. If the Primary Care Physician is accepting additional Plan Members, the change will become effective on the first day of the following month. You will receive a new Member ID card that shows this change.

Although we will not deny your request, for continuity of care reasons, it is recommended that you postpone a request to change your Primary Care Physician or Contracted Medical Group/IPA if you are an inpatient in a Hospital, a Skilled Nursing Facility or other medical institution at the time of your request.

If you change your Primary Care Physician to one who is in a different Contracted Medical Group/IPA or Network, any Referrals to Specialists or Referrals for Covered Services that you previously received may no longer be valid. In this situation, you will need to ask your new Primary Care Physician for a new Referral, which may require further evaluation. In some cases, the request for a new Referral will need to have Prior Authorization from your Contracted Medical Group/IPA or us.

Since your Primary Care Physician is responsible for the coordination of all of your health care needs, it is important that you notify him or her if you wish to continue to receive services or Specialist care from a Provider who is affiliated with your previous Primary Care Physician or Contracted Medical Group/IPA or Network.

If you think that you need to continue to receive ongoing services or Specialist care from the prior Contracted Medical Group/IPA or Network, then for continuity of care reasons, you should discuss this with your Primary Care Physician prior to the determination to transfer to a different Primary Care Physician or Contracted Medical Group/IPA or Network.

If you continue to receive services or Specialist care without a new Referral from your new Primary Care Physician, you may be financially responsible for the cost of those services. In certain circumstances, we may authorize continued care.

Continuity of care when you change your Contracted Medical Group/IPA or Network

To promote a smooth transition of your health care when you change your Contracted Medical Group/IPA or Network, please let us know if you are currently seeing a Specialist, receiving Home Health Agency services, or using Durable Medical Equipment. It is important that you contact Customer Service, who will assist you in transferring your care and/or equipment.

If your Primary Care Physician changes to a different Contracted Medical Group/IPA or Network

Sometimes a Primary Care Physician will change to a different Contracted Medical Group/IPA or Network. If you choose to continue care with the Primary Care Physician and change your Contracted Medical Group/IPA or Network, you may need to ask him or her for new Referrals to Specialists for Covered Services, which may require further evaluation. In some cases, this request for a new Referral will need to have Prior Authorization from your Contracted Medical Group/IPA or us.

Because your Primary Care Physician is affiliated with a different group of Specialists, if you think that you need to continue to receive ongoing services or Specialist care from the prior Contracted Medical Group/IPA or Network, then for continuity of care reasons, you should discuss this with your Primary Care Physician. A new authorization may be needed for continued care from the prior Specialist.

If you continue to receive services or Specialist care without a new Referral from your new Primary Care Physician, you may be financially responsible for the cost of those services. In certain circumstances, we may authorize continued care.

Please see the heading "Continuity of Care for Members with Terminating Physicians" on a following page of this section for more information.

It is important to remember that your Primary Care Physician selection determines the network of Specialists who are affiliated with your Primary Care Physician's Contracted Medical Group/IPA or Network.

Provider Terminations

It is our policy to give each affected Member timely and consistent notice when his or her Primary Care Physician or Specialist no longer contracts with us or a Contracted Medical Group/IPA. It is our goal to make a good faith effort to notify you within thirty (30) days of the termination of your Primary Care Physician. We will make the same effort to notify you when a Specialist is terminated, and you may be affected. If you choose, we will assist you in selecting a new Primary Care Physician or Contracted Specialist.

We will make a good faith effort to inform you of your right to maintain your treatment with the Specialist through other avenues which may include joining another Coordinated Care Plan or returning to Medicare.

How to Schedule an Appointment with Your Primary Care Physician

To schedule an appointment, call your Primary Care Physician's office. There are no special rules to follow. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner. If you have difficulty obtaining an appointment with your Primary Care Physician, please call Customer Service.

The telephone numbers for your Primary Care Physician and/or Contracted Medical Group/IPA or Network are listed on your Member ID card. If you are unable to keep a scheduled appointment, please call your Primary Care Physician twenty-four (24) hours in advance.

How to Receive Care After Hours

If you need to talk to or see your Primary Care Physician after the office has closed for the day, call your Primary Care Physician's office. When the physician on call returns your call, he or she will advise you on how to proceed. See Section 7, Emergency and Urgently Needed Services, for what to do in case of an emergency.

How to Receive Covered Services from a Specialist

Even though your Primary Care Physician is trained to handle the majority of common health care needs, there may be a time when he or she feels you need more specialized treatment. In that case, you may receive a Referral to an appropriate Specialist. In some cases, the request for a Referral will need to have Prior Authorization from us or your Contracted Medical Group/IPA. When you select a Primary Care Physician it is important to remember this limits you to the network of Specialists who are affiliated with your Primary Care Physician's Contracted Medical Group/IPA or Network.

Neither UnitedHealthcare nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a Referral is required, but was not obtained from your Primary Care Physician or Contracted Medical Group/IPA or us, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and post-stabilization services, or when you have a Prior Authorization and/or a Referral to a Non-Contracted Provider.

Please refer to the Provider Directory for a listing of Plan Specialists available through your Network. For a copy of the most recent Provider Directory, or to seek additional assistance, please call us at one of the phone numbers listed on the back cover, or you may consult the online Provider directory at www.UHCRetiree.com / www.AARPMedicareComplete.com.

Standing Referrals to Specialists

You may receive a standing Referral to a Specialist, if your Primary Care Physician determines, in consultation with the Specialist, your Contracted Medical Group/IPA's Medical Director or one of our Medical Directors that you need continuing care from a Specialist. A "standing Referral" means a Referral by your Primary Care Physician for more than one visit to a Specialist as indicated in the treatment plan without requiring the Primary Care Physician to provide a specific Referral for each visit. The standing Referral will be made according to a treatment plan approved by your Contracted Medical Group/IPA or one of our Medical Directors, in consultation with your Primary Care Physician, the Specialist, and you, if you have a complex or serious medical condition or a treatment plan is otherwise considered necessary. The treatment plan may limit the number of your visits to the Specialist or may limit the period of time your visits are authorized. The Specialist will provide your Primary Care Physician with regular reports on the health care provided to you. You may request a standing Referral from your Primary Care Physician or a Specialist.

Extended Referral for Coordination of Care by a Specialist

If you have a life-threatening, degenerative, or disabling condition or disease which requires specialized medical care over a prolonged period of time, you may receive a Referral to a Specialist or specialty care center with expertise in treating the condition or disease, for the purpose of having the Specialist coordinate your health care with your Primary Care Physician. To receive an "extended specialty Referral", your Primary Care Physician must determine, in consultation with the Specialist or specialty care center and your Contracted Medical Group/IPA's Medical Director or one of our Medical Directors, that this extended specialized medical care is Medically Necessary. The extended specialty Referral will be made according to a treatment plan approved by your Contracted Medical Group/IPA's Medical Director or one of our Medical Directors, in consultation with your Primary Care Physician, the Specialist and you. After the extended specialty Referral is made, the Specialist will serve as the main coordinator of your care, subject to the approved treatment plan. You may request an extended specialty Referral by asking your Primary Care Physician or Specialist.

Please refer to your Retiree Benefits Summary and Insert to determine which services require Prior Authorization/Precertification.

Access to OB/GYN Physician Services and Women's Routine and Preventive Health Care Services

You may self-refer to an obstetrical and gynecological (OB/GYN) Specialist within your Contracted Medical Group/IPA or Network for an annual routine Pap test, pelvic exam and breast exam. You may receive these Covered Services without Prior Authorization or a Referral from your Primary Care Physician. In all cases, however, you must receive Covered Services from an obstetrical and gynecological (OB/GYN) Specialist within your Contracted Medical Group/IPA or Network.

If you visit an OB/GYN or family practice Specialist not affiliated with your Contracted Medical Group/IPA or Network and **without Prior Authorization or a Referral, you will be**

financially responsible for these services. Any OB/GYN inpatient or Hospital services, except Emergency or Urgently Needed Services, must be Prior Authorized by your Contracted Medical Group/IPA or Primary Care Physician or us.

To receive OB/GYN Specialist services:

- Select an OB/GYN Specialist within your Contracted Medical Group/IPA or Network. You may select an OB/GYN Specialist from the on-line Provider Directory at www.UHCRetiree.com / www.AARPMedicareComplete.com, or call us at one of the phone numbers listed on the back cover for assistance in selecting an OB/GYN within your Contracted Medical Group/IPA or Network. You may also obtain OB/GYN Covered Services from your Primary Care Physician.
- Call and schedule an appointment with your selected OB/GYN or Primary Care Physician, if applicable.

Monitoring Services for Anticoagulation Medications

Physician services, including doctor's office visits, for monitoring services if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as 'Coumadin Clinic' services) are Covered Services according to Medicare coverage guidelines when Medically Necessary. You may pay a copayment or coinsurance for services obtained from a primary care physician or for services obtained from a specialist. Copayment or coinsurance amounts are listed under **Physician Services** in your Retiree Benefits Summary Insert. See **Outpatient Hospital Services** in the Retiree Benefits Summary Insert for any applicable copayments or coinsurance amounts for Medically Necessary services obtained in an outpatient hospital setting.

Continuity of Care for Members with Terminating Physicians

In the event your Contracted Medical Provider is terminated by us or your Contracted Medical Group/IPA for reasons other than a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from your physician following the termination, providing the terminated physician agrees to the terms and conditions of the contract. Continued care from the terminated physician may be provided for up to ninety (90) days, or a longer period if Medically Necessary, for chronic serious or acute conditions or through the post-partum period for pregnancy related conditions or until your care may safely be transferred to another physician. This does not apply to physicians who have voluntarily terminated their contract with us or a Contracted Medical Group/IPA.

If you are receiving treatment for:

- an acute condition (such as open surgical wounds or recent heart attack)
- serious chronic condition (such as chemotherapy or radiation therapy)
- a high-risk pregnancy (such as multiple babies, where there is a high likelihood of complications)
- pregnancy in the second or third trimester

and your physician is terminated, you may request to continue receiving treatment from the terminated physician beyond the termination date by calling Customer Service.

Your Contracted Medical Group/IPA's Medical Director or one of our Medical Directors in consultation with your terminated physician will determine the best way to manage your ongoing care. **In order for you to continue to receive treatment from the terminated physician, we must provide Prior Authorization of services for continued care.** If you have any questions, or would like a copy of our Continuity of Care Policy, or would like to appeal a denial of your request for continuation of services from your terminated physician, call Customer Service.

Access to Your Medical Records and Files

You have the right to access your medical records and files. We must provide timely access to your records and any information that pertains to them. Please contact your Contracted Medical Provider directly for a copy of your medical records. Except as authorized by federal and State laws, we must obtain written permission from you or your authorized representative before medical records may be made available to any person not directly concerned with your care, or responsible for making payments for the cost of such care.

Utilization Review

UnitedHealthcare and its Contracted Medical Groups/IPAs uses processes to review, approve, modify, delay or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members. This process of Utilization Review (or medical management) is a way to make sure that Members receive the right care, at the right place, by the right Provider.

UnitedHealthcare and its Contracted Medical Groups/IPAs may also use Utilization Review criteria or guidelines to determine whether to approve, modify, delay or deny, based on Medical Necessity, requests by Providers of health care services for Members. The criteria used as the basis of a decision to modify, delay or deny requested health care services in a specific case under review, will be disclosed to the Provider and the Member in that specific case. The criteria or guidelines used to determine whether to authorize, modify, delay or deny health care services are available to the public upon request, limited to the criteria or guidelines for the specific procedure or condition requested.

Decisions to modify, delay or deny requests for authorization of health care services for a Member, based on Medical Necessity, are made only by licensed physicians.

UnitedHealthcare and its Contracted Medical Groups/IPAs make these decisions at least within the timeframes required by federal law or regulation. Please see Section 10 of this Evidence of Coverage for specific information regarding the timeframes by which we must make a determination (decision) on your request for payment or the provision of health care services.

If you have general questions regarding Utilization Review and/or would like a copy of our policies and procedures (a description of the processes utilized for authorization, modification, delay or denial of health care services), or our criteria or guidelines, please call Customer Service. If you have specific questions regarding your case, Customer Service will direct you to the appropriate representative who can address issues of approvals or denials of care.

Practitioners and Utilization Review

Utilization Review decision-making is based only on appropriateness of care, service and existence of coverage. While we do compensate practitioners or other individuals conducting utilization review, we do not provide additional compensation to practitioners or other individuals specifically for denying the coverage or services. Financial incentives for Utilization Review decision-makers do not encourage denials of coverage or service.

Second Medical Opinions

You may ask your Primary Care Physician for an authorization for a Second Medical Opinion regarding the advisability of a particular surgery, major non-surgical procedure or therapeutic procedure. Your request will be evaluated by the Contracted Medical Group/IPA or Network (or one of our Medical Directors) based on Medical Necessity. In some instances, such as when you receive conflicting First and Second Medical Opinions, you may request an authorization for a Third Medical Opinion from your Primary Care Physician. All decisions regarding Second Medical Opinions will be made within the following time limits: emergency procedures within twenty-four (24) hours; urgent procedures within seventy-two (72) hours and elective procedures within fourteen (14) calendar days.

Second Medical Opinions can only be made by a physician qualified to review the Member's medical condition in question. Referrals to Non-Contracted Medical Providers or Facilities will be approved only when the services requested are not available within the network of Contracted Medical Providers available through your benefit plan. If the Provider giving the Second Medical Opinion recommends a particular treatment, we are not obligated to cover the recommended treatment unless the treatment is determined by us to be Medically Necessary and a Covered Service. If we determine the diagnostic test or service is Medically Necessary and a Covered Service, we or your Contracted Medical Group/IPA may then arrange the treatment, the diagnostic test or service. If you are denied a Second Medical Opinion, you may appeal the denial by following the procedures outlined in Section 9, the Appeals Process.

We have approved procedures to identify, assess and establish treatment plans (including direct access visits to Specialists) for Members with complex or serious medical conditions. In addition, we will maintain procedures to make sure that Members are informed of health care needs which require follow-up, and receive training in self-care and other measures to promote their own health.

Prior Authorization

Prior Authorization is required for a number of elective treatments, surgeries and drug therapies. The Prior Authorization process is used to make sure the requested procedure is a Covered Service and is necessary and appropriate for the Member's medical situation. The Member's Contracted Medical Group/IPA or our medical personnel evaluate whether or not the Member meets specific predetermined medical criteria, and either approve or deny the requested treatment based upon the assessment. While we or the Member's Contracted Medical Group/IPA, may determine the specific requested treatment is not necessary, and a more appropriate therapy is available, the Member may choose to privately pay for the requested treatment. As a Member, you have the right to file an Expedited Appeal or a Standard Appeal when a Prior Authorization is denied. For further information on how to file an Appeal, please refer to Section 10, Organization Determination, Appeal and Grievance Procedures. Decisions to deny coverage because a treatment is not Medically Necessary are made only by licensed physicians.

If you change your Primary Care Physician to one who is affiliated with a different Contracted Medical Group/IPA or Network, any Prior Authorizations for Covered Services that you received from your previous Contracted Medical Group/IPA or Network, may no longer be valid. In this situation, you will need to ask your new Primary Care Physician for assistance in receiving a new Prior Authorization from us for the requested procedure.

Neither UnitedHealthcare nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a Referral is required, but was not obtained from your Primary Care Physician or Contracted Medical Group/IPA,

except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis, post-stabilization services, or when you have a Prior Authorization and/or a Referral to a Non-Contracted Provider.

Hospitalization

If your Primary Care Physician or Specialist determines you require hospitalization, Outpatient Services, Home Health Agency Care or Skilled Nursing Care, he or she will arrange these Covered Services for you.

Coverage for Acute Care (referred to in the Member materials as "inpatient hospital benefits") consists of Medically Necessary inpatient Hospital services authorized by your Contracted Medical Group/IPA or by us, including Hospital room, intensive care, definitive observation, isolation, operating room, recovery room, labor and delivery room, laboratory, diagnostic and therapeutic radiology, nuclear medicine, pharmacy, inhalation therapy, dialysis, EKG, EEG, EMG, blood and blood plasma, anesthesia supplies, surgically implanted devices and post mastectomy implanted breast prosthesis, nursing services, professional charges by the Hospital pathologist or radiologist, coordinated discharge planning and other miscellaneous Hospital charges for Medically Necessary care and treatment.

Coverage for Acute Care and subacute care includes Medically Necessary inpatient services authorized by your Contracted Medical Provider provided in an Acute Care Hospital, a comprehensive, free-standing acute rehabilitation facility or a specially designed unit within a Skilled Nursing Facility.

With the exception of Emergency or Urgently Needed Services, you will only be admitted to those Hospitals, Acute Care and Skilled Nursing Facilities that are Prior Authorized by your Contracted Medical Group/IPA or Contracted Medical Provider and under contract with us. If you are Hospitalized as the result of a Medical Emergency Condition, it is important that you notify your Primary Care Physician or us within forty-eight (48) hours or as soon as reasonably possible, so your Primary Care Physician or we may be involved in the management of your health care. Please contact your Primary Care Physician or us at the number located on your Member ID card (See Section 7 for more information on emergency Hospital admissions.)

You may call Customer Service to request a copy of our Utilization Review and Prior Authorization processes that apply to care provided in subacute care, transitional inpatient care and Skilled Nursing Facilities.

One of our Medical Directors or designee determines the Hospital or Outpatient Services facility designated by us for elective services. We reserve the right to decline to pay for care for members stable for transfer unless the member is transferred to another facility based upon factors that may include Contracted Medical Provider Hospital privileges, capabilities of the Hospital and outcomes.

Please note: We will not pay federal Hospitals, such as Veteran's Administration (VA) Hospitals, for Emergency and non-emergency items and services furnished to veterans, retired military personnel or eligible dependents. However, we will reimburse Members who are veterans, retired military personnel or eligible dependents for any Copayments or Coinsurance paid to the VA Hospitals for Emergency Services, up to the amount of the Plan Emergency Services Copayment. For Members who are not eligible for VA benefits, we will cover emergency, urgent and post-stabilization care provided by a VA facility; these services are considered out-of-network.

Please refer to the Retiree Benefits Summary and Insert for further details.

Hospital Copayments, Coinsurance and Benefit Periods

Depending upon your benefit plan, Inpatient Hospital care Copayments or Coinsurance for each Hospital Stay are charged on either: 1) a per admission basis, or 2) a daily basis for a specified number of days. Once you are discharged from a Hospital, any subsequent Hospital admissions, even for the same medical condition at the same Hospital, will require a Hospital Copayment or Coinsurance. In certain circumstances, you may be discharged from a Hospital and transferred to a Skilled Nursing Care unit or transitional care unit within the same Hospital. If you are later re-admitted to the Hospital from the Skilled Nursing Care unit or transitional care unit, you will pay the Hospital Copayment or Coinsurance. **Original Medicare Hospital Benefit Periods do not apply.** For inpatient Hospital care, you are covered for an unlimited number of days, as long as the Hospital Stay is Medically Necessary and authorized by us or Contracted Medical Providers.

Hospitalist

When you are admitted to a Hospital, a Hospitalist may coordinate your inpatient care. Hospitalists are physicians who are specially trained to care for patients who are acutely ill in the Hospital, and are responsible for coordinating all aspects of your Hospital care. They remain in the Hospital and are available to react should your condition change. This allows your Primary Care Physician or Contracted Medical Provider to continue to see other patients in his or her office while you are Hospitalized. Hospitalists collect and manage all information related to your condition and treatment, and communicate with you, your family and your Primary Care Physician or Contracted Medical Provider throughout your Hospital Stay. Hospitalists work together with your Primary Care Physician or Contracted Medical Provider during the course of your stay and to transition your care upon discharge. Upon discharge, your Primary Care Physician will again assume coordination of your care.

Skilled Nursing Facility (SNF) Care

The Plan covers Medically Necessary inpatient Skilled Nursing Care and services in a Medicare-certified Skilled Nursing Facility under contract with us. Skilled Nursing Care is covered if the Member requires Skilled Nursing Care services or skilled rehabilitation services on a daily basis, and these skilled services can be provided only on an inpatient basis in a Skilled Nursing Facility. Inpatient stays solely to provide Custodial Care are not covered. Members may not self-refer to a Skilled Nursing Facility.

In certain circumstances, Members may be able to receive Skilled Nursing Care from a Skilled Nursing Facility that is not under contract with us. Generally, Members must use Skilled Nursing Facilities contracted with us. However, if certain conditions are met, we may be able to arrange for a Member to receive Skilled Nursing Care from one of the following facilities ("Home Skilled Nursing Facility"): a nursing home or continuing care retirement community where the Member was living prior to the Hospital admission (as long as the facility provides Skilled Nursing Care) or in a Skilled Nursing Facility where the Member's spouse resides at the time of the Member's Hospital discharge. In order to access these services, the Skilled Nursing Facility that is not under contract with us must be willing to accept our rates for payment.

Prosthetic Devices, Orthotic Appliances and Durable Medical Equipment and Supplies

Prosthetic devices, orthotic appliances and Durable Medical Equipment (and supplies) are Covered Services according to Medicare coverage guidelines when Medically Necessary. Prosthetic devices aid body functioning or replace a limb or body part. Orthotic appliances

are worn or used to correct a defect of body form or function. This includes therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts according to Medicare coverage guidelines.

Repair or replacement of such devices or equipment is covered only when the present device or equipment no longer fulfills its intended function due to: (a) loss, irreparable damage, or excessive wear, except when loss, damage, or excessive wear is due to your fault; or (b) a significant change in your condition. If more than one type of device or equipment can meet your functional needs, only the most cost-effective device or equipment is a Covered Service. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are covered when necessary to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device.

Ambulance

The Plan covers Medically Necessary ambulance services for Emergency or Urgently Needed Services, or when authorized by us or our designee, according to Medicare guidelines. Ambulance services will be provided to the nearest facility with the ability to treat your medical condition. Covered services include ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home.

The Plan will **not cover** ambulance services that are:

1. Member-initiated for social or convenience reasons, not primarily medical in nature, including, but not limited to changing to a different Contracted Medical Group/IPA, moving to be closer to family, and transferring from one nursing facility to another, while an inpatient in an acute, psychiatric or nursing facility.
2. From a Contracted facility to another Contracted facility, unless the transfer is necessary to deliver medical services authorized by us but not available at the first facility.
3. Air Ambulance services for return to the United States from another country.

Home Health Agency Care Services

If your Primary Care Physician or Specialist determines that you require Home Health Agency care, he or she will arrange these Covered Services for you. In order to qualify for home health benefits, a Member must be confined to his or her home, be under a plan of treatment reviewed and approved by a physician, and require a Medically Necessary qualifying skilled service.

Covered Home Health Agency services for those who **qualify** may include: part-time or intermittent skilled nursing and home health aide services, physical and occupational therapy and speech-language pathology services, medical social services, medical supplies and Durable Medical Equipment (such as wheelchairs, hospital beds, oxygen and walkers).

When you qualify for coverage of Home Health Agency services, the Plan covers both part-time or intermittent skilled nursing and home health aide services in accordance with Medicare guidelines. Part-time or intermittent means any number of days per week up to twenty-eight (28) hours per week of skilled nursing and home health aide services combined for less than eight (8) hours per day, based upon the reasonable need for such care. The Plan may cover, subject to review on a case-by-case basis depending on the need for such care, thirty-five (35) or fewer hours per week of skilled nursing and home health aide services combined for less than eight (8) hours per day.

A homebound Member has restricted ability, due to an illness or injury, to leave home without assistance of another person or aid of a supportive device (such as crutches, a cane, a wheelchair or a walker) or if leaving the home is contraindicated. You do not have to be bedridden in order to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home, and consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by the State, or to attend religious services. Home Health Agency services do not include the costs of housekeepers, food service arrangements or full-time nursing care at home.

Hospice

Hospice care provides palliative services. Generally, it is based on the philosophy that everyone has the right to spend his or her remaining days in peace and with dignity. Hospice focuses on comfort, dignity and pain control, responding to the symptoms, needs and goals of patients and families. Hospice is dedicated to helping the terminally ill live each day to the fullest throughout the dying process, and supporting them to be with their family and friends in a home setting if they wish.

“The original Medicare benefit includes:

- Physician and nursing services;
- Drugs, including outpatient prescription drugs for pain relief and symptom management;
- Physical therapy, occupational therapy, and speech therapy; medical social services and counseling to the Medicare beneficiary and family members; and
- Short-term inpatient care, including respite care; that is, a short inpatient stay for the person with the terminal illness, which is intended to give temporary relief (up to 5 days in a row) to the person who regularly assists with home care and other services not otherwise covered by Medicare and home care.”

Hospice care is not a Covered Service. However, we will cover one (1) Hospice evaluation for Members who have not yet chosen Hospice care to determine if Hospice care is an appropriate health care option.

In order to access Hospice care, Members must elect Hospice care under Medicare. Upon making this election, all care related to the terminal illness will be provided by the Medicare-certified Hospice, which is billed directly to Medicare. You may remain enrolled in the Plan even if you elect Medicare-certified Hospice coverage for your terminal condition. We will continue to arrange coverage of non-Medicare-covered benefits, to which you are entitled under your Plan, such as routine vision coverage, routine physical exams, and any Optional Supplemental Benefits to which you may be entitled. Any other Medicare-covered services that are not related to the terminal illness will also be billed to Medicare.

As a Plan Member, you have the right to obtain information about all available Medicare-certified Hospice Providers. For more information regarding electing Hospice care, including those Hospice facilities that have an agreement with your Contracted Medical Group/IPA or us, please call Customer Service.

Clinical Trials

A “clinical trial” is a method of testing new types of medical care and treatment. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. **Medical care provided as a part of a clinical trial is not a Covered Service.** Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs such as room and board for a Hospital Stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial. If you participate in a qualifying clinical trial, you will have to pay Original Medicare Coinsurance for the services you receive. For example, you will be responsible for Part B Coinsurance, usually 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no Coinsurance for Medicare-covered clinical laboratory services related to the clinical trial.

When you enroll in a clinical trial, the Providers are paid directly by Medicare for all services you receive that are covered by Medicare. The clinical trial Providers do not have to be Contracted Medical Providers.

You do not need to obtain a Referral or Prior Authorization to join a clinical trial, however, you should inform us before you begin a clinical trial. This allows us to continue to keep track of your health care services. You may remain enrolled in the Plan, even if you do elect to participate in a clinical trial. Your care unrelated to the clinical trial must continue to be arranged by us.

In 2010 CMS will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to Medicare Advantage Plan Members.

The Medicare program has written a booklet about “Medicare and Clinical Trials”. To receive a free copy, call **1-800-MEDICARE (1-800-633-4227) (TTY, 1-877-486-2048)**, 24 hours a day, 7 days a week, or visit www.medicare.gov on the Web.

Religious Non-medical Health Care Institutions (RNHCIs) Care

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by us under certain conditions. Covered Services in a RNHCI are limited to non-religious aspects of care. To be eligible for Covered Services in a RNHCI, you must have a medical condition that would allow you to receive inpatient Hospital care or extended care services, or care through a Home Health Agency. You may get services when furnished in the home, but only items and services ordinarily furnished by Home Health Agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of “non-excepted” medical treatment. (“Excepted” medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, State or local law. “Non-excepted” medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from us, or your stay in the RNHCI may not be covered.

Organ Transplants

Organ Transplant Definitions

- **Donor:** A person who undergoes a surgical procedure for the purpose of donating either a body organ or body tissue for transplant procedures.

- **Histocompatibility Testing:** Testing that involves matching or typing of the human leukocyte antigen in preparation for organ or tissue transplant.
- **UnitedHealthcare United Resource Network facility:** A network of transplant facilities that are: licensed in the State in which they operate, certified by Medicare as a transplant facility for a specific organ transplant, and satisfy our quality of care standards, to be designated by us as a transplant facility for a specific organ program. UnitedHealthcare United Resource Network Facilities may be located outside the Service Area based on a number of factors including quality, cost, and outcomes.
- **Regional Organ Procurement Agency:** An organization designated by the federal government and responsible for the procurement of organs for transplantation and the promotion of organ donation.

Transplant Services

Human organ and tissue transplants are limited to non-experimental/non-investigational procedures that are determined to be Medically Necessary. Coverage is provided for the medical, surgical and Hospital services required for pre-transplant, transplant and post-transplant. All transplant procedures must be performed by approved UnitedHealthcare United Resource Network Facilities. Examples of covered transplant services include:

- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Simultaneous pancreas/kidney transplants
- Pancreas transplant after kidney transplant
- Intestinal and multivisceral transplants
- Cornea transplants (not part of United Resource Network Program)
- Allogeneic bone marrow or stem cell transplant
- Autologous bone marrow or stem cell transplant

We shall intermittently review new developments in medical technology based on scientific evidence to determine if the list of covered transplants should be revised.

Heart transplants including Ventricular Assist Devices (as both “a bridge to transplant,” and for “destination therapy”) are only covered when the procedure is performed at a UnitedHealthcare United Resource Network Facility or other UnitedHealthcare authorized transplant facilities when determined medically necessary by the UnitedHealthcare United Resource Network Medical Director or designee.

Bone Marrow and Stem Cell Transplants: The testing of immediate blood relatives to determine compatibility of bone marrow and stem cells is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry are covered when the Member is the intended

recipient. An approved UnitedHealthcare United Resource Network facility must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor related clinical transplant services once a donor is identified.

Transportation provided for the Member and one person escort to a facility, if the facility is greater than sixty (60) miles from the Member's primary residence, or out-of-state, regardless of mileage, as Prior Authorized. Food and housing will be provided for the Member and one escort and is limited to \$125 per day (excludes liquor and tobacco).

1. Organ Procurement, Transplant and Transplant Services

Coverage of services shall include:

- Pre-transplant testing and evaluation, including histocompatibility testing of transplant recipient and non-related or related donor.
- Organ procurement from cadaver or live donor and organ transportation. Covered Services for living donor are limited to Medically Necessary services once a donor is identified.
- Oral or dental examination performed on an inpatient basis as part of comprehensive evaluation work-up prior to transplant procedure.
- When the transplant recipient is a Plan Member, reasonable and necessary Hospital services of the donor solely for the transplant procedure are covered (the donor does not need to be a Plan Member).
- Services and/or charges related to a national donor search.
- Outpatient, post-transplant, immunosuppressive drug therapy (Please see your Retiree Benefits Summary and Insert.)
- Reasonable transportation and lodging for the transplant recipient and one person escort determined by transplant facility and/or UnitedHealthcare. Transportation and non-clinical expenses of the living donor are excluded from coverage and are the responsibility of the Member, who is the recipient of the transplant.

2. Prior Authorization

Coverage for transplant services must be authorized by us prior to the transplant evaluation and prior to listing and services must be performed at a UnitedHealthcare United Resource Network designated facility, which may be located outside the Service Area based on a number of factors including quality, cost and outcomes. New Members, already listed at a non-UnitedHealthcare United Resource Network facility, will be evaluated for continuity of care. UnitedHealthcare requires thirty (30) days to obtain and review relevant clinical information. Transplant benefits are available only where a facility designated by us is utilized and the Member is a recipient of the transplant.

Note: We evaluate each transplant case to determine the appropriate transplant facility for each Member. We will select a transplant facility within the United Resource Network based on the medical needs of the Member in consultation with the Member's treating physician and our Transplant Medical Director. Notwithstanding the foregoing, we reserve the right to utilize alternative transplant facilities as authorized by UnitedHealthcare.

3. Continuity and Coordination of Care

UnitedHealthcare United Resource Network will continually work closely with the Member, the Member's family, the Member's treating physicians and facilities to monitor the continuity and coordination of services during the pre-transplant evaluation, transplant

hospitalization and post-transplant follow-up care. This includes, but is not limited to, reviewing requests from Primary Care Physicians/treating physician for transplant services, facilitating placement on the UnitedHealthcare United Resource Network waiting lists and coordinating post-transplant services.

Following a determination by UnitedHealthcare United Resource Network and the facility that a Member is a candidate for a transplant, the Member will be placed on the transplant waiting list of the UnitedHealthcare United Resource Network facility. For Members who receive transplant services from a UnitedHealthcare United Resource Network facility outside of the Service Area, UnitedHealthcare will work closely with the Member, the UnitedHealthcare United Resource Network facility and the Member's Primary Care Physician/treating physician to coordinate travel to the UnitedHealthcare United Resource Network facility, as appropriate, and at no expense to the Member.

Following transplant and the stabilization of the Member, UnitedHealthcare United Resource Network will coordinate post-transplant services between the UnitedHealthcare United Resource Network Facility and the Member's Primary Care Physician/treating physician. Depending on the UnitedHealthcare United Resource Network facility, the Member may receive post-transplant services locally, or the Member may be required to travel outside of the Service Area. If the Member is required to travel outside the Service Area, UnitedHealthcare will coordinate travel, as appropriate, at no expense to the Member.

4. Continuity of Care

Listing of the Member at a second UnitedHealthcare United Resource Network facility is excluded, unless the Regional Organ Procurement Agencies are different for the two facilities and the Member is accepted for listing by both facilities, when associated with continuity of care. If the Member is dual listed, his or her coverage is limited to the actual transplant facility. UnitedHealthcare will collaborate with the Member to determine to which transplant facility he or she should be referred. Duplicated diagnostic costs at a second UnitedHealthcare United Resource Network facility, when the Member has already been evaluated at a UnitedHealthcare United Resource Network facility, will be determined on a case-by-case basis when associated with continuity of care, hardship or when Medically Necessary as defined by UnitedHealthcare transplant policy.

The following services and items are excluded from coverage under the UnitedHealthcare United Resource Network transplant program:

- Unauthorized or not Prior Authorized organ procurement and transplant related services.
- Transplants performed in a non-UnitedHealthcare United Resource Network facility.
- Transplant services, including donor costs, when the transplant recipient is not a Member.
- Artificial or non-human organs.
- Transportation services for any day a Member is not receiving Medically Necessary transplant services.
- Transportation of any potential donor for typing and matching.
- Food and housing costs for any day a Member is not receiving Medically Necessary transplant services.
- Storage costs for any organ or bone marrow, unless authorized by the UnitedHealthcare Transplant Medical Director.

– Services for which government funding or other insurance coverage is available

How To Access Your Behavioral Health Benefit

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

Section 6 – How You Get Prescription Drugs

What Do You Pay For Covered Drugs?

The amount you pay for Covered Drugs is listed in your Retiree Benefits Summary Insert.

If You Have Medicare And Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

What Drugs Are Covered By This Plan?

What Is a Formulary?

A Formulary is a list of the drugs that we cover. We will generally cover the drugs listed in our Formulary as long as the drug is Medically Necessary, the prescription is filled at a Network Pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under “Utilization Management.”

The drugs on the Formulary are selected by our Plan with the help of a team of health care providers. Both Brand-Name Drugs and Generic Drugs are included on the Formulary. A Generic Drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the Brand-Name Drug. Generally, Generic Drugs cost less than Brand-Name Drugs.

Not all drugs are covered by our Plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See your Retiree Benefits Summary Insert for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our Formulary.

In certain situations, prescriptions filled at an Out-of-Network Pharmacy may also be covered. See information later in this section about filling a prescription at an Out-of-Network Pharmacy.

How Do You Find Out What Drugs Are on the Formulary?

Each year, we send you an updated Formulary so you can find out what drugs are on our Formulary. You can get updated information about the drugs our Plan covers by visiting our Web site at www.UHCRetiree.com/www.AARPMedicareComplete.com, or you may call us to find out if your drug is on the Formulary or to request an updated copy of our Formulary at one of the phone numbers listed on the back cover.

What Are Drug Tiers?

Drugs on our Formulary are organized into different drug tiers, or groups of different drug types. Your Coinsurance or Copayment depends on which drug tier your drug is in.

You may ask us to make an Exception (which is a type of Coverage Determination) to your drug's tier placement. See Section 10 to learn more about how to request an Exception.

Can the Formulary Change?

We may make certain changes to our Formulary during the year. Changes in the Formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of Formulary changes we may make include:

- Adding or removing drugs from the Formulary
- Adding Prior Authorizations, Quantity Limits, and/or Step-Therapy restrictions on a drug
- Moving a drug to a higher or lower Cost-Sharing tier

If we remove drugs from the Formulary, or add Prior Authorizations, Quantity Limits and/or Step Therapy restrictions on a drug or move a drug to a higher Cost-Sharing tier and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of Cost-Sharing for the remainder of the Plan year. However, if a Brand Name Drug is replaced with a new Generic Drug, or our Formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60 day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an Exception. (If a drug is removed from our Formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the Formulary. Instead, we will remove the drug immediately and notify Members taking the drug about the change as soon as possible.)

What if Your Drug Isn't on the Formulary?

If your prescription isn't listed on your copy of our Formulary, you should first check the Formulary on our Web site at www.UHCRetiree.com/www.AARPMedicareComplete.com which we update at least monthly (if there is a change). In addition, you may contact us at one of the phone numbers listed on the back cover to be sure it isn't covered. If we confirm that we don't cover your drug, you have two options:

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact us or go to our Formulary on our Web site.
2. You or your doctor may ask us to make an Exception (a type of Coverage Determination) to cover your drug. If you pay out-of-pocket for the drug and request an Exception that we approve, the Plan will reimburse you. If the Exception isn't approved, you may appeal the Plan's denial. See Section 10 for more information on how to request an Exception or Appeal.

In some cases, we will contact you if you are taking a drug that isn't on our Formulary. We can give you the names of Covered Drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it isn't on our Formulary.

Transition Policy

New Members in our Plan may be taking drugs that aren't on our Formulary or that are subject to certain restrictions, such as Prior Authorization or Step Therapy. Current Members may also be affected by changes in our Formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a Formulary Exception in order to get coverage for the drug. See Section 10 under "What is an exception?" to learn more about how to request an Exception. Please contact us if your drug is not on our Formulary, is subject to certain restrictions, such as Prior Authorization or Step Therapy, or will no longer be on our Formulary next year and you need help switching to a different drug that we cover or requesting a Formulary Exception.

During the period of time Members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those Members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current Member affected by a Formulary change from one year to the next, we will provide you with the opportunity to request a Formulary Exception in advance for the following year.

When a Member goes to a Network Pharmacy and we provide a temporary supply of a drug that isn't on our Formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 31-day supply (unless the prescription is written for fewer days). After we cover the temporary 31-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an Exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new Member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new Member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our Formulary or is subject to other restrictions, such as Step Therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new Member pursues a Formulary Exception.

Members who are discharged from an inpatient hospital or who are admitted to or discharged from a long-term care facility and who are prescribed a non-formulary medication must use the Plan's Exceptions process to continue coverage of the non-formulary drug.

If a new Member or current Member is stabilized on a medication that belongs to one of the special classes listed below, the Plan will not require the Member to transition to a Formulary alternative.

- Cancer Chemotherapy medications
- Anti-depressants
- Anti-psychotics
- Anti-seizure medications
- Immunosuppressants
- HIV/AIDS medications

A new Member or current Member, who is stabilized on a non-formulary medication that does not belong to one of the drug classes listed above, will be referred to his/her physician to discuss alternative drug therapy.

As necessary, a one-time supply of medication of up to 31 days will be provided to allow the Member time to discuss alternative drug therapy with his/her physician and/or to complete the non-formulary exceptions process.

The Member or Member's physician may initiate an Exceptions request for coverage of the non-formulary drug.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a Network Pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access. See your Retiree Benefits Summary Insert for information about non-Part D drugs.

Drug Management Programs

Utilization Management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our Members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our Members. Please consult your copy of our Formulary or the Formulary on our Web site at www.UHCRetiree.com/www.AARPMedicareComplete.com for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get Prior Authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we don't get the necessary information to satisfy the Prior Authorization, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 18 tablets every 31 days for a Formulary drug.

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a Generic version of a Brand-Name Drug available, our Network Pharmacies may recommend and/or provide you the Generic version, unless your doctor has told us that you must take the Brand-Name Drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the Formulary or on our Web site at www.UHCRetiree.com/www.AARPMedicareComplete.com, or by calling us at one of the phone numbers listed on the back cover. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for Medical Necessity reasons, you or your physician may request an Exception (which is a type of Coverage Determination). See Section 10 for more information about how to request an Exception.

Drug Utilization Review

We conduct drug utilization reviews for all of our Members to make sure that they are getting safe and appropriate care. These reviews are especially important for Members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication Therapy Management Programs

We offer medication therapy management programs at no additional cost to Members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our Members. For example, these programs help us make sure that our Members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact Members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How Does Your Enrollment in This Plan Affect Coverage For the Drugs Covered Under Medicare Part A or Part B?

We cover drugs under both Parts A and B of Medicare, as well as Part D. The Part D coverage we offer doesn't affect Medicare coverage for drugs that would normally be covered under Medicare Part A or Part B. Depending on where you may receive your drugs, for example in the doctor's office versus from a Network Pharmacy, there may be a difference in your Cost-Sharing for those drugs. You may contact our Plan about different costs associated with drugs available in different settings and situations.

Using Network Pharmacies to Get Your Prescription Drugs

With few exceptions, which are noted later in this section under “How do you fill prescriptions outside the network?”, **you must use Network Pharmacies to get your prescription drugs covered.** A Network Pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term “Covered Drugs” means all of the outpatient prescription drugs that are covered by our Plan. Covered Drugs are listed in our Formulary.

In most cases, your prescriptions are covered only if they are filled at one of our Network Pharmacies. You aren't required to always go to the same pharmacy to fill your prescription; you may go to any of our Network Pharmacies. However, if you switch to a different Network Pharmacy than the one you have previously used, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a Network Pharmacy in your area, please review your Pharmacy Directory. You can also visit our Web site at www.UHCRetiree.com / www.AARPMedicareComplete.com or call us at one of the phone numbers listed on the back cover.

What if a Pharmacy is no Longer a Network Pharmacy?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan Network Pharmacy. Please refer to your Pharmacy Directory or call us to find another Network Pharmacy in your area.

How Do You Fill a Prescription at a Network Pharmacy?

To fill your prescription, you must show your Member ID card at one of our Network Pharmacies. If you don't have your Member ID card with you when you fill your prescription, you may have the pharmacy call Prescription Solutions Help Desk to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your Coinsurance or Copayment) you may ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called “How do you submit a paper claim?”

Our Plan's Network Mail-Order-Pharmacy Service

When you order prescription drugs through our network mail-order-pharmacy service, you may order up to a 90-day supply of the drug.

Generally, it takes the mail-order pharmacy 7 days to process your order and ship it to you. However, sometimes your mail-order may be delayed. If you do run out of your prescription drug, you should ask your doctor for a new prescription for a one-month supply. Have this prescription filled at any Network Pharmacy and have the pharmacy call Prescription Solutions Help Desk for an override.

To get order forms and information about filling your prescriptions by mail, using our network mail-order-pharmacy service, follow the instructions below.

How To Fill a Prescription Through Our Network Mail-Order-Pharmacy Service

You may fill a prescription through our network mail-order-pharmacy service by mailing in a mail service pharmacy order form with your new prescription(s) or by calling Prescription Solutions at the number below to request a new prescription from your doctor. Additionally, your doctor may telephone prescriptions directly to a Prescription Solutions pharmacist.

– By telephone

1. Call Prescription Solutions to speak to one of our Prescription Solutions representatives at **1-877-889-6358 (TTY 1-800-498-5428)**, 24 hours a day, 7 days a week. When you speak to the Prescription Solutions representative, please have the name and telephone number of your doctor available, along with your specific drug information, such as the name(s) and strength(s) of the prescription drug(s) you are taking.
2. The Prescription Solutions representative will ask for your preferred method of payment – by check, money order or credit card.
3. Prescription Solutions will then call your doctor and request your prescription.
4. Processing time for these requests depends on the response time from your doctor. You can check on the status of the order by calling Prescription Solutions at the number listed below.

– Using the mail service pharmacy order form

1. Contact your doctor's office to request a 90-day prescription for each drug you need. Have your doctor write a prescription for a 90-day supply, including three additional 90-day refills. If you are trying a new drug for the first time, you may want to ask your doctor for two prescriptions; one that can be filled for a 31-day supply at a retail Network Pharmacy and one for a 90-day supply, which can be forwarded to Prescription Solutions. By trying a smaller quantity of the drug before receiving a 90-day supply, you and your doctor can determine if the new prescription is right for you. **Note:** A new written prescription is required to have your prescriptions filled using the mail service pharmacy order form.

You may also obtain an order form by calling Prescription Solutions at **1-877-889-6358 (TTY 1-800-498-5428)**, 24 hours a day, 7 days a week or by visiting our Web site at www.rxsolutions.com.

2. On the Web site you will need to enter some basic information, such as Member status, state of residence, plan type, etc. Select the Pharmacy tab, then click on "Mail Service Order Form" and print the form.
3. Enclose your written prescriptions (with your date of birth written on each prescription), payment information (check, money order or credit card) and order form. Make the check or money order payable to Prescription Solutions. Standard delivery is no charge to U.S. territories and if you prefer rush delivery, medications can be shipped overnight for an additional charge.
4. If you need assistance completing the form or determining your copayment or coinsurance amounts, call Prescription Solutions at **1-877-889-6358 (TTY 1-800-498-5428)**, 24 hours a day, 7 days a week.

How Do You Fill Prescriptions Outside the Network?

We have Network Pharmacies outside of the Service Area where you can get your drugs covered as a Member of our Plan. Generally, we only cover drugs filled at an Out-Of-Network Pharmacy in limited, non-routine circumstances when a Network Pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an Out-Of-Network Pharmacy. Before you fill your prescription in these situations, call us to see if there is a Network Pharmacy in your area where you can fill your prescription. If you do go to an Out-Of-Network Pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just the Coinsurance or Copayment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an Out-Of-Network Pharmacy, as any amount you pay for a covered Part D drug will help you qualify for Catastrophic Coverage. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?" If we do pay for the drugs you get at an Out-Of-Network Pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

Generally, we will only cover drugs obtained from Out-Of-Network Pharmacies under limited circumstances when a Network Pharmacy is not available. If you are away from home and have an urgent or emergency situation that requires a prescription, and you do not have access to a Network Pharmacy, you may have your prescription filled at any pharmacy. You may also have your prescriptions filled at an Out-Of-Network Pharmacy, in the following situations:

- If you are unable to get a Covered Drug in a timely manner, because there are no 24-hour Network Pharmacies within a reasonable driving distance.
- If your Covered Drug is not carried at a Network Pharmacy or through mail service (for example, high-cost or unique drugs).
- If you need a prescription while traveling in the United States because you become ill, lose or run out of your prescription drug.
- If you receive certain Part D Covered Drugs, such as vaccines administered in your doctor's office.
- Dialysis you get when you are traveling outside of the plan's service area.

How Do You Submit a Paper Claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

- **Drugs purchased out-of-network.** When you go to a Network Pharmacy and use your Member ID card, your claim is automatically submitted to us by the pharmacy. However, if you go to an Out-Of-Network Pharmacy and attempt to use your Member ID card for one of the reasons listed in the section above (How do you fill prescriptions outside the network?), 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 and submit a paper claim to us. This type of reimbursement request is considered a request for a Coverage Determination and is subject to the rules contained in Section 10.

- **Drugs paid for in full when you don't have your Member ID card.** If you pay the full cost of the prescription (rather than paying just your Coinsurance or Copayment) because you don't have your Member ID card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a Coverage Determination and is subject to the rules contained in Section 10.
- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription (rather than paying just your Coinsurance or Copayment) because it is not covered for some reason (for example, the drug is not on the Formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a Coverage Determination and is subject to the rules contained in Section 10.
- **Drugs purchased at a better cash price.** In rare circumstances when you are in a coverage gap or Deductible period (if your Plan has a coverage gap or a Deductible) and have bought a covered Part D drug at a Network Pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for Catastrophic Coverage.
- **Copayments for drugs provided under a drug manufacturer patient assistance program.** If you get help from, and pay Copayments under, a drug manufacturer patient assistance program outside our Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for Catastrophic Coverage.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. Although not required, you may use our reimbursement claim form to submit your written request. Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

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

- You don't have to use the form, but it's helpful.
- Either download a copy of the form from our Web site (www.UHCRetiree.com / www.AARPMedicareComplete.com) or call Customer Service at the phone number on the back cover of this booklet to get a copy of the form.

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

Prescription Solutions
PO Box 29045
Hot Springs, AR 71903

Please be sure to contact Customer Service if you have any questions. If you don't know what you owe, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

How Does Your Prescription Drug Coverage Work if You Go to a Hospital or Skilled Nursing Facility?

If you are admitted to a hospital for a Medicare-covered stay, our Plan's medical (Part C) benefit should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, our plan's Part D benefit will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our Formulary, filled at a Network Pharmacy, and they aren't covered by our medical benefit (Part C)). We will also cover your prescription drugs if they are approved under the Part D Coverage Determination, Exceptions, or Appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After our plan's medical benefit (Part C) stops paying for your prescription drug costs as part of a Medicare-covered skilled nursing facility stay, our plan's Part D benefit will cover your prescription drugs as long as the drug meets all of our coverage requirements (such as that the drugs are on our Formulary, the skilled nursing facility pharmacy is in our pharmacy network, and the drugs aren't otherwise covered by our plan's medical benefit (Part C)). When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Advantage Plan, Prescription Drug Plan, or the Original Medicare Plan. See Section 11 for more information about leaving this Plan and joining a new Medicare Plan.

Long-Term Care (LTC) Pharmacies

Generally, residents of a long-term-care facility (like a nursing home) may get their prescription drugs through the facility's LTC pharmacy or another network LTC pharmacy. Please refer to your Pharmacy Directory to find out if your LTC pharmacy is part of our network. If it is not, or for more information, contact us.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through our Plan's pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies). Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, contact us.

Home Infusion Pharmacies

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, contact us.

Some Vaccines and Drugs May be Administered in Your Doctor's Office

We may cover vaccines that are preventive in nature and aren't already covered by our Plan's medical benefit (Part C). This coverage includes the cost of vaccine administration. The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you

may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, following our out-of-network paper claims policy (see How Do You Submit a Paper Claim? earlier in this Section), and then you will be reimbursed up to our normal coinsurance or copayment for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

Remember you are responsible for all of the costs associated with vaccines (including their administration) during the coverage gap phase of your benefit, if your plan has no or partial coverage in the coverage gap.

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal coinsurance or copayment for the vaccine.
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your coinsurance or copayment for the vaccine (including administration) less any difference between the amount the Doctor charges and what we normally pay.*
The Pharmacy	Your Doctor	You pay your normal coinsurance or copayment for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine less any difference between what the Doctor charges for administering the vaccine and what we normally pay.*

*If you receive extra help, we will reimburse you for this difference.

As described above, **when you receive a Medicare Part D vaccine at the pharmacy** you pay your normal coinsurance or copayment for a Part D vaccine. For example, if the vaccine is listed as a Tier 2 drug in the formulary, you would pay the Tier 2 copayment at the pharmacy. If the vaccine is listed as a Tier 3 drug in the formulary, you would pay the Tier 3 copayment at the pharmacy.

When you receive a Medicare Part D vaccine at your doctor's office, you pay up-front for the entire cost of the vaccine and its administration by your doctor.

You will then be reimbursed for the cost of the vaccine, minus the applicable copayment or coinsurance for the vaccine. For example, if the actual cost of a Part D vaccine is \$50, you pay the full amount at your doctor's office. If your copayment for this particular vaccine is \$20, you will be reimbursed \$30 (the cost of the drug, minus your copayment). The actual cost of Part D vaccines varies by vaccine.

You will also be reimbursed for the cost of the administration of the vaccine by your doctor, minus any difference between what your doctor charges for administering the vaccine and what we pay. You do not pay your usual doctor's office visit copayment for the administration of the vaccine. You instead pay what your doctor actually charges for administration of the vaccine. For example, if your doctor charges \$30 for the administration of the vaccine, we will reimburse you up to \$20, our standard reimbursement rate for the administration of the vaccine. The actual cost of the administration will vary by doctor.

When you pay for your Medicare Part D vaccine at the pharmacy and take it to your doctor's office for administration, you pay your usual coinsurance or copayment for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine.

You will be reimbursed for the cost of the administration of the vaccine by your doctor, minus any difference between what your doctor charges for administering the vaccine and what we pay. You do not pay your usual doctor's office visit copayment for the administration of the vaccine. You instead pay what your doctor actually charges for administration of the vaccine. For example, if your doctor charges \$30 for the administration of the vaccine, we will reimburse you up to \$20, our standard reimbursement rate for the administration of the vaccine. The actual cost of the administration will vary by doctor.

To be reimbursed for the cost of the vaccine and/or the administration amount, please keep your receipts and call Customer Service at the phone number listed on the back of your membership card for more information.

For best coverage, UnitedHealthcare recommends that you get vaccines at a network pharmacy wherever possible. If the administration fee is less than \$20, all you will have to pay is your copayment or coinsurance amount. And you won't have to fill out a form to get reimbursed so getting your vaccine at a network pharmacy rather than at your doctor's office may be more convenient. If the administration fee is more than \$20, you will need to pay the difference between the \$20 and the administrative fee your doctor charges. Check your Pharmacy Directory for a list of network pharmacies.

We can help you understand the costs associated with vaccines (including administration) available under our Plan before you go to your doctor. For more information, please contact Customer Service.

How is Your Out-of-Pocket Cost Calculated?

What Type of Prescription Drug Payments Count Toward Your Out-of-Pocket Costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision

on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- Your annual deductible (if applicable to your plan)
- Your coinsurance or copayments up to the initial coverage limit
- Any payments you make for drugs in the coverage gap (if applicable to your plan)
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

For most plans, when you have spent a total of \$4,550 for these items, you will reach the catastrophic coverage level. Please refer to your Retiree Benefits Summary Insert for the amount of out-of-pocket costs required to reach the catastrophic level for your plan.

What Type of Prescription Drug Payments Will Not Count Toward Your Out-of-Pocket Costs?

The amount you pay for your monthly Part D Premium (if applicable to your plan) doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare

Who Can Pay For Your Prescription Drugs, And How Do These Payments Apply to Your Out-of-Pocket Costs?

Except for your monthly Part D Premium payments (if applicable to your plan), any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs) (SPAPs are not available in all states, and have different names in different states. See "If You Are a Member of a State Pharmacy Assistance Program (SPAP)" earlier in this Section for the name and phone number for the SPAP in your area, if available in your state.);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following don't count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period (if applicable to your plan) and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

What Information is Included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future and affect the prescriptions you have gotten filled;
- A summary of your coverage this year, including information about:
 - **Amount Paid For Prescriptions** – The amounts paid that count towards your deductible and/or initial coverage limit (if applicable to your plan).
 - **Total Out-Of-Pocket Costs that count toward Catastrophic Coverage** – The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your coinsurance or copayments, and payments made on covered Part D drugs after you reach the initial coverage limit (if applicable to your plan). (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

What Extra Help is Available to Help Pay My Plan Costs?

Medicare provides “extra help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for any Medicare drug plan’s monthly premium, and prescription copayments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do You Qualify For Extra Help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. **You automatically qualify for extra help and don’t need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails a letter to people who automatically qualify for extra help.
2. **You apply and qualify for extra help.** You may qualify if you have limited income and resources. The yearly income and resource amounts vary, and they are published each year by the Centers for Medicare & Medicaid Services (CMS) in their “Medicare & You” handbook. Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at **1-800-772-1213 (TTY users should call 1-800-325-0778)** or visit www.socialsecurity.gov on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

How Do Costs Change When You Qualify For Extra Help?

If you qualify for extra help, we will send you by mail an “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs” that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs”.

What If You Believe You Have Qualified For Extra Help and You Believe That You Are Paying an Incorrect Copayment Amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

Call Customer Service for assistance. You may be given instructions to fax or mail in the following supporting documentation:

- Centers for Medicare & Medicaid Service (CMS) or Social Security Administration (SSA) Award letters dated August 1, 2008 or later;
- Award letters from State Medicaid agencies or a copy of a State Medicaid card that confirms Medicaid coverage during the discrepant period;
- Confirmation from a State or federal database/Web site that confirms an extra help subsidy during the discrepant period.

We can accept this documentation for a period of up to 90 days following the date your prescription(s) were filled.

When we receive the evidence showing your copayment level, we will update our system or implement other procedures so that you can pay the correct copayment when you get your next prescription at the pharmacy. Please be assured that if you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. Of course, if the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

Section 7 – Emergency and Urgently Needed Services

As a Member of the Plan, you are covered anywhere in the world for Emergency Services.

What is an Emergency Medical Condition?

An Emergency Medical Condition is a medical condition recognizable by symptoms serious enough (including severe pain, serious injury) that a person with an average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in:

1. placing your health at serious risk;
2. serious harm to bodily functions;
3. serious dysfunction of any bodily organ or part.
4. In the case of a pregnant woman, an Emergency Medical Condition exists if the pregnant woman is in Active Labor, meaning labor at a time in which either of the following would occur: a) there is not enough time to safely transfer the pregnant woman to another hospital before delivery; or b) a transfer may pose a threat to the health and safety of the pregnant woman or the unborn child.

Emergency Services are covered for inpatient or outpatient services that are:

1. **provided by a Provider qualified to provide Emergency Services, and**
2. **needed to evaluate or stabilize a Medical Emergency Condition.**

Please note: Under federal law we cannot pay federal Hospitals, such as Veterans Administration (VA) Hospitals, for Emergency and non-Emergency items and services furnished to veterans, retired military personnel or eligible dependents. However, we will reimburse Members who are veterans, retired military personnel or eligible dependents for any Copayments or Coinsurance paid to VA Hospitals for Emergency Services, in excess of the Plan's Emergency Services Copayment. For Members who are not eligible for VA benefits, we will cover Emergency and urgent care provided by a VA facility.

What To Do in an Emergency

In the event of a Medical Emergency, **go to the closest emergency room or call 911** for assistance. We will cover Emergency Services whether you are in or out of the Service Area, unless listed as a limitation and/or exclusion in the Retiree Benefits Summary. We discuss filling prescriptions when you cannot access a network pharmacy in Section 6. Ambulance services dispatched through 911 are only covered if transportation in any other vehicle could endanger your life.

Emergency Services are covered whether or not a Contracted Medical Provider provides them.

If you have a Medical Emergency while outside of the Service Area, we will cover your follow-up care outside of the Service Area, if the follow-up care still qualifies as either Emergency or Urgently Needed Care. Follow-up care received out of the Service Area, after treatment for a Medical Emergency that does not qualify as either Emergency or Urgently Needed Care, is not a Covered Service. If your medical condition no longer requires Emergency or Urgently Needed Care, you must return to your Service Area for follow-up

care from your Primary Care Physician. If you receive follow-up care outside of the Service Area that does not qualify as Emergency or Urgently Needed Care, you may be financially responsible for the cost of the follow-up care.

You must pay the Emergency or Urgent Care Copayment, whether you receive the Emergency or Urgently Needed Care services in a doctor's office from a physician or a Specialist, or if you receive the Emergency or Urgently Needed Care services in an Urgent Care Facility or a Hospital.

It is important to notify your Primary Care Physician or us of a Medical Emergency, so your Primary Care Physician or we may be involved in the management of your health care. If the Medical Emergency requires that you be admitted to an Inpatient Hospital, it is important that you notify your Primary Care Physician or us, so a transfer may be arranged when your medical condition is stable (as determined by your treating physician). You are strongly encouraged to call, or to have someone call your Primary Care Physician or us at the number listed on your Member ID card as soon as reasonably possible, preferably within forty-eight (48) hours.

What if it wasn't a Medical Emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above). However, please note that:

- If you get any extra care after the doctor says it wasn't a medical emergency, the Plan will pay its portion of the covered additional care **only if you get it from a plan provider.**
- If you get any extra care from a Non-Contracted Provider after the doctor says it wasn't a medical emergency, the Plan will usually *not* cover the extra care. We will pay our portion of the covered additional care from a Non-Contracted Provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

Post-Stabilization Care

Medically Necessary, non-emergency services following receipt of emergency care to enable you to remain stabilized are covered: when we or our Contracted Medical Providers give Prior Authorization for such services; when we or our Contracted Medical Providers do not respond within one (1) hour to a request for a Prior Authorization from a Non-Contracted Provider or Facility; or when we or our Contracted Medical Providers could not be contacted for Prior Authorization.

Coverage for post-stabilization care provided by a Non-Contracted Provider continues to be covered until one of the following:

- You are discharged.
- A Contracted Medical Provider arrives and assumes responsibility for your care.
- The Non-Contracted Provider and we agree to other arrangements.
- A Contracted Medical Provider assumes responsibility for your care through the transfer to a Contracted facility.

When You Need Urgent Care and You Are Out of Your Service Area

The plan also covers Urgently Needed Services inside the United States. Urgently Needed Services are Covered Services provided when you are temporarily* absent from the area served by your Primary Care Physician, Contracted Medical Group/IPA or Network or Contracted Medical Provider (or, under unusual and extraordinary circumstances, you are in the Service Area, but your Contracted Medical Group/IPA or Network or Primary Care Physician is temporarily unavailable or inaccessible), when such services are immediately required:

- as a result of an unforeseen illness, injury, or condition, and
- it is not reasonable to obtain the services through your Primary Care Physician or Contracted Medical Provider

* *A temporary absence is an absence from the Service Area lasting not more than six months and it is not a permanent move.*

If possible, contact your Primary Care Physician or us, then go to a local doctor. If this is not possible, you may go to a Hospital emergency room or other urgent care medical facility.

If you must visit a Provider or a Hospital emergency room for Urgently Needed Services when outside the Service Area, you should contact your Primary Care Physician or Contracted Medical Group/IPA or us as soon as possible, preferably within forty-eight (48) hours so we may be involved in the management of your care. After treatment for out of the Service Area Urgently Needed Care, follow-up care that does not qualify as Urgently Needed Care must be received in the Service Area from your Primary Care Physician. If you receive out of the Service Area follow-up care that does not qualify as Urgently Needed Care, you may be financially responsible for the cost of the follow-up care.

Neither UnitedHealthcare nor Medicare will pay for services you receive from Non-Contracted Providers without Prior Authorization outside of this Service Area, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis or post-stabilization services.

When You Need Urgent Care and You Are In Your Service Area

Many Contracted Medical Providers have on-site urgent care centers and many of these centers have extended hours and do not require appointments. We encourage you to take advantage of this convenience in an urgent medical situation.

If you need urgent medical care within your Service Area:

1. Call your Contracted Medical Group/IPA or Primary Care Physicians office at the number listed on your Member ID card.
2. Identify yourself as a Plan Member, and tell them you feel you need immediate medical attention.
3. Follow any first aid instructions provided (you may be advised to go to your Provider or to a nearby Hospital).

All Contracted Medical Groups/IPAs have a twenty-four (24) hour emergency number. If, for any reason, you are unable to reach your Contracted Medical Provider, follow the steps for Out-of-Area Urgently Needed Services, as previously described. Follow-up medical care must be received or authorized by your Primary Care Physician or Contracted Medical Group/IPA.

What is the difference between a “Medical Emergency” and “Urgently Needed Care”?

The two main differences between Urgently Needed Care and a Medical Emergency are in the danger to your health and your location. A “Medical Emergency” occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. “Urgently Needed Care” is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

Reimbursement for Services Paid by Member

In most instances, Providers submit bills to us for payment. However, if you paid for Emergency Services, Urgently Needed Services, out-of-area renal dialysis or post-stabilization services from a Non-Contracted Medical Provider, submit your bills to us for a payment determination. Bills should be submitted to the following address:

For Oregon:
UnitedHealthcare
Claims Department
P.O. Box 30974
Salt Lake City, UT 84130-0976

For Washington:
UnitedHealthcare
Claims Department
P.O. Box 30976
Salt Lake City, UT 84130-0976

If you have questions about any bills you receive, call Customer Service.

Right to Appeal

We provide you with a written notice if a service or payment is denied. If we have denied payment for services you think should have been covered, or if we refused to arrange for services that you believe are covered by Medicare, you have the right to appeal. If you think waiting for a decision about authorization for a service could seriously harm your health, you may request an Expedited Appeal. (Please see Section 10.)

Section 8 – Premiums and Payments

As a Member of the Plan, you will be financially responsible for the Health Plan Premiums (if applicable), Copayments and Coinsurance amounts that are listed in the Retiree Benefits Summary and Insert. You must also continue to pay your Medicare Part A and Part B premiums, if applicable.

- **Your Health Plan Premium** – In most cases, your former employer, union group or trust administrator (Plan Sponsor) is responsible for making payment of any applicable Health Plan Premium directly to UnitedHealthcare on behalf of its enrolled Plan Members and their eligible dependent(s). Your Plan Sponsor determines the amount of any retiree subscriber contribution toward Health Plan Premiums. Some Plan Sponsors, however, have made arrangements with UnitedHealthcare to bill you, the Member, directly for Health Plan Premiums. If this is the case, your monthly Health Plan Premium amount will be listed in your Retiree Benefits Summary Insert and it is due on the first of each month for that month's coverage.
 - **Medicare Part A Premium** – Most Medicare beneficiaries are automatically entitled to Medicare Hospital Insurance (Part A). If you are not entitled to Medicare Part A and you have purchased Part A through Social Security, you must continue to pay your Medicare Part A Premium.
 - **Medicare Part B Premium** – A monthly premium paid to Medicare to cover Supplemental Medical Insurance (Part B). The Medicare Part B Premium amounts vary according to income and marital status, and they are published annually by the Centers for Medicare & Medicaid Services (CMS) in their "Medicare & You" handbook. As a Plan Member, you must continue to pay your Medicare Part B Premium. If you receive a Social Security annuity check, this premium is usually automatically deducted from your check. Otherwise your Premium is paid directly to Medicare by you or someone on your behalf such as Medicaid.
 - **Medicare Part D Premium** – A monthly premium paid to Medicare Part D providers, such as UnitedHealthcare, to cover Part D prescription drug coverage (if you are responsible to pay your Health Plan Premium directly to UnitedHealthcare). Not all of our Medicare Advantage plans that offer Medicare Part D prescription drug coverage have a Medicare Part D Premium. Please refer to the Retiree Benefits Summary and Insert to find out if your Plan includes a Medicare Part D Premium. (If you qualify for extra help from Medicare, called the Low-Income Subsidy or LIS, you or your Plan Sponsor may not have to pay for all or part of the monthly premium.)
- Note:** If you are getting extra help (LIS) with paying for your drug coverage, the Medicare Part D premium amount that you pay (or your Plan Sponsor pays on your behalf) as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs". Or, if available in your state and you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP at the phone number listed in Section 6 to determine what benefits are available to you.
- **Optional Supplemental Benefits Premium (if applicable to your plan)** – If available to you and you signed up for extra benefits, also called "optional supplemental benefits," then you pay a premium each month for these extra benefits.

If you have any questions about your Plan premiums, please call us at one of the phone numbers listed on the back cover.

What Happens if You Do Not Pay Your Health Plan Premiums?

If your Plan Sponsor does not pay the Health Plan Premium for the Plan, then you will be transferred to one of our individual Medicare Advantage plans. Once the transfer is effective, you will be responsible for Health Plan Premium payments, if applicable, for the individual Medicare Advantage plan. Monthly Health Plan Premiums and benefits for our individual Medicare Advantage plans vary by the Member's county of residence. If an individual Medicare Advantage plan is not available in the county in which you live, UnitedHealthcare may disenroll you from the Plan. UnitedHealthcare will contact you to inform you of your options.

If you are responsible to pay your Health Plan Premium directly to UnitedHealthcare, we have the right to disenroll you from the Plan for failure to pay Health Plan Premiums except for plan premiums that cover Optional Supplemental Benefits (See Section 8.). However, prior to such action, we will attempt to contact you by letter within ten (10) days after the date of the delinquent charges are due. This letter will advise you that failure to pay Health Plan Premiums within a thirty (30) day grace period may result in your disenrollment, and include an explanation of your rights under the Grievance procedures.

Should you decide later to re-enroll in this Plan or to enroll in another plan insured by us, you may be required to pay any outstanding Health Plan Premiums due from your previous enrollment in this Plan. If you signed up for extra benefits ("optional supplemental benefits"), and you don't pay the additional monthly plan premium for these extra benefits on time, we will tell you in writing that if you don't pay the monthly plan premium for these extra benefits within 60 days we will end coverage for the extra benefits.

Until you are notified of your disenrollment, you will continue to be a Plan Member and must continue to use Contracted Medical Providers and network pharmacies. For details on disenrollment for non-payment of Health Plan Premiums, please see Section 11.

Your Premium Payment Options (if applicable)

As a Plan Member who is responsible for paying a monthly Health Plan Premium directly to UnitedHealthcare, you have two (2) options for paying your monthly Health Plan Premium, or any other premiums that may be associated with Optional Supplemental Benefits, if applicable to your plan. Your options are the Automatic Payment Plan or Coupon Book.

With the convenient **EasyPay method (Automatic Payment)**, you may have your monthly Health Plan Premium, including your Medicare Part D Premium (if applicable) and Optional Supplemental Benefit premium (if applicable), automatically deducted monthly from your personal checking account and electronically transmitted for payment.

If you do not elect the EasyPay payment option above, you will receive a **Coupon Book**. As your monthly premium becomes due, send the appropriate coupon from the coupon book along with a check or money order for the amount shown on the coupon, in a return envelope provided to you. Call Customer Service if you lose the coupon book or run out of coupons.

If you have any questions regarding your plan premium payment choices, please call Customer Service.

Changes in Health Plan Premiums

Rate changes and Plan Sponsored benefit changes for Plan Members are subject to contractual arrangements between UnitedHealthcare and your former employer, union group

or trust administrator (Plan Sponsor). Your Plan Sponsor is responsible for notifying you of any Plan premium changes, contribution changes, or Plan Sponsored benefit changes thirty (30) days before they become effective.

Changes in the level of health care coverage may occur at the beginning of each Calendar Year and/or your retiree group contract year. You will receive a written notice at least thirty (30) days prior to the date when such change shall become effective.

Members in some states may be eligible for certain Medigap protections if their Plan has a reduction in benefits or increases in Plan Premiums, Copayments or Coinsurance. For State specific information, please call Customer Service, your State's Department of Insurance or SHIP.

Section 9 – Optional Supplemental Plans (if applicable to your plan)

Adding Optional Supplemental benefits to your Plan

Depending upon your benefit plan and service area, you may have the choice of adding an Optional Supplemental Plan to your Plan. An Optional Supplemental Plan provides you with supplemental benefits, in addition to your Basic Benefits, for a monthly plan premium. For more information regarding whether an Optional Supplemental Plan is available in your Service Area and to determine your eligibility for these plans, please call Customer Service.

Enrolling in an Optional Supplemental Plan

If eligible, you may enroll in an Optional Supplemental Plan by completing an Optional Supplemental Plan Application available through Customer Service. Members may also call Customer Service to enroll in an Optional Supplemental Plan over the phone. If you are an existing Member, you may enroll in an Optional Supplemental Plan **only once** during the Open enrollment Period, November 15, 2009 through September 30, 2010. If you are a new Member, you may enroll once in an Optional Supplemental Plan either at the time of your initial enrollment, within the thirty (30) days of your Effective Date or until September 30, 2010.

In general, completed Optional Supplemental Plan Applications received by the last day of the month will be effective the first day of the following month. For example, if we receive your completed Optional Supplemental Plan Application on December 31, your Optional Supplemental Plan benefits will begin on January 1.

Disenrolling from an Optional Supplemental Plan

If you wish to Disenroll from an Optional Supplemental Plan, you may mail or fax to us a signed letter requesting Disenrollment from your Optional Supplemental Plan, or you may call Customer Service. Your letter must clearly state that you wish to Disenroll only from the Optional Supplemental Plan, not this Plan.

Optional Supplemental Plan Disenrollment requests received by the last day of the month will be effective the first day of the following month. Members will be responsible for their Optional Supplemental Plan premium payment if the Disenrollment request is received after the last day of the month. Disenrollment from an Optional Supplemental Plan will not result in Disenrollment from this Plan.

Non-payment of plan premiums for an Optional Supplemental Plan will not result in Disenrollment from this Plan, only the loss of the Optional Supplemental Plan and your return to the basic benefit plan.

Refund of Premium

Members enrolled in an Optional Supplemental Plan have a monthly plan premium and are entitled to a refund for any overpayments of plan premiums made during the course of the year or at the time of Disenrollment. Overpayments of Optional Supplemental Plan premiums will be refunded upon request or Disenrollment. We will refund any overpayments within thirty (30) business days of notification. We may apply your overpayment of Optional Supplemental benefit plan premiums to your Health Plan Premiums for your benefit plan, if any.

Section 10 – What to do if You Have a Problem or Complaint (Coverage Decisions, Appeals, Complaints)

What to do if you have a problem or concern - Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Service at the phone number listed on the back cover of this booklet. We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This Section explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and making appeals.**
- For other types of problems you need to use the **process for making complaints.**

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you. Which one do you use? That depends on the type of problem you are having. Please see below for more information regarding how to identify the right process to use.

What about legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this Section. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this Section explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this Section generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

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

You can get help from government organizations that are not connected with our plan

Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through 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. Perhaps both are true for you.

Get help from an independent government organization

Our plan is always available to help you. But in some situations you may also want help or guidance from someone who is not part of our plan. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do. Their services are free. You will find phone numbers in Section 2 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 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 visit the Medicare Web site (www.medicare.gov).

To deal with your problem, which process should you use? Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole Section. You just need to find and read the parts of this Section that apply to your situation. The information that follows will help.

Is your problem or concern about your benefits and coverage? (This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

If the answer is yes, please see the below information. If the answer is no, please see the part entitled "*How to make a complaint about quality of care, waiting times, customer service, or other concerns*" later in this Section.

A guide to the basics of coverage decisions and appeals

Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision our plan makes about your benefits and coverage or about the amount we will pay for your medical services or drugs. You ask us for a coverage decision whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service is covered and pay our share of the cost
- But in some cases we might decide the services are not covered for you. Or we may decide it is time to stop covering services you have been receiving. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If our plan makes a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking our plan to review and change a coverage decision we have made.

When you make an appeal, our plan reviews the coverage decision we have made to check to see if our plan was being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through several more levels of appeal.

How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call Customer Service** at the phone number listed on the back cover of this booklet.
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this booklet).
- **You can, and probably need to, get your doctor involved.** In most situations involving a coverage decision or appeal, your doctor must explain the medical reasons that support your request.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor, or other person to be your representative, call Customer Service at the phone number listed on the back cover of this booklet, and

ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Your medical care: How to ask for a coverage decision or make an appeal

This part is about your benefits for medical care and services. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this part, instead of repeating “medical care or treatment or services” every time.

This part tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- **NOTE: If the care that will be stopped is hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) Services,** you need to read a separate part of this Section because special rules apply to these types of care.

Here’s what to read in those situations:

- Later in this Section, the part titled *“How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.”*
- Later in this Section, the part *“How to ask our plan to keep covering a medical service you have been getting if you think your coverage is ending too soon.”* This part is about three services only: home health care, skilled nursing facility care, and outpatient rehabilitation care.
- For *all other* situations that involve being told that medical care you have been getting will be stopped, use the following information as your guide for what to do.

Which of these situations are you in?

Do you want to find out whether our plan will cover the medical care and services you want? If the answer is yes, you need to go ask our Plan to make a coverage decision for you.

Has our Plan already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for? If the answer is yes, you can make an appeal (this means you are asking us to reconsider).

Do you want to ask our Plan to pay you back for medical care or services you have already paid for? If the answer is yes, you can send us a bill.

Please see below for more information about these situations.

Step-by-step how to ask for a coverage decision (how to ask our plan to provide the medical care coverage you want)

A coverage decision is called an **“initial determination”** or “initial decision.” When a coverage decision involves your medical care, the initial determination is called an **“organization determination.”**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **“fast decision”**

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

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, including how to reach us on evenings and weekends, please see below:

CALL AARP MedicareComplete Retiree Plan (HMO) from SecureHorizons
1-888-736-7430

The SecureHorizons MedicareComplete Retiree Plan (HMO)
1-888-867-5548
Calls to this number are free.

8 a.m. to 8 p.m. local time, 7 days a week.

TTY 711
This number requires special telephone equipment.
Calls to this number are free.

FAX 1-800-891-8034

WRITE UnitedHealthcare
Attention: Customer Service Department (Organization Determinations)
P.O. Box 29800
Hot Springs, AR 71903-0800

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- 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. (The process for making a complaint is different from the process for coverage decisions and appeals. For more about the process for making complaints, including fast complaints, see the part later in this Section titled “*How to make complaints about quality of care, waiting times, customer service, or other concerns*”).

If your health requires it, ask us to give you a “fast decision”

– A fast decision means we will answer within 72 hours.

- **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If we decide to take extra days, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more about the process for making complaints, including fast complaints, see the part later in this Section titled “*How to make complaints about quality of care, waiting times, customer service, or other concerns*”). We will call you as soon as we make the decision.

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

- You can get a fast decision only if you are asking for medical care *you have not yet received*. (You cannot get a fast decision if your request is about medical care you have already received.)
- You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.

– If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.

- If you ask for a fast decision on your own, without your doctor’s support, our plan will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more about the process for making complaints, including fast complaints, see the part later in this Section titled “*How to make complaints about quality of care, waiting times, customer service, or other concerns*”).

Step 2: Our plan considers your request for medical care coverage and we give you our answer.

Deadlines for a “fast” coverage decision.

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more days under certain circumstances. If we take extra days, it is called “an extended time period.”
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Please see below to find out how to make an appeal.

- **If our answer is yes to part or all of what you requested**, we must provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “standard” coverage decision.

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
 - We can extend the time up to 14 more days (“an extended time period”) under certain circumstances.
 - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. The part in this Section below titled *“Step-by-step: How to make a Level 1 Appeal”* tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 14 days. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal

- If our plan says no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see below).

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

When you start the appeal process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”

An appeal to the plan about a medical care coverage decision is called a plan **“reconsideration.”**

Step 1: You contact our plan and make your appeal. If your health requires a quick response, you must ask for a **“fast appeal.”**

What to do

- **To start your appeal, you (or your doctor or your representative) must contact our plan.** For details on how to reach us for any purpose related to your appeal, see below:

CALL For standard medical appeals call:
 AARP Medicare Complete Retiree Plan (HMO) from SecureHorizons
 1-888-736-7430

SecureHorizons Medicare Complete Retiree Plan (HMO)

1-888-867-5548

Calls to these numbers are free.

8 a.m. to 8 p.m., local time, 7 days a week.

For fast/expedited medical appeals call:

1-877-262-9203

8 a.m. to 6 p.m. local time, Monday through Friday.

TTY 711

This number requires special telephone equipment.

Calls to this number are free.

FAX **For fast/expedited medical appeals only:**

1-866-373-1081

WRITE UnitedHealthcare

Attention: Appeals and Grievances Department

P.O. Box 6106

Cypress, CA 90630

CY 124-0157

- **Make your appeal in writing by submitting a signed request.**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information in your appeal and add more information if you like.**
 - You have the right to ask us for a copy of the information regarding your appeal. If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

A “fast appeal” is also called an “expedited appeal.”

- If you are appealing a decision our plan made about care you have not yet received, you and your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this Section).

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were being fair and following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more days**.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this part, we tell about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more days**.
 - If we do not give you an answer within 30 days (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this part, we tell about this review organization and explain what happens at Appeal Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If our plan says no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your appeal, **our plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Step-by-step: How to make a Level 2 Appeal

If our plan says no to your level 1 appeal, your case will *automatically* be sent on to the next level of the appeals process. During the level 2 appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: The Independent Review Organization reviews your appeal

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

Deadlines for a “fast” appeal

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.

Deadlines for a “standard” appeal

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.

Step 2: The Independent Review Organization gives you their answer

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must provide the medical care coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If this organization says no to your appeal,** it means they agree with our plan that your request for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- Appeal Level 3 is handled by a judge. The part titled *Taking your appeal to Level 3 and beyond* later in this Section tells more about Levels 3, 4, and 5 of the appeals process.

What if you are asking our plan to pay you for our share of a bill you have received for medical care?

If you want to ask our plan for payment for medical care, please see the Welcome Section of this booklet for more information on what to do if you have paid a bill you have received from a provider. It tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more about coverage decisions, see above in this part). To make this coverage decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care. Or, if you haven't paid for the services, 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 medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you think we have made a mistake in turning you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe above. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, the **standard deadlines** apply to all parts of the appeals process. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- At any stage of the appeals process, if the answer to your appeal is yes, then our plan must send the payment you have requested. We are required to send payment to you or to the provider **within 30 days**.

Your Part D prescription drugs: How to ask for an exception or make an appeal

This part tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our plan's *List of Covered Drugs (Formulary)* and they are medically necessary for you, as determined by your primary care doctor or other provider in the plan's network.

This part is about your Part D drugs only. To keep things simple, we generally say “drug” in the rest of this part, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.

Which of these situations are you in?

Do you want to ask us to make an exception to the rules or restrictions on our Plan's coverage of drug? If so, to ask for an exception to the rules or restrictions on your drug coverage, you need to ask our Plan to make a **coverage decision** for you. Please see below for more information.

Has our Plan already told you that we will not cover or pay for a drug in the way that you want it to be covered? If so, you can make an **appeal** (this means you are asking us to reconsider). Please see below for more information.

Do you want to ask our Plan to **pay you back** for a drug you have already received and paid for? If so, you can send us the bill. Please see below for more information.

What kinds of exceptions to the coverage rules can you ask for?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception" to our coverage rules. An exception is a type of coverage decision. Like for other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception to our Part D drug coverage rules, your doctor will need to explain the medical reasons. We will then consider your request. You or your doctor can ask us to make any of these four types of exceptions:

1. **Make an exception to the rules and cover a drug for you that is not on our plan's List of Covered Drugs (Formulary).** (We call it the "Drug List" for short.)

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

- 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 Tier 3. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
- You cannot ask for coverage of any "excluded drugs" which are drugs that Medicare does not cover.

2. **Make an exception to the rules and cover a brand-name drug for you instead of the generic version.**

Asking for coverage of a brand-name drug when a generic is available is sometimes called asking for a **"formulary exception."**

- Generally, we require the network pharmacies to fill your prescription for a brand-name drug with a generic drug, if a generic is available.
- If your doctor thinks you need the brand-name version and we agree to cover it, your share of the cost may be greater than it would be for the generic.

3. **Make an exception to the rules by removing a restriction on the plan's coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on the plan's List of Covered Drugs.

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

The extra rules and restrictions on coverage for certain drugs include:

- Being required to use the generic version of a drug instead of the brand-name drug.
- Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
- 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, there are restrictions on the amount of the drug you can have.

Make an exception to the rules by changing coverage of a drug to a lower tier. Every drug on the plan’s Drug List is in one of 4 Tiers. In general, the lower the tier number, the less you will pay as your share of the cost of the drug.

Asking for a change to the tier is called asking for a **“tiering exception.”**

- If your drug is in Tier 3 you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing for any drug in Tier 4.
- If our plan agrees to make an exception and cover a drug for you that is not on our Drug List, you cannot ask for a change to the cost-sharing for that drug.
- If your plan agrees to make an exception and waive a restriction for you, you can ask for another exception to change the cost-sharing for that drug.

Important things to know about asking for exceptions to the rules for coverage of Part D drugs

Who can ask for an exception?

You or your doctor or someone else who is acting on your behalf can ask for an exception to our rules for coverage of your Part D drugs. Later in this Section you can find out how you can give written permission to someone else to act as your representative. (You can also have a lawyer act on your behalf.)

Your doctor must tell us the medical reasons

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe 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. Below you can find out how to ask for an exception and how to make an appeal if we say no.

Ask for help if you need it

- If you have questions or need help at any time, please call Customer Service at the phone number listed on the back cover of this booklet. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this booklet).

Step-by-step: How to ask for an exception (how to ask our plan to make an exception for you)

An exception is a type of coverage decision. A coverage decision is called an **“initial determination”** or “initial decision.” When the coverage decision is about your Part D drugs, the initial determination is called a **“coverage determination.”**

Step 1: You ask our plan to make an exception to the plan’s rules for drug coverage. When you ask us to make this exception, *you are asking us to make a coverage decision* about your drugs. If your health requires a quick response, you must ask us to make a **“fast decision.”**

What to do

- **Request the exception you want.** Start by calling, writing, or faxing our plan to make your request for an exception. You, or your doctor, or your representative can do this (see above). For the details, including how to reach us on evenings and weekends, please see below:

CALL AARP MedicareComplete Retiree Plan (HMO) from SecureHorizons
1-888-736-7430

SecureHorizons MedicareComplete Retiree Plan (HMO)
1-888-867-5548
Calls to this number are free.

8 a.m. to 8 p.m., local time, 7 days a week.

TTY 711
This number requires special telephone equipment.
Calls to this number are free.

FAX 1-800-891-8034

WRITE UnitedHealthcare
Attention: Part D Coverage Determinations Department
P.O. Box 29800
Hot Springs, AR 71903-0800

- **Provide the “doctor’s statement.”** Your doctor must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor can fax or mail the statement to our plan. Or your doctor can tell us on the phone and follow up by faxing or mailing the signed statement.

If your health requires it, ask us to give you a “fast decision”

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision only if you are asking for an exception for a *drug you have not yet received*. (You cannot get a fast decision if your request is about a drug you are already taking.)
 - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.

If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.

- If you ask for a fast decision on your own, without your doctor’s support, our plan will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more about the process for making complaints, see the part titled *How to make complaints about quality of care, waiting times, customer service, or other concerns* later in this Section.)

Step 2: Our plan considers your request for a drug coverage exception and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - (If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this part, we tell about this review organization and explain what happens at Appeal Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested**, we must provide the coverage exception we have agreed to provide within 24 hours. Generally, this means within 24 hours after we receive your doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “standard” coverage decision

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours. Generally, this means within 72 hours after we receive your doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for a drug coverage exception, you decide if you want to make an appeal

- If our plan says no, you have the right to make an appeal. Making an appeal means making another try to get the exception you want. It means asking us to reconsider – and possibly change – the decision we made.

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

When you start the appeals process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”

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

Step 1: You contact our plan and make your level 1 appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start your appeal, you (or your doctor or your representative) must contact our plan.**

- For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, see below:

CALL For standard Part D appeals call:

AARP MedicareComplete Retiree Plan (HMO) from SecureHorizons
1-888-736-7430

SecureHorizons MedicareComplete Retiree Plan (HMO)
1-888-867-5548

Calls to this number are free.

8 a.m. to 8 p.m., local time, 7 days a week.

For fast/expedited Part D appeals call:

1-800-595-9532,
24 hours a day, 7 days a week.

TTY

711

This number requires special telephone equipment.
Calls to this number are free.

FAX

For standard Part D appeals:

1-866-308-6294

For fast/expedited Part D appeals:

1-866-308-6296

WRITE UnitedHealthcare
Attention: Part D Appeals and Grievances Department
P.O. Box 6106
Cypress, CA 90630-9948
CA124-0197

- **Make your appeal in writing by submitting a signed request.**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

A “fast appeal” is also called an “expedited appeal.”

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision that are given above.

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for an exception to the drug coverage rules. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this part, we tell about this review organization and explain what happens at Appeal Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this part, we tell about this review organization and explain what happens at Appeal Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Step-by-step: How to make a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**

Step 2: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for a “fast” appeal

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for a “standard” appeal

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means they agree with our plan that your request for a drug coverage exception should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- Appeal Level 3 is handled by a judge. The part titled *Taking your appeal to Level 3 and beyond* in this Section tells more about Levels 3, 4, and 5 of the appeals process.

If your case meets the requirements, you choose whether you want to take your appeal further

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision. To make this coverage decision, we will check to see if the drug you paid for is a covered drug. We will also check to see if you followed all the rules for using your coverage for drugs.

We will say yes or no to your request

- If the drug is covered and you followed all the rules, we will send you the payment for our share of the cost of your drug. (When we send the payment, it's the same as saying yes to your request for a coverage decision.)
 - NOTE: It is possible that you followed all the rules but you are in certain stage of drug coverage. During certain stages of drug coverage, you may pay the full cost of your drugs until you qualify for the next period. If you have followed all the rules, we will count your payment towards your out-of-pocket total even though we cannot reimburse you. (For more information about the type of drug coverage you have, please see your Retiree Benefits Summary (RBS) and Insert)
- If the drug is *not* covered, or you did *not* follow all the rules, we will not reimburse you. Instead, we will send you a letter that says we will not reimburse you and explains why. (When we turn down your request for reimbursement, it's the same as saying *no* to your request for a coverage decision.)

What if you ask us to reimburse you and we say that we will not?

If you think we have made a mistake in turning you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for reimbursement.

To make this appeal, follow the process for appeals that we describe above. When you are following these instructions, please note:

- If you make an appeal for reimbursement, the **standard deadlines** apply to all parts of the appeals process. (If you are requesting payment for a drug you have already received, you are not allowed to ask for a fast appeal.)
- At any stage of the appeals process, if the answer to your appeal is *yes*, then our plan must provide the reimbursement you have requested. We are required to send payment to you **within 30 days**.

How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the plan's coverage for your hospital care, including any limitations on this coverage, see your Retiree Benefits Summary (RBS) and Insert.

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

- The day you leave the hospital is called your **“discharge date.”** Our plan’s coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This part tells you how to ask.

During your hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

1. Read this notice carefully and ask questions if you don’t understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- What to do if you think you are being discharged from the hospital too soon.

The written notice from Medicare tells you how you can **“make an appeal.”** Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (The part titled *Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date* below tells how to make this appeal.)

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

- You or someone who is acting on your behalf must sign the notice. (The part titled *How to get help when you are asking for a coverage decision or making an appeal* earlier in this Section tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

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

- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service at the phone number listed on the back cover of this booklet, or

1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.
TTY users should call 1-877-486-2048. You can also see it online at
www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage.

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. For general information about the appeals process, see above. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service at the phone number listed on the back cover of this booklet. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this booklet).

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

When you start the appeal process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”

Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization 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. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state later in this Section.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.

- If you do *not* meet this deadline, 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 receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see the part titled: *Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date* below.

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 for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

A **“fast review”** is also called an **“immediate review”** or an **“expedited review.”**

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

This written explanation is called the **“Detailed Notice of Discharge.”** (You can get a sample of this notice by calling Customer Service at the phone number listed on the back cover of this booklet, 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 you can get see a sample notice online at www.cms.hhs.gov/BNI/).

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

What happens if the answer is yes?

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

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **our plan’s coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

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. During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Step-by-Step: How to make a Level 2 Appeal to change your hospital discharge date

Step 1: You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review **within 60 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.

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

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

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made to your Level 1 appeal and will not change it. This is called “upholding the decision.” It is also called “turning down your appeal.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

What if you miss the deadline for making your Level 1 Appeal to change your hospital discharge date?

You can appeal to our plan instead

As explained above in the part titled *Step-by-step: How to make a level 1 Appeal to change your hospital discharge date*, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

A “fast” review (or “fast appeal”) is also called an “expedited” review (or “expedited appeal”).

Step 1: Contact our plan and ask for a “fast review.”

- For details on how to contact our plan (including how to reach us on evenings and weekends), go to *Step-by step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)* under the part of this Section titled *Your medical care: How to ask for a coverage decision or make an appeal.*
- **Be sure to ask for a “fast review!”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: Our plan does a “fast” review of your planned discharge date, checking to see if it was medically appropriate

- During this review, our plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: Our plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to

reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If our plan says no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services will end on that date and our plan will stop paying its share of the costs of this care.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If our plan says no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 Alternate Appeal

If our plan says no to your level 1 appeal, your case will *automatically* be sent on to the next level of the appeals process. During the level 2 appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

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

Step 1: Our plan asks the Independent Review Organization to conduct a “fast review” of your case. (Our plan asks for this review on your behalf.)

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. The part of this Section titled: *How to make complaints about quality of care, waiting times, customer service, or other concerns* tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal**, it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to Appeal Level 3, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- The part in this Section titled: *Taking your appeal to Level 3 and beyond* tells more about Levels 3, 4, and 5 of the appeals process.

How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon?

This part is about three services only: Home health care, skilled nursing facility care, and outpatient rehabilitation care

This part is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see the definition Section of this booklet.
- **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.
- When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see your Retiree Benefits Summary (RBS) and Insert.

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

If you think we are ending the coverage of your care too soon, **you can ask us to keep covering the care for a longer time** and we will consider your request. This part tells you how to ask.

We tell you in advance when your coverage will be ending

1. You receive a notice in writing.

At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a letter or notice.

- The written notice tells you the date when our plan will stop covering the care for you.

In this written notice, we are telling you about a **“coverage decision”** we have made about when to stop covering your care.

- The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.
- In telling what you can do, the written notice is telling how you can **“make an appeal!”** Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (The part below titled: *We will tell you in advance when your coverage will be ending* tells how you can make an appeal.)

The written notice is called the **“Notice of Medicare Non-Coverage!”** To get a sample copy, call Customer Service at the phone number listed on the back cover of this booklet, 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 see a copy online at www.cms.hhs.gov/BNI/.

2. You must sign the written notice to show that you received it.

- You or someone who is acting on your behalf must sign the notice. (The part earlier in this Section titled *How to get help when you are asking for a coverage decision or making an appeal* tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. For general information about the appeals process, see the part earlier in this Section titled *A guide to the basics of coverage decisions and appeals*. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **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. The part titled *How to make complaints about quality of care, waiting times, customer service, or other concerns* 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 Customer Service at the phone number listed on the back cover of this booklet. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this booklet).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

When you start the appeal process by making an appeal, it is called the “first level of appeal” or “Level 1 Appeal.”

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state later in this Section.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our plan to end coverage for your medical services.

You have one of two deadlines.

- Your deadline for contacting the Quality Improvement Organization depends on when you receive the written notice telling when coverage for your care will end.
 - If you get the written notice 2 days before your coverage ends, you must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you get the notice.*
 - If you get the notice *more than 2 days* before your coverage ends, you must contact the Quality Improvement Organization to start your appeal *no later than noon of the day before the date that your coverage ends.*
 - (If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see the part titled: *Step-by-step: How to make a level 2 Appeal to have our plan cover your care for a longer time.*)

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- During this review process, you will also get a written explanation from the plan that gives our reasons for wanting to end the plan's coverage for your services.

This written explanation is called the **“Detailed Explanation of Non-Coverage.”**

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or outpatient rehabilitation care *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

- This first appeal you make is “Level 1” of the appeals process. If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review

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

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

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

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

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

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 appeal and will not change it. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- The part in this Section titled: *Taking your appeal to level 3 and beyond* tells more about Levels 3, 4, and 5 of the appeals process.

What if you miss the deadline for making your Level 1 Appeal to have our plan cover your care for a longer time?

You can appeal to our plan instead

As explained above in the part titled: *Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time*, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different*.

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

A “fast” review (or “fast appeal”) is also called an **“expedited” review** (or **“expedited appeal”**).

Step 1: Contact our plan and ask for a “fast review.”

- For details on how to contact our plan (including how to reach us on evenings and weekends), go to *Step-by step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)* under the part of this Section titled *Your medical care: How to ask for a coverage decision or make an appeal*.
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: Our plan does a “fast” review of the decision we made about when to stop coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were being fair and following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: Our plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If our plan says yes to your fast appeal,** it means we have agreed to keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal,** then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If our plan says no to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 Alternate Appeal

If our plan says no to your level 1 appeal, your case will *automatically* be sent on to the next level of the appeals process. During the level 2 appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

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

Step 1: Our plan asks the Independent Review Organization to conduct a “fast review” of your case. (Our plan asks for this review on your behalf.)

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. The part of this Section titled: *How to make complaints about quality of care, waiting times, customer service, or other concerns* tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 24 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it. (This is called “upholding the decision” It is also called “turning down your appeal.”)
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to Appeal Level 3.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- The part in this Section titled: *Taking your appeal to Level 3 and beyond* tells more about Levels 3, 4, and 5 of the appeals process.

Taking your Appeal to Level 3 and beyond (Levels of Appeal 3, 4 and 5)

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

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

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

Level 3 Appeal: A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last stage of the appeals process. The Level 5 Appeal decision is final.

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

If your problem is about decisions related to benefits, coverage, or payment, then this part is *not for you*. Instead, you need to use the process for coverage decisions and appeals as described above in this Section.

What kinds of problems are handled by the complaint process?

This part explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can **“make a complaint”**

Quality of your medical care

- Are you unhappy with the quality of care you've received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Plan's Customer Service has dealt with you?
- Do you feel you are being encouraged to leave our Plan (disenroll from our Plan)

Cleanliness

- Are you unhappy with the cleanliness or condition of the doctor's office, clinic or hospital?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long:
 - By doctors, pharmacists, or other health care professionals?
 - By Customer Services or other staff at our Plan?
 - Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.

Information you get from our Plan

- Do you believe we haven't given you a notice that we're required to give?
- Do you think written information we have given you is hard to understand?

The reasons shown below are about *timeliness* of the Plan's actions related to coverage and decisions and appeals.

The process of asking for a coverage decision and making appeals is explained above in this Section. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our Plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked our Plan to give you a "fast response" for a coverage decision or appeal and we have said we will not, you can make a complaint.
- If you believe our Plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our Plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

- When our Plan does not give you a decision on time, we are required to forward your case to the Independent Reviewer. If we don't do that, you can make a complaint.

The formal name for “making a complaint” is “filing a grievance”

- What this part calls a **“complaint”** is also called a **“grievance.”**
- Another term for **“making a complaint”** is **“filing a grievance.”**
- Another way to say **“using the process for complaints”** is **“using the process for filing a grievance.”**

Step-by-step: Making a complaint (filing a grievance)

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

- **Usually, calling us is the first step.** If there is anything else you need to do, we will let you know. Our phone numbers and hours of operation are listed below.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:
- The complaint must be submitted within 60 days of the event or incident. The address for filing complaints is located below.

Part C Grievances (about your Medical Care and Services)

CALL For standard medical grievances call:

AARP MedicareComplete Retiree Plan (HMO)
1-888-736-7430

SecureHorizons MedicareComplete Retiree Plan (HMO)
1-888-867-5548

Calls to this number are free.

8 a.m. to 8 p.m. local time, 7 days a week.

For fast/expedited medical grievances call:

1-877-262-9203

8 a.m. to 6 p.m. local time, Monday through Friday.

TTY 711

This number requires special telephone equipment.
Calls to this number are free.

FAX For fast/expedited medical grievances only:

1-866-373-1081

WRITE UnitedHealthcare
Attention: Appeals and Grievances Department
P.O. Box 6106
Cypress, CA90630
CY 124-0157

Part D Grievances (about your Part D Prescription Drugs)

- CALL** **For standard Part D grievances call:**
AARP Medicare Complete Retiree Plan (HMO)
1-888-736-7430
- SecureHorizons Medicare Complete Retiree Plan (HMO)
1-888-867-5548
Calls to this number are free.
8 a.m. to 8 p.m., local time, 7 days a week.
- For fast/expedited Part D grievances call:**
1-800-595-9532,
24 hours a day, Monday - Friday
- TTY** 711
This number requires special telephone equipment.
Calls to this number are free.
- FAX** **For standard Part D grievances:**
1-866-308-6294
- For fast/expedited Part D grievances:**
1-866-308-6296
- WRITE** UnitedHealthcare
Attention: Part D Appeals and Grievances Department
P.O. Box 6106
MS CA 124-0197
Cypress, CA 90630-9948

We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 days after you had the problem you want to complain about.
- **If needed, you may ask for a “fast” complaint.** If you ask for a “fast” complaint, and we agree to give it to you, we will give you **an answer within 24 hours.** You can ask for a “fast” complaint if you think a slower response could harm your health or hurt your ability to function.

What this part calls a “fast complaint” is also called a “fast grievance.”

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **The longest time we can take to answer a complaint is 30 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 days (44 days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know in writing. Our response will include our reasons for this answer.

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

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state please see the chart below. If you make a complaint to this organization, we will work together with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

ALABAMA

Alabama Quality Assurance Foundation (AQAF)
Two Perimeter Park South Suite 200
West Birmingham, AL 35243-2337
1-800-760-4550
TTY 711
www.aqaf.com

ARIZONA

Health Services Advisory Group
1600 East Northern Ave. Suite 100
Phoenix, AZ 85020
1-800-359-9909

ARKANSAS

Arkansas Foundation for Medical Care
401 West Capitol Suite 508
Little Rock, AR 72201
1-877-375-5700
TTY 711
www.afmc.org

CALIFORNIA

Health Services Advisory Group Attn: Beneficiary Protection
5201 W. Kennedy Boulevard Suite 900
Tampa, FL 33609-1822
1-800-841-1602
TTY 711
www.hsag.com/medicare/index.asp

COLORADO

Colorado Foundation for Medical Care
23 Inverness Way East, Suite 100
Englewood, CO 80112-5708
1-800-727-7086

CONNECTICUT

Qualidigm
1111 Cromwell Avenue, Suite 201
Rocky Hill, CT 06067-3454
1-800-553-7590

DELAWARE

Quality Insights of Delaware
3411 Silverside Road, Baynard Building, Suite 100
Wilmington, DE 19810-4812
1-866-475-9669
TTY 711
www.qide.org

DISTRICT OF COLUMBIA

Delmarva Foundation for Medical Care
 2175 K Street NW Suite 250
 Washington, DC 20037
 1-800-937-3362
 TTY 711
www.dcqio.org

FLORIDA

Florida Medical Quality Assurance (FMQAI)
 5201 W. Kennedy Boulevard Suite 900
 Tampa, FL 33609-1822
 1-800-844-0795

GEORGIA

Georgia Medical Care Foundation (GMCF)
 1455 Lincoln Parkway Suite 800
 Atlanta, GA 30346
 1-800-982-0411
 TTY 711
www.gmcf.org

HAWAII

Mountain-Pacific Quality Health Foundation
 1360 South Beretania Suite 501
 Honolulu, HI 96814
 1-800-524-6550

IDAHO

Qualis Health
 720 Park Blvd. #120
 Boise, ID 83712
 1-800-488-1118
 TTY 711
www.qualishealthmedicare.org

ILLINOIS

Illinois Foundation for Quality Health Care
 711 Jorie Blvd, Suite 301
 Oak Brook, IL 60523-4425
 1-800-647-8089
 TTY 711
www.ifqhc.org

INDIANA

Health Care Excel
 2901 Ohio Blvd., Suite 112
 Terre Haute, IN 47803
 1-800-288-1499
 TTY 711
www.hce.org

IOWA

Iowa Foundation for Medical Care
 1776 West Lakes Parkway
 West Des Moines, IA 50266
 1-800-383-2856
 TTY 711
www.internetifmc.com

KANSAS

Kansas Foundation for Medical Care
 2947 SW Wanamaker Drive
 Topeka, KS 66614-4193
 1-800-432-0407

KENTUCKY

Health Care Excel
 1951 Bishop Lane,
 Suite 300
 Louisville, KY 42018
 1-800-288-1499
 TTY 711
www.hce.org

LOUISIANA

Louisiana Health Care Review
 8591 United Plaza Blvd. Suite 270
 Baton Rouge, LA 70809
 1-800-433-4958
 TTY 711
www.lhcr.org

MAINE

Northeast Health Care Quality Foundation
 15 Old Rollingsford Road Suite 302
 Dover, NH 03820
 1-800-772-0151
 TTY 711
www.nhcqf.org

MARYLAND

Delmarva Foundation for Medical Care
 9240 Centreville Road
 Easton, MD 21601
 1-800-492-5811
 TTY 711
www.mdqio.org

MASSACHUSETTS

MassPRO
245 Winter Street
Waltham, MA 02451-1231
1-800-252-5533
TTY 711
www.masspro.org

MICHIGAN

Michigan Peer Review Organization (MPRO)
22670 Haggerty Road Suite 100
Farmington Hills, MI 48335
1-800-365-5899
TTY 711
www.mpro.org

MINNESOTA

Stratis Health
2901 Metro Drive, Suite 400
Bloomington, MN 55425
1-877-787-2847
TTY 711
www.stratishealth.org

MISSISSIPPI

Information and Quality Healthcare
385 B Highland Colony Parkway, Suite 504
Ridgeland, MS 39157
1-800-844-0600
TTY 711
www.iqh.org

MISSOURI

Primaris
200 North Keene Street
Columbia, MO 65201
1-800-347-1016

MONTANA

Mountain-Pacific Quality Health Foundation
3404 Cooney Drive
Helena, MT 59602
1-800-497-8232
TTY 711
www.mpqhf.org

NEBRASKA

CIMRO of Nebraska
1230 O Street Suite 120
Lincoln, NE 68508
1-800-458-4262
TTY 711
www.cimronebraska.org

NEVADA

HealthInsight
6830 W. Oquendo Road, Suite 102
Las Vegas, NV 89118
1-800-748-6773
TTY 711
www.healthinsight.org

NEW HAMPSHIRE

Northeast Health Care Quality Foundation
15 Old Rollinsford Road Suite 302
Dover, NH 03820
1-800-772-0151
TTY 711
www.nhcqf.org

NEW JERSEY

Healthcare Quality Strategies, Inc.(HQSI)
557 Cranbury Road Suite 21
East Brunswick, NJ 08816-4026
1-800-624-4557
TTY 1-800-752-8420
www.hqsi.org

NEW MEXICO

New Mexico Medical Review Association
5801 Osuna Road NE Suite 200
Albuquerque, NM 87109
1-800-663-6351

NEW YORK

IPro
1979 Marcus Avenue
Lake Success, NY 11042-1002
1-800-331-7767
TTY 1-866-446-3507
www.ipro.org

NORTH CAROLINA

The Carolinas Center for Medical Excellence
100 Regency Forest Drive Suite 200
Cary, NC 27518-8598
1-800-682-2650
TTY 1-800-735-2962
www.thecarolinascenter.org

NORTH DAKOTA

North Dakota Health Care Review, Inc.
800 31st Avenue SW
Minot, ND 58701
1-800-472-2902
TTY 711
www.ndhcri.org

OHIO

Ohio KePRO
Rock Run Center 5700 Lombardo Center
Drive Suite 100
Seven Hills, OH 44131
1-800-589-7337
TTY 711
www.ohiokepro.com

OKLAHOMA

Oklahoma Foundation for Medical Quality
14000 Quail Springs Parkway Suite 400
Oklahoma City, OK 73134-2600
1-800-522-3414

OREGON

Acumentra Health
2020 SW Fourth Avenue Suite 520
Portland, OR 97201
1-800-344-4354

PENNSYLVANIA

Quality Insights of Pennsylvania
2601 Market Place St., Suite 320
Harrisburg, PA 17110
1-877-346-6180

RHODE ISLAND

Quality Partners of Rhode Island
235 Promenade Street Suite 500 Box 18
Providence, RI 02908
1-800-662-5028
TTY 711
www.riqualitypartners.org

SOUTH CAROLINA

The Carolinas Center for Medical Excellence
246 Stoneridge Drive Suite 200
Columbia, SC 29210
1-800-922-3089
TTY 1-800-735-8583
www.thecarolinascenter.org

SOUTH DAKOTA

South Dakota Foundation for Medical Care
2600 W. 49th Street, Suite 300
Sioux Falls, SD 57105
1-800-658-2285
TTY 711
www.sdfmc.org

TENNESSEE

Qsource
3175 Lenox Park Blvd. Suite 309
Memphis, TN 38115
1-800-528-2655
TTY 711
www.qsource.org

TEXAS

TMF Health Quality Institute
5918 West Courtyard Dr., Bridgepoint I,
Suite 300
Austin, TX 78730-5036
1-800-725-9216

UTAH

HealthInsight
348 East 4500 South Suite 300
Salt Lake City, UT 84107
1-800-748-6773

VERMONT

Northeast Health Care Quality Foundation
15 Old Rollinsford Rd., Suite 302
Dover, NH 03820-2830
1-800-772-0151
TTY 711
www.nhcqf.org

VIRGINIA

Virginia Health Quality Center
9830 Mayland Drive, Suite J
Richmond, VA 23233
1-866-263-8402
TTY 711
www.vhqc.org

WASHINGTON

Qualis Health
10700 Meridan Ave. N., Suite 100
Seattle, WA 98133
1-800-949-7536
TTY 711
www.qualishealthmedicare.org

WEST VIRGINIA

West Virginia Medical Institute
3001 Chesterfield Avenue
Charleston, WV 25304
1-800-642-8686
TTY 711
www.qiww.org

WISCONSIN

MetaStar, Inc.
2909 Landmark Place
Madison, WI 53713
1-800-362-2320

WYOMING

Mountain-Pacific Quality Health Foundation
409 South 4th
Glenrock, WY 82637
1-877-810-6248
TTY 711
www.mpqhf.org

Section 11 – Disenrollment from the Plan

Voluntary Disenrollment

You may choose to end your membership in the Plan for any reason. If you wish to Disenroll:

You or your authorized representative may request Disenrollment directly from UnitedHealthcare. In order to do so, you must send a signed and dated letter stating your intent to UnitedHealthcare at the address listed on the back cover. If you have any questions regarding this letter please contact Customer Service at the phone number located on the back of your Member ID card or the back cover of this Evidence of Coverage.

– Call the national Medicare help line at 1-800-MEDICARE (1-800-633-4227), (for the hearing impaired, 1-877-486-2048), 24 hours a day, 7 days a week to Disenroll via the phone.

In the event you choose to cancel your membership under the Plan, re-enrollment may not be permitted, or you may have to wait until your next Open Enrollment Period. **You should consult with your Plan Sponsor regarding the availability of other coverage prior to canceling your Plan membership outside of your Plan Sponsor's Open Enrollment Period. It is important to understand your plan administrator's Disenrollment and move notification policies and the possible impact to your retiree health care coverage options and other retirement benefits before submitting your disenrollment request to UnitedHealthcare.**

Please note that if you cancel your membership in this Plan you may be eligible to enroll in one of our individual Medicare Advantage plans. Please refer to Section 2 of this Evidence of Coverage for further information regarding enrollment. As a member of one of our individual Medicare Advantage plans, you will receive the benefit package approved by CMS for your county of residence. The individual Medicare Advantage plan benefits may be different than the benefit package available through your Plan Sponsor, and a Health Plan Premium may apply.

The Effective Date of Your Disenrollment

Please contact your Plan Sponsor or UnitedHealthcare for more information regarding your Disenrollment effective date. In most cases, a written Disenrollment request received by UnitedHealthcare by the end of the month will make your Disenrollment effective the first of the following month. For example, if your Disenrollment request is received on March 31, your Disenrollment from the Plan would be processed for an Effective Date of April 1. There is an exception to this general rule. The Disenrollment date for requests made in November may be effective December 1, or January 1. If you do not choose an Effective Date for your Disenrollment request made in November, your Disenrollment will be effective on December 1.

Until your membership ends, you will continue to be a Member of the Plan and must continue to receive all routine Covered Services from Contracting Medical Providers, and/or prescription drugs as usual through our Plan, until the date your Disenrollment is effective. UnitedHealthcare will send you a letter that informs you when your Disenrollment is effective. Once your Disenrollment is effective, you may begin using your red, white and blue Medicare card to obtain services under Medicare unless you have joined another Coordinated Care Plan. (Note: If you need a new Medicare card, call the Social Security Administration Office at **1-800-772-1213**.)

*As a Member of this Plan, offered to you by your Plan Sponsor, the information below **does not** apply to you because you are allowed to make enrollment changes at times designated by your Plan Sponsor (see above). However, if you ever choose to discontinue your Plan Sponsored health care coverage, the information below (up to Moves or an Extended Absence from the Service Area) will apply to you.*

In general, there are only certain times during the year when you can Disenroll from one of our individual Medicare Advantage Plans. There are also Medicare program limits on how often you can make a change to your Medicare coverage and what types of changes you are allowed to make as described below.

From **November 15 through December 31**, you may Disenroll from one of our individual Medicare Advantage plans and choose another health plan or return to Original Medicare for a January 1 effective date. During this same time period, all Medicare beneficiaries may make a change to the way they get their Medicare coverage by choosing to enroll in a plan which offers Medicare Part D drug coverage or Disenrolling from a plan which offers Medicare Part D drug coverage.

From **January 1 through March 31**, you may choose to end your membership in one of our individual Medicare Advantage plan for any reason. However, there are Medicare program limits on the types of changes you are allowed to make. If on January 1, you are enrolled in one of our individual Medicare Advantage plans without Medicare Part D drug coverage, you may **not** use this time period to enroll in a Medicare Part D drug plan. Also, if on January 1, you are enrolled in one of our individual Medicare Advantage plans with Medicare Part D drug coverage, you may **not** use this time period to Disenroll from a Medicare Part D drug plan.

Generally, after **March 31** you cannot Disenroll from an individual Medicare Advantage plan unless you qualify for a special exception such as moving out of the Service Area or if you have Medicaid. (For more information on enrollment rules, see Section 2).

If you wish to enroll in an individual Medicare Advantage plan and you are an institutionalized Medicare beneficiary, or receive Medicaid, or if you qualify for a Medicare Savings Program such as Medicaid Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual, you may enroll at any time of the calendar year.

If you do not receive Medicaid, or qualify for a Medicare Savings Program such as Medicaid Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual, in general, there are only certain times during the year when you can enroll in an individual Medicare Advantage Plan. There are also Medicare program limits on how often you can make a change to your Medicare coverage and what types of changes you are allowed to make as described below.

If you wish to Disenroll from one of our individual Medicare Advantage plans between November 15 and December 31:

- You or your authorized representative may request Disenrollment directly from us. In order to proceed with your Disenrollment request, you must send a written, signed and dated letter or fax to us. If you have any questions about the letter, please contact Customer Service.
- You or your authorized representative may call the national Medicare help line at **1-800-MEDICARE (1-800-633-4227) (TTY, 1-877-486-2048)**, 24 hours a day, 7 days a week to Disenroll over the phone.

- You may switch to another Medicare Advantage Plan with Medicare Part D drug coverage by simply enrolling in that plan. This will result in your Disenrollment from our individual Medicare Advantage plan.
- If you want to return to Original Medicare and also want to join a Prescription Drug Plan, simply enroll in a Prescription Drug Plan available in your area. This will automatically Disenroll you from our individual Medicare Advantage plan and return you to Original Medicare.
- If you want to return to Original Medicare and do not want to join a Prescription Drug Plan, simply call Customer Service, or Medicare at the phone number above, and request to be Disenrolled from our individual Medicare Advantage plan. You will automatically return to Original Medicare.

If you want to Disenroll from one of our “medical only” individual Medicare Advantage plans without Medicare Part D drug coverage between January 1 and March 31:

- You may switch to another Medicare Advantage Plan without Medicare Part D drug coverage by simply enrolling in that plan. This will result in your Disenrollment from our individual Medicare Advantage plan.

If you want to Disenroll from one of our individual Medicare Advantage plans with Medicare Part D drug coverage between January 1 and March 31:

- You may switch to another Medicare Advantage Plan with Medicare Part D drug coverage by simply enrolling in a Medicare Advantage Plan with Medicare Part D drug coverage. This will result in your Disenrollment from our individual Medicare Advantage plan.
- You may enroll in a Prescription Drug Plan and return to Original Medicare by simply enrolling in a Prescription Drug Plan. This will result in your Disenrollment from our individual Medicare Advantage plan and your return to Original Medicare.

We cannot accept Disenrollment requests from Members in one of our individual Medicare Advantage plans with Medicare Part D drug coverage after March 31.

The Effective Date of Your Disenrollment

Written Disenrollment requests received by us between **November 15 and December 31** will make your individual Medicare Advantage plan Disenrollment effective on January 1. Until January 1, you will continue to be a Member of the individual Medicare Advantage plan and must continue to receive all routine Covered Services from Contracted Medical Providers, and/or prescription drugs as usual through our Plan.

In most cases, a written Disenrollment request from a Member enrolled in an individual Medicare Advantage plan without Medicare Part D drug coverage received by us between **January 1 and March 31** will make your Disenrollment effective the first day of the month following the month of your request. For example, if your Disenrollment request is received on January 31, your Disenrollment from the individual Medicare Advantage plan would be processed for an Effective Date of February 1.

Until your membership ends, you will continue to be a Member of the individual Medicare Advantage plan and must continue to receive all routine Covered Services from Contracted Medical Providers, and/or prescription drugs as usual through our Plan, until the date your Disenrollment is effective. We will send you a letter that informs you when your Disenrollment is effective. Once your Disenrollment is effective, you may begin using your red, white and blue

Medicare card to obtain services under Medicare unless you have joined another Coordinated Care Plan. **Note:** If you need a new Medicare card, call the Social Security Administration Office at **1-800-772-1213** toll free, (TTY the toll-free number **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday. You also may visit the Social Security Web site at www.ssa.gov.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy including our mail-order-pharmacy service, are listed on our formulary, and you follow other coverage rules.

Moves or an Extended Absence from the Service Area

If you are permanently moving out of the Service Area or plan an extended absence of more than six (6) months, you must notify us and your Plan Sponsor of the move or extended absence before you leave the Service Area. If you move permanently out of our Service Area, or if you are away from our Service Area for more than six (6) consecutive months, you will need to Disenroll from the Plan.

Failure to notify us of a permanent move or an extended absence may result in your involuntary Disenrollment from the Plan, because we are required to Disenroll you if you have moved out of the Service Area for more than six (6) months. If you remain enrolled after a move or extended absence (and have not been involuntarily Disenrolled as described above), you should be aware that services will not be covered unless they are received from Contracted Medical Providers (except for Emergency Services and Urgently Needed Services).

Our Medicare Advantage plans are currently offered in many states. If you are moving outside of your Service Area, you may be eligible to enroll in a Medicare Advantage plan in your new location. Please contact your Plan Sponsor to determine the availability of their Plan, or other health plan options available to you. Health Plan Premiums if applicable, Copayments, Covered Services and benefit plan types may vary from one area to another. For information and assistance in completing any necessary paperwork, call Customer Service.

For information on other plans available in your area, call **1-800-MEDICARE (1-800-633-4227) (TTY, 1-877-486-2048)**, 24 hours a day, 7 days a week or visit the CMS Web site at www.medicare.gov.

What happens if the Plan leaves the Medicare Program or leaves the Service Area where you live?

If we leave the Medicare program or discontinue the Plan in your Service Area, we will notify you in writing. **If either of these situations occurs, you will be allowed to change the way you receive Medicare coverage.** Your choices will always include Original Medicare, and they may also include joining another Medicare Advantage Plan, if such plans are available in your area and are accepting new Members. However, you should consult with your Plan Sponsor to determine your health care coverage options.

We have a contract with CMS. At the end of each year, the contract is reviewed, and either we or CMS may decide to terminate the contract. It is also possible our contract may terminate at some other time. If the contract is going to terminate, we will generally notify you at least ninety (90) days in advance. Your advance notice may be as little as thirty (30) days, or even fewer days if CMS terminates our contract in the middle of the year.

Until we notify you in writing that you must Disenroll from the Plan and indicate the date when your membership ends, you will continue as a Member of the Plan, and you must continue to receive all Covered Services from Contracted Medical Providers, and/or prescription drugs as usual through our Plan, until the date your Disenrollment is effective. All Covered Services and rules described in this document will continue until your membership ends.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy including our mail-order-pharmacy service, are listed on our formulary, and you follow other coverage rules.

Once we have notified you in writing we are leaving the Medicare program or the area where you live, you may switch to another way of getting your Medicare benefits at any time. If you decide to switch from the Plan to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called "guaranteed issue rights." You may contact your SHIP about how and when to buy a Medigap policy if you need one.

Coverage that ends during an inpatient Hospital Stay

If your coverage under the Plan ends while you are an inpatient in a Hospital (or Hospital unit), we may be responsible for the inpatient services until the date of your discharge. Our Customer Service Representatives can advise you if we are responsible for your inpatient services. We are not responsible for services, other than inpatient Hospital services, furnished on or after the Effective Date of your Disenrollment.

Involuntary Disenrollment

We **must** Disenroll you from the Plan under the conditions listed below (you will not be Disenrolled due to your health status):

- If you move out of the Service Area or live outside the Service Area for more than six (6) months at a time and do not voluntarily Disenroll.
- If you do **not** stay continuously enrolled in both Medicare Part A and Medicare Part B.

You **may** be Disenrolled from the Plan under the following conditions:

- If you provide information on your Enrollment Request Form that is false or deliberately misleading and it affects whether or not you may enroll in the Plan.
- If you behave in a way that is unruly, uncooperative, disruptive or abusive, and this behavior seriously affects our ability to arrange Covered Services for you or for others who are Members of the Plan. Before we can Disenroll you for this reason, **we must obtain permission** from the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare.
- If you allow someone else to use your Member ID card to obtain Covered Services. Before we will Disenroll you for this reason, we must refer your case to the Inspector General, which may result in criminal prosecution.
- If your Plan Sponsor does not pay the Health Plan Premiums on your behalf, you may be disenrolled. See Section 8 "Premiums and Payments" of this Evidence of Coverage. If you are responsible to pay Health Plan Premiums directly to UnitedHealthcare and you do

not pay the applicable Health Plan Premiums, you may be Disenrolled from the Plan. We will inform you of a thirty (30) day grace period during which you can pay the Health Plan Premiums before you are required to Disenroll from the Plan. Should you decide later to re-enroll in the Plan, you must pay any outstanding Health Plan Premiums due from your previous enrollment.

You have the right to file a complaint if we Disenroll you from the Plan

If we Disenroll you from the Plan, we will inform you of the reasons in writing and explain how you may file a Grievance if you so choose.

Until we notify you in writing that you have been Disenrolled, you will continue to be a Plan Member and must continue to obtain routine Covered Services from Contracted Medical Providers. Neither we nor Medicare will pay for services received from Non-Contracted Providers except for Urgently Needed Services, Emergency Services anywhere in the world and out-of-area renal dialysis services.

We cannot Disenroll you due to your health

You may only be Disenrolled from the Plan under certain special conditions that are described above. These conditions do not include Disenrolling you due to your health status. No Member of any Medicare Advantage health plan may be Disenrolled from the plan for any health-related reasons.

If you ever feel you are being encouraged or asked to Disenroll from the Plan due to your health status, you should call the national Medicare help line **1-800-MEDICARE (1-800-633-4227), (TTY, 1-877-486-2048)**, 24 hours a day, 7 days a week.

Section 12 – Coordinating Other Benefits You May Have

If you have other health insurance coverage, in addition to the Plan, it is important to use this other coverage **in combination with** your Plan coverage to help pay for the cost of the Covered Services you receive. The use of other health insurance available to you with your Plan coverage is called “coordination of benefits” because it involves coordinating all of your health care coverage.

Please keep us up to date on any other health insurance coverage you have, such as the following:

- Coverage that you have from an employer’s group health insurance for employees or retirees, either through yourself or your spouse
- Coverage that you have under Workers’ Compensation because of a job-related illness or injury or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid
- Coverage through the “TriCare for Life” program (veterans’ benefits)
- Coverage you have for dental insurance or prescription drugs
- “Continuation coverage” that you have through the Consolidated Omnibus Budget Reconciliation Act (COBRA)

Who Pays First?

As a Member, you are always entitled to receive Covered Services through the Plan. Medicare law, however, gives us or our designee the right to recover payments from certain “third party” insurance companies or from you, if you were paid by a “third party.” Because of this, we may ask you for information about other insurance you may have. If you have other insurance, you can help us obtain payment from the other insurer by promptly providing the requested information.

If any no-fault or any liability insurance is available to you, benefits under that plan must be applied to the costs of health care covered by that plan. Where we have provided benefits, and a judgment or settlement is made with a no-fault or liability insurer, you must reimburse us or our designee (entity or person selected for this purpose) to the extent of your medical expenses. However, our reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers’ Compensation from treatment of a work-related illness or injury should also be applied to covered health care costs.

If you do not have end-stage renal disease (ESRD), and have coverage under an employer group plan of an employer of twenty (20) or more employees, either through your own current employment or the employment of a spouse, you must use the benefits under that plan prior to using your Plan benefits. Similarly, if you do not have end-stage renal disease (ESRD), but have Medicare based on disability and are covered under an employer group plan of an employer of one hundred (100) or more employees (or a multiple employer plan that includes an employer of one hundred or more employees) through a spouse’s employer group coverage, you must use the benefits under that plan prior to using your Plan benefits.

In such cases, you will only receive benefits not covered by your employer group plan through our contract with Medicare (and we will only be paid an amount by Medicare to cover such “wrap-around” benefits). A special rule applies if you have or develop ESRD.

If you have (or develop) ESRD and are covered under an employer group plan, you must use the benefits of that plan for the first thirty (30) months after becoming eligible for Medicare based on ESRD. Medicare is the primary payer after this coordination period. However, if your employer group plan coverage was secondary to Medicare when you developed ESRD, because it was not based on current employment as described above, Medicare continues to be the primary payer.

Section 13 – Advance Directives: Making Your Health Care Wishes Known

We are required by law to inform you of your right to make health care decisions and to execute an Advance Directive. An Advance Directive is a formal document, written by you in advance of an incapacitating illness or injury. As long as you can speak for yourself, Contracted Medical Providers will honor your wishes. If you become so sick that you cannot speak for yourself, this directive will guide your health care Providers in treating you, and will save your family, friends and physicians from having to guess what you would have wanted.

There may be several types of Advance Directives you may choose from, depending on State law. Most States recognize:

1. DPAHC (Durable Power of Attorney for Health Care)/Medical Durable Power of Attorney
2. Health Care Directive
3. Living Wills
4. Natural Death Act Declarations
5. Cardiopulmonary Resuscitation (CPR) Directive
6. Do Not Resuscitate (DNR) Orders

You are not required to initiate an Advance Directive, and you will not be denied care if you do not have an Advance Directive.

If you choose to have an Advance Directive, you must provide copies of your completed directive to the following:

1. Your Primary Care Physician/Contracted Medical Provider
2. Your agent or representative (if you have one)
3. Your family

If you decide that you want to have an Advance Directive, there are several ways to get this type of legal form. You may get a form from your lawyer, from a social worker, the Internet and from some office supply stores.

Take a copy of your Advance Directive to the Hospital when you are hospitalized.

If you have questions regarding the creation of an Advance Directive or end of life treatment decisions, or if you want to file a complaint because believe your rights related to the creation and use of an Advance Directive have not been respected, please contact your SHIP for assistance.

Section 14 – General Provisions

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in may apply.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans or Medicare Prescription Drug Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Your Financial Liability as a Plan Member

As a Member of the Plan, you have the following financial obligations:

All Copayments and Coinsurance specified in the Retiree Benefits Summary and Insert must be paid to the Contracting Medical Provider at the time of service.

Health Plan Premium (if applicable)

Rate changes for Plan Members are subject to contractual arrangements between UnitedHealthcare and your former employer, union group or trust administrator (Plan Sponsor). Your Plan Sponsor is responsible for notifying you of any Plan health plan premium changes, contribution changes or Plan Sponsored benefit changes thirty (30) days before they become effective. If you are responsible to pay a Health Plan Premium directly to UnitedHealthcare, the amount will be specified in the Retiree Benefits Summary and Insert.

Member Liability

In the event we fail to reimburse network provider's charges for covered services, you will not be liable for any sums owed by us.

You will be liable if you receive services from non-network providers. Neither the Plan nor Medicare will pay for those services except for the following eligible expenses:

- Emergency services
- Urgently needed health services
- Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

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

Third Party Liability and Subrogation

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, we shall furnish all covered services. However, you agree to fully reimburse us or our designee for the cost of all such services and benefits provided, immediately upon obtaining a monetary recovery, whether due to settlement or judgment, as a result of such injuries.

You agree to cooperate in protecting the interests of UnitedHealthcare or its designee under this provision. You shall not settle any claim, or release any person from liability, without the written consent of UnitedHealthcare, wherein such release or settlement will extinguish or act as a bar to our right of reimbursement.

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by us to you from: (a) third parties, including any person (or any insurer of any person) alleged to have negligently or intentionally, or by reason of product liability or breach of warranty, caused you to suffer sickness or injury; (b) your employer; or (c) any other person or entity legally liable for damages or harm to you, including but not limited to damages under any medical payment, uninsured or underinsured motorist coverage benefits payable by your own automobile insurer, or any damages payable by any homeowner insurance carrier or any other insurer's medical payment provision. These third parties, persons and entities are collectively referred to as "Third Parties" herein, and claims against them are "Third Party Claims." You agree to assign us all rights of recover against such Third Parties; to the extent of the reasonable value of services and benefits we provide to you, plus reasonable costs of collection. We or any of our subsidiaries or owned affiliates are not a Third Party under this Plan.

The following is agreed upon between you and us:

- You will cooperate with us in protecting our legal rights to subrogation and reimbursement; and you acknowledge that our rights under this Section will be considered as the first priority claim against any Third Parties, to be paid before any of your other claims are paid. Specifically, but without limitation, you agree to: (i) provide any relevant information we may request; (ii) sign and deliver such documents as we or our agents may reasonably request to secure the subrogation claim; (iii) respond to requests for information about any accidents or injuries; (iv) make court appearances; and (v) obtain the consent of the Plan or our agents before releasing any party from liability for or payment of medical expenses. We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf.
- You will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under this Evidence of Coverage and the Retiree Benefits Summary and Insert. We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit on our own behalf as your subrogee. Your failure to cooperate in this manner shall be deemed a breach of this contract and may result in the institution of legal action against you.
- We will not use the rights enumerated throughout this Section to affect or impair any parental financial obligations, such as child support, associated with Pregnancy.
- No court costs or attorneys fees may be deducted from our recovery without our express written consent; and no so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right. We are not required to participate in or pay court costs or attorneys fees to any attorney or other representative or agent hired by you to pursue a claim relating to your sickness or injury.

- We may collect, at our option, amounts from proceeds of any Third Party settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether or not you have been made whole. You will hold any proceeds of such a Third Party settlement or judgment in a constructive trust for our benefit under these subrogation provisions. We will be entitled to recover from you reasonable attorney fees incurred in collecting proceeds held by you.

Reimbursement of Third Party Medical Expenses

If you receive medical services under your Plan coverage after being injured through the actions of another person (a third party) for which you receive a monetary recovery, you will be required to reimburse us, or our designee, to the extent permitted under State and federal law, for the cost of such medical services and benefits provided and the reasonable costs actually paid to perfect any lien.

You must obtain the written consent of UnitedHealthcare or its nominee (entity or person authorized to give consent) prior to settling any claim, or releasing any third party from liability, if such settlement or release would limit the reimbursement rights of UnitedHealthcare or its nominee.

You are required to cooperate in protecting the interests of UnitedHealthcare or its nominee by providing all liens, assignments or other documents necessary to secure reimbursement to us or our nominee. Failure to cooperate with us or our nominee in this regard could result in termination of your Plan Membership.

Should you settle your claim against a third party and compromise the reimbursement rights of UnitedHealthcare or its nominee without our written consent, or otherwise fail to cooperate in protecting the reimbursement rights of UnitedHealthcare or its nominee, we may initiate legal action against you. Attorney fees will be awarded to the prevailing party.

Non Duplication of Benefits With Automobile, Accident or Liability Coverage

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

Acts Beyond Our Control

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

Contracting Medical Providers and Network Hospitals Are Independent Contractors

The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare is an employee or agent of the network providers or network hospitals.

Our Contracting Arrangements

In order to obtain quality service in an efficient manner, we pay providers using various payment methods, including capitation, per diem, incentive and discounted Fee-for-Service arrangements. Capitation means paying an agreed upon dollar amount per month for each member assigned to the provider. Per Diem means paying a fixed dollar amount per day for all services rendered, such as inpatient hospital and skilled nursing facility stays. Incentive means a payment that is based on appropriate medical management by the provider. Discounted Fee-for-Service means paying an agreed upon fee schedule which is a reduction from their usual and customary charges.

You are entitled to ask if we have special financial arrangements with the network providers that may affect the use of referrals and other services that you might need. To obtain this information, call Customer Service and request information about the network provider's payment arrangements.

How Our Network Providers are Compensated

The following is a brief description of how we pay our network providers:

We typically contract with individual physicians and medical groups, often referred to as Independent Practitioner Associations (IPAs), to provide medical services and with hospitals to provide services to members. The contracting medical groups/IPAs in turn, employ or contract with individual physicians.

Most of the individual physicians are paid on a Fee-for-Service arrangement. In addition, some physicians receive an agreed-upon monthly payment from us to provide services to members. The monthly payment may be either a fixed dollar amount for each member, or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by individual physicians and may also cover certain referral services.

Most of the contracted medical groups/IPAs receive an agreed upon monthly payment from us to provide services to members. The monthly payment may be either a fixed dollar amount for each member or a percentage of the monthly plan premium received by us. The monthly payment typically covers professional services directly provided by the contracted medical group/IPA, and may also cover certain referral services. Some of our network hospitals receive similar monthly payments in return for arranging hospital services for members. Other hospitals are paid on a discounted Fee-for-Service or fixed charge per day of hospitalization.

Each year, we and the contracted medical group/IPA agree on a budget for the cost of services covered under the program for all plan members treated by the contracted medical group/IPA. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the

contracted medical group/IPA shares in the savings. The network hospital and the contracted medical group/IPA typically participate in programs for hospital services similar to that described above.

Stop-loss insurance protects the contracted medical groups/IPAs and network hospitals from large financial losses and helps the providers with resources to cover necessary treatment. We provide stop-loss protection to the contracted medical groups/IPAs and network hospitals that receive capitation payments. If any capitated providers do not obtain stop-loss protection from us, they must obtain stop-loss insurance from an insurance carrier acceptable to us. You may obtain additional information on compensation arrangements by contacting Customer Service or your contracted medical group/IPA, however, specific compensation terms and rates are confidential and will not be disclosed.

Technology Assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for our Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service it will be subject to all other Terms and Conditions of the plan, including Medical Necessity and any applicable Member Copayments, Coinsurance, Deductibles or other payment contributions.

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

Section 15 – Notices

Any notices required to be given by us to the Member under this Evidence of Coverage shall be in writing, delivered by United States mail and sent to the Member at the address last known to us. Any notices required to be given to us by the Member under this Evidence of Coverage shall be in writing, and delivered either in person or by United States mail to the address on the back cover.

Member Statements

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

Information Upon Request

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

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare

Internal Protection of Information within UnitedHealth Group

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We provide physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information to protect against risks such as loss, destruction or misuse. We conduct regular audits to guarantee appropriate and secure handling and processing of our enrollees' information.

How You Can Fight Healthcare Fraud

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

Here are some examples of potential Medicare fraud cases:

- A health care provider – such as a physician, pharmacy, or medical device company – bills for services you never got,
- A supplier bills for equipment different from what you got
- Someone uses another person's Medicare card to get medical care, prescriptions, supplies or equipment
- Someone bills for home medical equipment after it has been returned.

- A company offers a Medicare drug or health plan that hasn't been approved by Medicare.
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call UnitedHealthcare Insurance Company's dedicated fraud hotline at 1-877-637-5595 , 24 hours a day, 7 days a week. TTY/TDD users may call 1-877-730-4203

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

You may also report potential prescription drug program fraud cases to the Medicare program directly at 1-877-7SafeRx (1-877-772-3379) (TTY 711). For potential medical or non-prescription fraud cases, you may report to the Medicare program directly at 1-800-Medicare (1-800-633-4227) **(TTY, 1-877-486-2048), 24 hours a day, 7 days a week.** The Medicare fax number is 1-717-975-4442 and the Web site is www.medicare.gov.

For more information, request the guide titled "Protecting Medicare and You from Fraud" by calling 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. A customer service representative can answer your questions 24 hours a day, 7 days a week.

Section 16 – The Geographic Service Area For Our Plan

This is the statewide Service Area listing for the Plan. Benefit plans are specific to the service area.

You are eligible for enrollment and continued coverage as long as you reside in one of the states and/or counties listed below:

For Oregon: Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk and Washington Counties

For Washington: Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman and Yakima Counties

Section 17 – HEALTH PLAN NOTICES OF PRIVACY PRACTICES

Internal Protection of Information within UnitedHealth Group

NOTICE FOR MEDICAL INFORMATION: Pages 1 - 5.

NOTICE FOR FINANCIAL INFORMATION: Pages 6 - 7.

MEDICAL INFORMATION PRIVACY NOTICE

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, 2010

We¹ are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

¹ This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Insurance Company of California; American Medical Security Life Insurance Company; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Arnett HMO, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Evercare of New Mexico, Inc.; Evercare of Texas, LLC; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Health Plan of Nevada, Inc.; IBA Health and Life Assurance Company; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; PacifiCare Behavioral Health of California, Inc.; PacifiCare Behavioral Health, Inc.; PacifiCare Dental; PacifiCare Dental of Colorado, Inc.; PacifiCare Insurance Company; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of California; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; PacifiCare of Oklahoma, Inc.; PacifiCare of Oregon, Inc.; PacifiCare of Texas, Inc.; PacifiCare of Washington, Inc.; Sierra Health & Life Insurance Co., Inc.; Spectera, Inc.; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Family Health Plan of Pennsylvania, Inc.; Unison Health Plan of Delaware, Inc.; Unison Health Plan of Ohio, Inc.; Unison Health Plan of Pennsylvania, Inc.; Unison Health Plan of South Carolina, Inc.; Unison Health Plan of Tennessee, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Insurance Company of Ohio; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

Questions? Call our Sales or Customer Service Departments listed on the back cover.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide a revised notice by direct mail to you reflecting that change within 60 days of the change and we will otherwise post the revised notice on our Web site www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law as of February 17, 2010.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. As of February 17, 2010, our business associates also will be directly subject to federal privacy laws.

Questions? Call our Sales or Customer Service Departments listed on the back cover.

- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. “Highly confidential information” may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
 1. HIV/AIDS;
 2. Mental health;
 3. Genetic tests;
 4. Alcohol and drug abuse;
 5. Sexually transmitted diseases and reproductive health information; and
 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a Summary of Federal and State Laws on Use and Disclosure of Certain Types of Medical Information.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or “revoke” your written authorization at anytime in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your Member ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to request that a provider not send health information** to us in certain circumstances if the health information concerns a health care item or service for which you have paid the provider out of pocket in full.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will

accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. As of February 17, 2010, if we maintain an electronic health record containing your health information, you have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may also obtain a copy of this notice at our Web site, www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call **the phone number on the back of your Member ID card** or you may contact Customer Service at the phone number listed on the back cover.
- **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for amendments to your record, at the following address:

UnitedHealth Group
PSMG Privacy Office
MN006-W800
P.O. Box 1459
Minneapolis, MN 55440
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

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

FINANCIAL INFORMATION PRIVACY NOTICE

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

Effective January 1, 2010

We² are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

In the course of our general business practices, we may disclose personal financial information about you or others without your permission to our corporate affiliates to provide them with information about your transactions, such as your premium payment history.

² For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group IPA of New York, Inc.; ACN Group, Inc.; Administration Resources Corporation; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Behavioral Healthcare Options, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; Innoviant, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Care, Inc.; National Benefit Resources, Inc.; OneNet PPO, LLC; OptumHealth Bank, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; PacificDental Benefits, Inc.; ProcessWorks, Inc.; RxSolutions, Inc.; Sierra Health-Care Options, Inc.; Sierra Nevada Administrators, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; United Healthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc.

Confidentiality and Security

We restrict access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with federal standards to guard your personal financial information. We conduct regular audits to guarantee appropriate and secure handling and processing of our enrollees' information.

Your Right to Access and Correct Personal Information

If you reside in certain States³, you may have a right to request access to the personal financial information that we record about you. Your right includes the right to know the source of the information and the identity of the persons, institutions, or types of institutions to whom we have disclosed such information within 2 years prior to your request. Your right includes the right to view such information and copy it in person, or request that a copy of it be sent to you by mail (for which we may charge you a reasonable fee to cover our costs). Your right also includes the right to request corrections, amendments or deletions of any information in our possession. The procedures that you must follow to request access to or an amendment of your information are as follows:

To obtain access to your information: Submit a request in writing that includes your name, address, social security number, telephone number, and the recorded information to which you would like access. State in the request whether you would like access in person or a copy of the information sent to you by mail. Upon receipt of your request, we will contact you within 30 business days to arrange providing you with access in person or the copies that you have requested.

To correct, amend, or delete any of your information: Submit a request in writing that includes your name, address, social security number, telephone number, the specific information in dispute, and the identity of the document or record that contains the disputed information. Upon receipt of your request, we will contact you within 30 business days to notify you either that we have made the correction, amendment or deletion, or that we refuse to do so and the reasons for the refusal, which you will have an opportunity to challenge.

Send written requests to access, correct, amend or delete information to:

UnitedHealth Group
PSMG Privacy Office
MN006-W800
P.O. Box 1459
Minneapolis, MN 55440

³ California and Massachusetts.

**UNITEDHEALTH GROUP
HEALTH PLAN NOTICE OF PRIVACY PRACTICES:
FEDERAL AND STATE AMENDMENTS**

Revised: January 1, 2010

The first part of this Notice, which provides our privacy practices for Medical Information (pages 1 - 5), describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information	
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.	
Genetic Information	
We are not allowed to use genetic information for underwriting purposes.	

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	CA, NE, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NV
We are not allowed to use health information for certain purposes.	CA, NH
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, MI, OK

Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	MT, NJ, WA
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, HI, KY, IL, IN, IA, LA, MD, MA, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, HI, IL, KY, NY, TN
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	GA, MD, MA, MO, NV, NH, NM, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, LA, MD, OH, SD, UT, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, HI, IL, IN, MI, MT, NY, NC, PA, PR, RI, TX, VT, WV
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, HI, IL, IN, KY, MA, MI, PR, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI

Copyright 2009 United HealthCare Services, Inc.

Questions?

AARP® MedicareComplete®

Prospective Members,
call our Sales Department:
1-888-422-6000
TTY 711
8 a.m. to 8 p.m. local time,
7 days a week

Members, call our
Customer Service Department:
1-888-736-7430
TTY 711
8 a.m. to 8 p.m. local time,
7 days a week

Write

UnitedHealthcare
Attention: Customer Service
P.O. Box 29800
Hot Springs, AR 71903-0800

AARP® | MedicareComplete®
from SecureHorizons

SecureHorizons

Prospective Members,
call our Sales Department:
1-800-610-2660
TTY 711
8 a.m. to 8 p.m. local time,
7 days a week

Members, call our
Customer Service Department:
1-888-867-5548
TTY 711
8 a.m. to 8 p.m. local time,
7 days a week

SecureHorizons®
by UnitedHealthcare

A UnitedHealthcare® Medicare Solution

AARP does not make health plan recommendations for individuals. You are strongly encouraged to evaluate your needs before choosing a health plan.

AARP is not an insurer. UnitedHealthcare pays a fee to AARP for use of the AARP trademark. Amounts paid are used for the general purposes of AARP and its members. The AARP® MedicareComplete® plans are available to all eligible Medicare beneficiaries, including both members and non-members of AARP. AARP and the AARP Logo are trademarks or registered trademarks of AARP. The SecureHorizons and MedicareComplete marks are trademarks or registered trademarks of United Healthcare Alliance, LLC and its affiliates.