Evidence of Coverage 2027

AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO)

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January 1 – December 31, 2027

Evidence of Coverage for 2027

Your Medicare Health Benefits and Services as a Member of our plan

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027.

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

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost-sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Service at 1-866-272-1967 (TTY users call 711). Hours are 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept.This call is free.

This plan, AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO), is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO).)

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UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-866-272-1967 for additional information (TTY users should call 711). Hours are 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al 1-866-272-1967,

OMB Approval 0938-1051 (Expires: July 31, 2029)

para obtener información adicional (los usuarios de TTY deben llamar al 711). El horario es 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept.
Benefits, premium and/or copayments/coinsurance may change on January 1, 2028.

Our provider network can change at any time. You'll get notice about any changes that can affect you at least 30 days in advance.

OMB Approval 0938-1051 (Expires: July 31, 2029)

2027 Evidence of Coverage

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Chapter 1:
Get started as a member

Section 1 You're a member of AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO)

Section 1.1 You're enrolled in AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO), which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO). Our plan covers all Part A and Part B services. However, cost-sharing and provider access in this plan are different from Original Medicare.

AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan doesn't include Part D drug coverage.

Section 1.2 Legal information about the Evidence of Coverage

This **Evidence of Coverage** is part of our contract with you about how AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) covers your care. Other parts of this contract include your enrollment form, and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months you're enrolled in the plan between January 1, 2027 and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of the plan after December 31, 2027. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

Section 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You are eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they are physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO)

Our plan is only available to individuals who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in West Virginia: Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at 1-866-272-1967 (TTY users call 711) to see if we have a plan in your new area.

When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

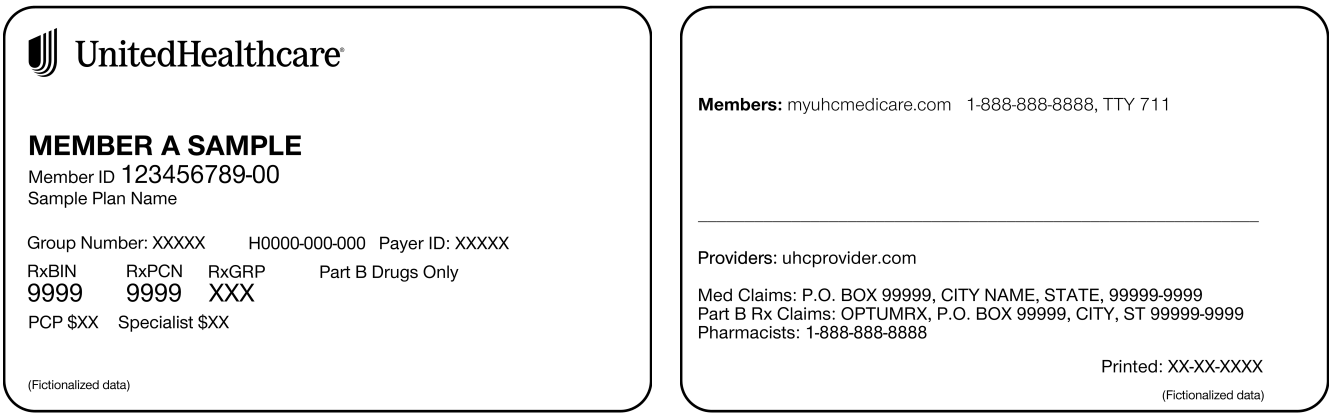
Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) if you're not eligible to stay a member of our plan on this basis. AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) must disenroll you if you do not meet this requirement.

Section 3 Important membership materials

Section 3.1 Your UnitedHealthcare member ID card

Use your UnitedHealthcare member ID card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample UnitedHealthcare member ID card:



DON’T use your red, white and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your UnitedHealthcare member ID card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If your UnitedHealthcare member ID card is damaged, lost, or stolen, call Customer Service at 1-866-272-1967 (TTY users call 711) right away and we’ll send you a new card.

Section 3.2 Provider Directory

The **Provider Directory**, available at myAARPMedicare.com, lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Go to Chapter 3 for more specific information.

Get the most recent list of providers and suppliers on our website at myAARPMedicare.com.

If you don't have a **Provider Directory**, you can ask for a copy (electronically or in paper form) from Customer Service at 1-866-272-1967 (TTY users call 711). Requested paper Provider Directories will be mailed to you within 3 business days.

Section 4 Summary of Important Costs for 2027

	Your costs in 2027
Monthly plan premium	$0
Annual medical deductible	For 2027, your plan has a $1,000 out-of-network deductible. The deductible does not apply to insulin furnished through durable medical equipment (DME). Please see Chapter 4 of your Evidence of Coverage for details.
Maximum out-of-pocket amounts This is the **most** you will pay out-of-pocket for your covered Part A and Part B services. (Go to Chapter 4 Section 1.3 for details.)	From network providers: $9,850 From in-network and out-of-network providers combined: $14,800
Primary care office visits	$0 copayment per visit (in-network). $0 copayment per visit (out-of-network).
Specialist office visits	$55 copayment per visit (in-network). $55 copayment per visit (out-of-network).
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	$490 copayment each day for days 1 to 5 (in-network). $0 copayment for additional Medicare covered days (in-network).

	Your costs in 2027
	$490 copayment each day for days 1 to 5 (out-of-network). $0 copayment for additional Medicare covered days (out-of-network).

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for our plan.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the Medicare & You 2027 handbook in the section called "2027 Medicare Costs." Download a copy from the Medicare website at (medicare.gov/medicare-and-you) or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

As a member of AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) you receive up to a $110 reduction of your monthly Medicare Part B premium. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Rebates apply only to amounts you pay toward the Medicare Part B premium and are not issued on any premium amount paid by Medicaid. Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Reductions may take several months to be issued; however, you will receive a full credit for amounts you have paid.

You must continue paying your Medicare premiums to stay a member of the plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called “optional supplemental benefits”, you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.1 for details. The premium amount for the Platinum Dental Rider is $54.

Section 5 More information about your monthly plan premium

Section 5.1 How to pay your plan premium

There are four ways you can pay your plan premium.

Option 1: Pay by check

We will send you a monthly bill for our monthly plan premium. Make your payment payable to UnitedHealthcare. Please see your bill for the mailing address and other information. Include your member ID number on your check or money order. If making a payment for more than one member, include a payment slip for each member. Include the member ID number for each member on the check or money order. All payments must be received on or before the due date shown on the monthly bill. If you need your monthly bill replaced, please call Customer Service at 1-866-272-1967 (TTY users call 711).

Option 2: Electronic Funds Transfer

Instead of paying by check, you can have our monthly plan premium automatically deducted from your checking account. Your monthly payment will be deducted around the 5th of each month. If you wish to sign up for Electronic Funds Transfer (EFT), you may follow the instructions on your monthly bill, or you may call Customer Service at 1-866-272-1967 (TTY users call 711).

Option 3: Paying by credit card

Instead of paying by check, you can pay our monthly plan premium with your credit card. If you wish to sign up to use your credit card to pay our monthly plan premium please call Customer Service at 1-866-272-1967 (TTY users call 711).

Option 4: Have plan premium deducted from your monthly Social Security check

Changing the way you pay our premium

If you decide to change how you pay your premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you’re still responsible for making sure your plan premium is paid on time. Please contact Customer Service at 1-866-272-1967 (TTY users call 711) to notify us of your premium payment option choice or if you’d like to change your existing option.

If you have trouble paying your plan premium

Your plan premium is due in our office by the first day of the month. If we don't get your payment by the first day of the month, we'll send you a notice. In addition, we have the right to pursue collection of these premium amounts you owe.

Section 5.2 Your monthly plan premium won't change during the year

We're not allowed to change our plan's monthly premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

Section 6 Keep your plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.
The doctors, hospitals, and other providers in our plan's network **use your membership record to know what services are covered and your cost-sharing amounts.** Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number.
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid).
- Any liability claims, such as claims from an automobile accident.
- If you're admitted to a nursing home.
- If you get care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you participate in a clinical research study. (**Note:** You're not required to tell our plan about the clinical research studies you intend to participate in but we encourage you to do so.)

If any of this information changes, please let us know by calling Customer Service at 1-866-272-1967 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits.**

Once each year, we'll send you a letter that lists any other medical or drug coverage that we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Service at 1-866-272-1967 (TTY users call 711). You may need to give your plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer") pays up to the limits of its coverage. The insurance that pays second (the "secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

Chapter 2:
Phone numbers and resources

Section 1 AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) contacts

For help with claims, billing, or UnitedHealthcare member ID card questions, call or write to Customer Service. We'll be happy to help you.

Customer Service - Contact Information	
Call	1-866-272-1967 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept Customer Service 1-866-272-1967 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept
Write	UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	myAARPMedicare.com

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions for Medical Care – Contact Information	
Call	1-866-272-1967 Calls to this number are free.

Coverage Decisions for Medical Care – Contact Information	
	Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept
Fax	1-888-950-1170
Write	UnitedHealthcare Customer Service Department (Organization Determinations) P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	myAARPMedicare.com

Appeals for Medical Care – Contact Information	
Call	1-866-272-1967 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept For fast/expedited appeals for medical care: 1-877-262-9203 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept
Fax	For fast/expedited appeals only: 1-866-373-1081
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA120-0360, Cypress, CA 90630-0016
Website	myAARPMedicare.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	1-866-272-1967 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept For fast/expedited complaints about medical care: 1-877-262-9203 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept
Fax	For fast/expedited complaints only: **1-866-373-1081**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA120-0360, Cypress, CA 90630-0016
Medicare website	To submit a complaint about AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Call	1-866-272-1967 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept

Payment Requests – Contact Information	
Write	Medical claims payment requests: UnitedHealthcare P.O. Box 31362, Salt Lake City, UT 84131-0362
Website	myAARPMedicare.com

Section 2 Get help from Medicare

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

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

Medicare – Contact Information	
Call	**1-800-MEDICARE, (1-800-633-4227)** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities,

Medicare – Contact Information	
	hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO). **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

Section 3 State Health Insurance Assistance Program (SHIP)

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

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

SHIP counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems, and help you understand your Medicare plan choices, and answer questions about switching plans.

State Health Insurance Assistance Program (SHIP) – Contact Information West Virginia West Virginia State Health Insurance Assistance Program (WV SHIP)	
Call	**1-877-987-4463**
TTY	**711**
Write	1900 Kanawha BLVD E, Charleston, WV 25305
Website	**www.wvship.org**

Section 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For West Virginia, the Quality Improvement Organization is called Commence Health BFCC-QIO Program.

Your state's Quality Improvement Organization has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. The state's Quality Improvement Organization is an independent organization. It's not connected with our plan.

Contact your state's Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Quality Improvement Organization (QIO) – Contact Information **West Virginia** **Commence Health BFCC-QIO Program**	
Call	1-888-396-4646 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	P.O. Box 2687, Virginia Beach, VA 23454
Website	https://www.commencehealthqio.cms.gov/

Section 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

Section 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings programs, contact your state Medicaid agency.

State Medicaid Program – Contact Information West Virginia West Virginia Bureau for Medical Services (Medicaid)	
Call	**1-304-558-1700** **8:30 a.m.-5 p.m. ET, Monday-Friday**

State Medicaid Program – Contact Information West Virginia West Virginia Bureau for Medical Services (Medicaid)	
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	350 Capitol ST, RM 251, Charleston, WV 25301
Website	https://bms.wv.gov/about-us

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the State.

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

AIDS Drug Assistance Program (ADAP) – Contact Information West Virginia AIDS Drug Assistance Program (ADAP)	
Call	1-304-558-5358 8 a.m.-4 p.m. local time, Monday-Friday
Website	https://bph.wv.gov/photo-call-out/epidemiology-and-prevention-services

Section 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through

the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number aren’t free.
Website	RRB.gov

Section 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service 1-866-272-1967 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

Chapter 3:
Using our plan for your medical services

Section 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

The plan will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** "Medically necessary" means that the services, supplies, equipment, or Part B prescription drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who's eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).

– The providers in our network are listed in the **Provider Directory (myAARPMedicare.com).**

– If you use an out-of-network provider, your share of the costs for your covered services may be higher.

– **Note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

Section 2 Use network and out-of-network providers to get medical care

Section 2.1 You may choose a primary care provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

What is a PCP?

A primary care provider (PCP) is a network physician who is selected by you to provide and coordinate your covered services.

What types of providers may act as a PCP?

PCPs are generally physicians specializing in Internal Medicine, Family Practice or General Practice.

What is the role of my PCP?

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

How to choose a PCP

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

For a copy of the most recent **Provider Directory**, or for help in selecting a PCP, call Customer Service or visit the website listed in Chapter 2 of this booklet for the most up-to-date information about our network providers.

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

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP in our plan or you'll pay more for covered services.

If you want to change your PCP, call Customer Service or go online. If the PCP is accepting additional plan members, the change will become effective on the first day of the following month.

Section 2.2 How to get care from specialists and other network providers

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

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

If you use an out-of-network provider, your share of the costs for your covered services will be as shown in the Benefits Chart in Chapter 4 under "Out-of-Network." You pay the out-of-network cost-sharing even if you received a referral for the services, or if you requested a pre-visit coverage decision from us. However, in the event that no contracted network provider is available, you can ask to access care at in-network cost-sharing from an out-of-network provider. Call Customer Service to let us know if you need to see an out-of-network provider, or to get help finding an in-network provider. (Phone numbers for Customer Service are printed on the cover of this booklet.)

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

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

When a specialist or another network provider leaves our plan

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

You may call Customer Service for assistance at the number listed in Chapter 2 of this booklet.

Some services require prior authorization from the plan in order to be covered. Obtaining prior authorization is the responsibility of the PCP or treating provider. Services and items requiring prior authorization are listed in Medical Benefits Chart in Chapter 4, Section 2.

If you are receiving an active course of treatment from a provider when you enroll in our plan, we cannot require a prior authorization for at least 90 days, even if the provider is out-of-network. Call Customer Service to let us know if you are receiving an active course of treatment so that we can ensure it is covered.

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, **if you use an out-of-network provider, your share of the costs for covered services may be higher.** Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- If you are receiving an active course of treatment from an out-of-network provider when you enroll in our plan, your share of costs may be higher if you continue the treatment with that provider.
- When you obtain services out-of-network, we will pay for covered services using Original Medicare rules. Under Original Medicare, providers can choose whether to accept Medicare assignment. Assignment means that the doctor, provider, or supplier has signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services. Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. You may also want to find out how much you have to pay for each service or supply before you get it. To determine whether non-network doctors or suppliers accept assignment (participate in Medicare), contact Medicare (See Chapter 2, Section 2 of this **Evidence of Coverage**).
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and are medically necessary (go to Chapter 7, Section 4). This is important because:

– Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 7).

- It is best to ask an out-of-network provider to bill our plan first. But, if you have already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment (go to Chapter 5).
- When using out-of-network providers for supplemental benefits, you'll need to pay out of pocket and submit a reimbursement request following the directions outlined in Chapter5, Section 2.

- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

Section 3 How to get services in an emergency, disaster, or urgent need for care in the United States

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need to get approval or a referral first from your PCP. You **don't** need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.

Covered services in a medical emergency in the United States

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost-sharing.

Emergency care outside of the United States or its territories is not covered by Original Medicare or the plan.

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 it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor has said that it **wasn't** an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2 Get care when you have an urgent need for services in the United States

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area anywhere in the United States or its territories, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed services even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our plan doesn't cover emergency services, urgently needed services, or any other services you get outside of the United States and its territories. Emergency and urgently needed services outside the United States are not covered under any circumstances.

Section 3.3 Get care during a disaster

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

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

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost-sharing.

Section 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. For example, if your plan covers one routine physical exam per year and you receive that routine physical but choose to have a second routine physical within the same year, you pay the full cost of the second routine physical. Any amounts that you pay after you have reached the benefit limitation do not count toward your annual out-of-pocket maximum. (See Chapter 4 for more information on your plan's out-of-pocket maximum.)

Section 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you get as part of the study. If you tell us that you are in a qualified clinical trial, you're only responsible for in-network cost-sharing for the services in that trial. If you paid more - for example, if you already paid the Original Medicare cost-sharing amount – we'll reimburse the difference between what you paid and the in-network cost-sharing. You'll need to provide documentation to show us how much you paid.

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

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.

- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

> **Example of cost sharing in a clinical trial:** Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copayment required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare **won't** pay for the new item or service the study is testing unless Medicare would cover the item or service even if you **weren't** in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies, available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

Section 6 Rules for getting care in a "religious non-medical health care institution"

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is non-excepted.

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers **non-religious** aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - **and –** you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

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

Section 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of our plan, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan**. You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited

circumstances, we'll transfer ownership of the DME item to you. Call Customer Service at **1-866-272-1967** (TTY: **711**) for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage our plan will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you with services for 5 years. During the first 36 months you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

Chapter 4:
Medical Benefits Chart (what's covered and what you pay)

Section 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Deductible**: the amount you must pay for certain medical services before our plan begins to pay its share. Section 1.2 tells you more about our plan deductible.
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 Our plan deductible

Your deductible is **$1,000**. Until you've paid the deductible amount, you must pay the full cost of your covered services. After you pay your deductible, we'll start to pay our share of the costs for covered medical services, and you'll pay your copayment or coinsurance amount for the rest of the calendar year.

The deductible doesn't apply to some services, including any Medicare-covered services provided at a Federally Qualified Health Center (FQHC). This means that we'll pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible applies to the following services:

- Acupuncture for chronic low back pain – Medicare-covered (out-of-network only)

- Ambulance services – non-emergency (out-of-network only)
- Cardiac rehabilitation services (out-of-network only)
- Chiropractic services – Medicare-covered (out-of-network only)
- Diabetes monitoring supplies (out-of-network only)
- Diabetes therapeutic shoes or inserts (out-of-network only)
- Diabetes self-management training (out-of-network only)
- Durable medical equipment (DME) and related supplies (out-of-network only)
- Home health agency care (out-of-network only)
- Inpatient hospital care (out-of-network only)
- Inpatient mental health care (out-of-network only)
- Medicare Part B prescription drugs, including chemotherapy drugs, excluding Part B covered insulin (out-of-network only)
- Opioid treatment services (out-of-network only)
- Outpatient diagnostics – X-rays (out-of-network only)
- Outpatient diagnostics – radiation therapy (including supplies) (out-of-network only)
- Outpatient diagnostics – lab services (out-of-network only)
- Blood (out-of-network only)
- Outpatient diagnostics – non-radiological diagnostic services (out-of-network only)
- Outpatient diagnostics – radiological diagnostic services, not including X-rays (out-of-network only)
- Outpatient mental health care – individual and group therapy sessions (out-of-network only)
- Outpatient rehabilitation services – physical and speech-language therapy (out-of-network only)
- Outpatient rehabilitation services – occupational therapy (out-of-network only)
- Outpatient substance use disorder services – individual and group therapy sessions (out-of-network only)
- Ambulatory surgical center (ASC) (out-of-network only)
- Outpatient hospital services (out-of-network only)
- Outpatient hospital observation services (out-of-network only)
- Partial hospitalization services and Intensive outpatient services (out-of-network only)

- Primary care provider (out-of-network only)
- Specialist (out-of-network only)
- Hearing and balance exams – Medicare-covered (out-of-network only)
- Non-routine dental care – Medicare-covered (out-of-network only)
- Podiatry services – Medicare-covered (out-of-network only)
- Prostate cancer screening exams – digital rectal exam (out-of-network only)
- Prosthetic and orthotic devices and related supplies (out-of-network only)
- Pulmonary rehabilitation services (out-of-network only)
- Kidney disease education services (out-of-network only)
- Outpatient dialysis treatments (kidney) (out-of-network only)
- Skilled nursing facility (SNF) care (out-of-network only)
- Supervised exercise therapy (SET) (out-of-network only)
- Vision services – Medicare-covered glaucoma screening (out-of-network only)
- Vision services – Medicare-covered eye exams to evaluate for eye disease (out-of-network only)
- Vision services – eyeglasses or contact lenses after cataract surgery (out-of-network only)
- Medicare-covered EKG screening following "Welcome to Medicare" preventive visit (out-of-network only)

Section 1.3 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount (MOOP)** is **$9,850**. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. The amounts you pay for plan premiums, and services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you pay $9,850 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium

(unless your Part B premium is paid for you by West Virginia Bureau for Medical Services (Medicaid) or another third party).

- Your **combined maximum out-of-pocket amount** is **$14,800**. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. The amounts you pay for plan premium don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you pay $14,800 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by West Virginia Bureau for Medical Services (Medicaid) or another third party).

Section 1.4 Network providers aren't allowed to balance bill you

As a member of AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO), you have an important protection because, after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, then you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has "balance billed" you, call Customer Service at **1-866-272-1967** (TTY users call **711**).

Section 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) **must** be medically necessary. "Medically necessary" means that the services, supplies, or Part B drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You have a Primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered as in-network services **only** if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
  - –Covered services that may need approval in advance to be covered as in-network services are marked by a double dagger (††) in the Medical Benefits Chart.
  - –Network providers agree by contract to obtain prior authorization from the plan and agree not to balance bill you.
  - –You never need approval in advance for out-of-network services from out-of-network providers.
  - –While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
  - –If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:

–If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).

–If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

–If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay **more** in our plan than you would in Original Medicare. For others, you pay **less**. (To learn more about the coverage and costs of Original Medicare, go to your **Medicare & You 2027** handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you when you use a network provider. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition. See the Medical Benefits Chart for information about your share of the **out-of-network** costs for these services.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

This apple shows preventive services in the Medical Benefits Chart.

Medically Necessary - means health care services, supplies, or drugs needed for the prevention, diagnosis, or treatment of your sickness, injury or illness that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with **Generally accepted standards of medical practice**.
- Most appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, or illness.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Meet, but do not exceed your medical need, are at least as beneficial as an existing and available medically appropriate alternative, and are furnished in the most cost-effective manner that may be provided safely and effectively.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Medical Benefits Chart

Covered service	What you pay in-network	What you pay out-of-network
Providers may ask you for more than one cost share payment if you get more than one service at an appointment. For example: • Your doctor will ask for a copayment for the office or urgent care center visit and additional copayments for each x-ray that is performed while you are there. • Your hospital may ask for separate cost-sharing for certain outpatient hospital medical services for example but not limited to; radiological tests or Medicare Part B drugs administered while you are there. • The specific cost-sharing that will apply depends on which services you receive. The Medical benefits chart below lists the cost-sharing that applies for each specific service.		
Abdominal aortic aneurysm screening A one-time (once per lifetime) screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	40% coinsurance for members eligible for this preventive screening. You pay these amounts until you reach the out-of-pocket maximum.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days performed by, or under the supervision of a physician (or other medical provider as described below) are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy	You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/practitioner services, including doctor's office visits") depending on if you receive services from a primary care physician or specialist.[††]	You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/practitioner services, including doctor's office visits") depending on if you receive services from a primary care physician or specialist.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor.** Provider Requirements: Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs) /clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. • Benefit is not covered when solely provided by an independent acupuncturist. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS as required by our regulations.		

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
Acupuncture services performed by providers that do not meet CMS acupuncture provider requirements are not covered even in locations where there are no providers available that meet CMS requirements.		
Ambulance services Medicare-covered ambulance services within the United States or its territories, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Outside of the United States or its territories, ambulance transportation is not covered under any circumstances. Transportation back to the United States from another country is not covered under any circumstances, regardless of whether that transportation is via ambulance or some other method of transportation.	$350 copayment for each one-way Medicare-covered ground trip (in-network). $350 copayment for each one-way Medicare-covered air trip. You pay these amounts until you reach the out-of-pocket maximum. All Medicare-covered trips (in or out-of-network) will apply to the in-network out-of-pocket maximum. *Your provider may need to obtain prior authorization for non-emergency transportation.*	
Annual routine physical exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during	$0 copayment for a routine physical exam each year.	40% coinsurance for a routine physical exam each year.*

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam visits do not need to be scheduled 12 months apart but are limited to one in or out-of-network visit each calendar year.		
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **Note**: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.	40% coinsurance for the annual wellness visit. You pay these amounts until you reach the out-of-pocket maximum.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	40% coinsurance for Medicare-covered bone mass measurement. You pay these amounts until you reach the out-of-pocket maximum.

Covered service	What you pay in-network	What you pay out-of-network
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.	40% coinsurance for covered screening mammograms. You pay these amounts until you reach the out-of-pocket maximum.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	$0 copayment for each Medicare-covered cardiac rehabilitative visit.††	40% coinsurance for each Medicare-covered cardiac rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit.	40% coinsurance for the cardiovascular disease preventive benefit. You pay these amounts until you reach the out-of-pocket maximum.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.	40% coinsurance for cardiovascular disease testing that is covered once every five years. You pay these amounts until you reach the out-of-pocket maximum.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years • For asymptomatic women between the ages of 30 and 65: HPV testing once every 5 years, in conjunction with the Pap test	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	40% coinsurance for Medicare-covered preventive Pap and pelvic exams. You pay these amounts until you reach the out-of-pocket maximum.

Covered service	What you pay in-network	What you pay out-of-network
Chiropractic services Covered services include: • Manual manipulation of the spine to correct a vertebral subluxation (when one or more of the bones of your spine move out of position). Manual manipulation is a treatment that uses hands-on pressure to gently move your joints and tissues. Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation, including: • Maintenance therapy. Chiropractic treatment is considered maintenance therapy when continuous ongoing care is no longer expected to provide clinical improvements and the treatment becomes supportive instead of corrective. • Extra charges when your chiropractor uses a manual, hand-held device to add controlled pressure during treatment. • X-rays, massage therapy, and acupuncture (unless the acupuncture is for the treatment of chronic low back pain).	$15 copayment for each Medicare-covered visit.[††] You pay these amounts until you reach the out-of-pocket maximum.	$55 copayment for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or	40% coinsurance for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible

Covered service	What you pay in-network	What you pay out-of-network
colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy.	sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy. You pay these amounts until you reach the out-of-pocket maximum. If you have a prior history of colon cancer, or have had polyps removed during a previous colonoscopy, ongoing colonoscopies are considered diagnostic and are subject to cost sharing as described under the outpatient diagnostic colonoscopy benefit below. Therefore, the screening colonoscopy benefit is not available for members who have signs or symptoms prior to the colonoscopy. A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient diagnostic

Covered service	What you pay in-network	What you pay out-of-network
• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.		colonoscopy cost sharing shown below.
Outpatient diagnostic colonoscopy	There is no coinsurance, copayment, or deductible for each Medicare-covered diagnostic colonoscopy.[††]	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you received the service.

Covered service	What you pay in-network	What you pay out-of-network
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	20% coinsurance for Medicare-covered dental services.[††] You pay these amounts until you reach the out-of-pocket maximum.	40% coinsurance for Medicare-covered dental services. You pay these amounts until you reach the out-of-pocket maximum.
Routine dental benefits You can get more information about this benefit by viewing the Vendor Information Sheet at myAARPMedicare.com or by calling Customer Service to have a paper copy sent to you.	You are covered for routine dental benefits. See the routine dental benefit description at the end of this chart for details.*	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	40% coinsurance for an annual depression screening visit. You pay these amounts until you reach the out-of-pocket maximum.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	40% coinsurance for the Medicare-covered diabetes screening tests. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every plan year following the date of your most recent diabetes screening test.		
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users), covered services include:		
• Supplies to monitor your blood glucose: continuous glucose monitors (CGMs), blood glucose monitors (BGMs), blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	$0 copayment for each Medicare-covered continuous glucose monitor (CGM) and supplies with an approved prior authorization. There are no brand limitations for CGMs.††	50% coinsurance for each Medicare-covered continuous glucose monitor (CGM) and supplies with an approved prior authorization. You pay these amounts until you reach the out-of-pocket maximum.
• You can get certain CGMs from your pharmacy, and all are available from a DME provider at the same cost. Your provider may need to request prior authorization for a CGM.	$0 copayment for each Medicare-covered blood glucose monitor (BGM).†† For BGMs we only cover Contour® and Accu-Chek® brands. Other BGM brands are not covered by your plan.	50% coinsurance for each Medicare-covered blood glucose monitor (BGM). You pay these amounts until you reach the out-of-pocket maximum.
• For details on Medicare's CGM requirements, visit medicare.gov/coverage/continuous-glucose-monitors.	Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me	Insulin and syringes are not covered.
We cover the BGMs and test strips in this list. We don't usually cover other BGM brands		

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
unless your provider tells us it's medically necessary. If you're new to the plan and using a brand that isn't on our list, you can request a temporary supply within the first 90 days of enrollment while you talk with your provider. They can help you decide if any of the preferred brands work for you. If you or your provider think it's medically necessary for you to keep using a different brand, you can request a coverage exception to have it covered for the rest of the plan year. After the first 90 days of enrollment, non-preferred products will only be covered with an approved exception. If you (or your provider) don't agree with the plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about the appropriate product or brand for your condition. (For more information about appeals, see Chapter 7.)	and Accu-Chek Guide. Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus. Insulin and syringes are not covered.	
• For people with diabetes who have severe diabetic foot disease one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting	20% coinsurance for each pair of Medicare-covered therapeutic shoes.[††]You pay these amounts until you reach the out-of-pocket maximum.	50% coinsurance for each pair of Medicare-covered therapeutic shoes. You pay these amounts until you reach the out-of-pocket maximum.
• Diabetes self-management training under certain conditions. Limited to 20 visits of 30 minutes per year for a maximum of 10 hours the initial year. Follow-up training subsequent years	$0 copayment for Medicare-covered benefits.	40% coinsurance for Medicare-covered benefits. You pay these amounts until you

Covered service	What you pay in-network	What you pay out-of-network
after, limited to 4 visits of 30 minutes for a maximum of 2 hours per year.		reach the out-of-pocket maximum.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," go to Chapter 10 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of supplies is available on our website at myAARPMedicare.com.	20% coinsurance for Medicare-covered benefits.[††] Your cost-sharing for Medicare oxygen equipment coverage is 20% coinsurance, every time you get covered equipment or supplies.[††] Your cost-sharing won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in our plan, your cost-sharing in our plan is 20% coinsurance.[††] You pay these amounts until you reach the out-of-pocket maximum.	50% coinsurance for Medicare-covered benefits. Your cost sharing for Medicare oxygen equipment coverage is 50% coinsurance every time you get covered equipment or supplies. Your cost sharing won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in our plan, your cost sharing in our plan is 50% coinsurance. You pay these amounts until you reach the out-of-pocket maximum.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition	$115 copayment for each emergency room visit within the United States or its territories. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost-sharing as described in the "Inpatient hospital care" section in this benefit chart.	

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Within the United States or its territories, cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Emergency care outside of the United States or its territories is not covered by Original Medicare or the plan.	You pay these amounts until you reach the out-of-pocket maximum. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must either receive authorization to stay at the out-of-network hospital or move to a network hospital to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you'll pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.	
Fitness program Your fitness program helps you stay active and connected at the gym. It's available to you at no additional cost and includes: • Free gym membership at core locations • Access to a large national network of gyms and fitness locations See Chapter 11, Section 15 for the fitness program terms and conditions of coverage. You can get more information by viewing the Vendor Information Sheet at myAARPMedicare.com or by calling Customer Service to have a paper copy sent to you.	$0 copayment	90% coinsurance if you use an out-of-network provider Directions for submitting a reimbursement request can be found in Chapter 7 Section 2.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as	$0 copayment for each Medicare-covered exam.††	$55 copayment for each Medicare-covered exam.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
outpatient care when you get them from a physician, audiologist, or other qualified provider.		You pay these amounts until you reach the out-of-pocket maximum.
Hearing services - routine hearing exam We cover 1 in or out-of-network hearing exam every year.	$0 copayment	$55 copayment*
Hearing services - hearing aids Through UnitedHealthcare Hearing, you can choose from a broad selection of prescription hearing aids. This includes brand-name manufacturers, as well as Relate®, a private-label brand accessed exclusively through UnitedHealthcare Hearing that offers affordable, high quality hearing aids with a variety of technology options and helpful features. This benefit is limited to 2 hearing aids every year. Hearing aid accessories, additional batteries and optional services are available for purchase, but they are not covered by the plan. You can get more information by viewing the Vendor Information Sheet at myAARPMedicare.com or by calling Customer Service to have a paper copy sent to you.	Provided by: UnitedHealthcare Hearing Hearing aid allowance is $700 Contact UnitedHealthcare Hearing to access your hearing aid benefit and get connected with a network provider. You must obtain prior authorization from UnitedHealthcare Hearing. Additional fees may apply for optional follow-up visits.	90% coinsurance on the first $700 for up to 2 hearing aids. You are responsible for all costs over $700.* Directions for submitting a reimbursement request can be found in Chapter 7, Section 2.
HIV screening	There's no coinsurance,	40% coinsurance for members eligible for

Covered service	What you pay in-network	What you pay out-of-network
For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	Medicare-covered preventive HIV screening. You pay these amounts until you reach the out-of-pocket maximum.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.[††] Other copayments or coinsurance may apply (Please see Durable medical equipment and related supplies for applicable copayments or coinsurance).	50% coinsurance for all home health visits provided by a home health agency when Medicare criteria are met. Other copayments or coinsurance may apply (Please see Durable medical equipment and related supplies for applicable copayments or coinsurance). You pay these amounts until you reach the out-of-pocket maximum.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a	You will pay the cost-sharing that applies to primary care services, specialist physician services, or home health (as described under "Physician/practitione	You will pay the cost-sharing that applies to primary care services, specialist physician services, or home health (as described under "Physician/practitione

Covered service	What you pay in-network	What you pay out-of-network
pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	r services, including doctor's office visits" or "Home health agency care") depending on where you received administration or monitoring services.†† See "Durable medical equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to home infusion therapy.†† See "Medicare Part B prescription drugs" later in this chart for any applicable cost-sharing for drugs related to home infusion therapy.††	r services, including doctor's office visits" or "Home health agency care") depending on where you received administration or monitoring services. See "Durable medical equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to home infusion therapy. See "Medicare Part B prescription drugs" later in this chart for any applicable cost-sharing for drugs related to home infusion therapy.
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not AARP Medicare Advantage Patriot No Rx WV-MA01 (PPO).	

Covered service	What you pay in-network	What you pay out-of-network
be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice you have the right to stay in your plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there is a requirement to obtain prior authorization): • If you get the covered services from a network provider and follow plan rules for getting service, you only pay our		

Covered service	What you pay in-network	What you pay out-of-network
plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, your share of the costs for covered services may be higher **For services covered by AARP Medicare Advantage Patriot No Rx WV-MA01 (PPO) but not covered by Medicare Part A or Part B:** AARP Medicare Advantage Patriot No Rx WV-MA01 (PPO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B	There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered immunizations.	There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered immunizations.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
• COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules		
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include, but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.The plan has a network of facilities that perform organ transplants. The plan's hospital network	$490 copayment each day for days 1-5 for Medicare-covered hospital care each time you are admitted. $0 copayment for additional Medicare-covered days.[††] You pay these amounts until you reach the out-of-pocket maximum. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Medicare hospital benefit periods do not apply. (See definition of benefit periods in Chapter 10.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient	$490 copayment each day for days 1-5 for Medicare-covered hospital care each time you are admitted. $0 copayment for additional Medicare-covered days. You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods do not apply. (See definition of benefit periods in Chapter 10.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital

Covered service	What you pay in-network	What you pay out-of-network
for organ transplant services is different than the network shown in the 'Hospitals' section of your provider directory. Some hospitals in the plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, please call AARP Medicare Advantage Patriot No Rx WV-MA01 (PPO) Customer Service at 1-866-272-1967 TTY 711. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If AARP Medicare Advantage Patriot No Rx WV-MA01 (PPO) provides transplant services at a location outside of the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. See Chapter 4, Section 3 "Services that aren't covered by our plan (exclusions) " for more details. • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Physician services	Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.	stay is covered in accordance with plan rules.

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Covered service	What you pay in-network	What you pay out-of-network
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "outpatient observation" stay. If you are not sure if you are an inpatient or an outpatient, ask the hospital staff. • Get more information from the Medicare fact sheet "Medicare Hospital Benefits" available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Inpatient services in a psychiatric hospital Covered services include: • Mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. • Inpatient substance use disorder services	$490 copayment each day for days 1-4 for Medicare-covered hospital care each time you are admitted. $0 copayment for additional Medicare-covered days, up to 90 days per benefit period. Plus an additional 60 lifetime reserve days.[††] You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods are	$490 copayment each day for days 1-5 for Medicare-covered hospital care each time you are admitted. $0 copayment for additional Medicare-covered days, up to 90 days per benefit period. Plus an additional 60 lifetime reserve days. You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods are

Covered service	What you pay in-network	What you pay out-of-network
	used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in Chapter 10.) However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.	used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in Chapter 10.) However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.
Inpatient stay: covered services received in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we will not cover your inpatient stay. In some cases, we will cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:	When your stay is no longer covered, these services will be covered as described in the following sections:
• Physician services	Please refer below to Physician/practitioner services, including doctor's office visits.	Please refer below to Physician/practitioner services, including doctor's office visits.
• Diagnostic tests (like lab tests)	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
• X-ray, radium, and isotope therapy including technician materials and services	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.

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Covered service	What you pay in-network	What you pay out-of-network
• Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	Please refer below to prosthetic and orthotic devices and related supplies.	Please refer below to prosthetic and orthotic devices and related supplies.
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	Please refer below to prosthetic and orthotic devices and related supplies.	Please refer below to prosthetic and orthotic devices and related supplies.
• Physical therapy, speech language therapy, and occupational therapy	Please refer below to Outpatient rehabilitation services.	Please refer below to Outpatient rehabilitation services.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	40% coinsurance for members eligible for Medicare-covered medical nutrition therapy services. You pay these amounts until you reach the out-of-pocket maximum.

Covered service	What you pay in-network	What you pay out-of-network
your treatment is needed in the next calendar year.		
Medicare diabetes prevention program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B Drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor	$0 copayment for Medicare-covered Part B allergy antigens.†† 20% coinsurance for each Medicare-covered chemotherapy drug and the administration of that drug. You may pay less for certain rebatable drugs. This list and the cost of each rebatable drug changes every quarter.†† You pay these amounts until you reach the out-of-pocket maximum. 20% coinsurance for all other Medicare-covered Part B drugs.†† You may pay	$0 copayment for Medicare-covered Part B allergy antigens. 40% coinsurance for each Medicare-covered chemotherapy drug and the administration of that drug. You pay these amounts until you reach the out-of-pocket maximum. 40% coinsurance for all other Medicare-covered Part B drugs. For the administration of these drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient

Covered service	What you pay in-network	What you pay out-of-network
about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some Antigens (for allergy shots): Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a	less for certain rebatable drugs. This list and the cost of each rebatable drug changes every quarter. For the administration of these drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you received drug administration or infusion services. You will pay a maximum of $35 for each 1-month supply of Part B covered insulin. The deductible does not apply to Part B covered insulin. You pay these amounts until you reach the out-of-pocket maximum.	hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you received drug administration or infusion services. You pay these amounts until you reach the out-of-pocket maximum.

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Covered service	What you pay in-network	What you pay out-of-network
full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, such as the intravenous medication Parsabiv® and the oral medications Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) • Chemotherapy Drugs, and the administration of chemotherapy drugs This link will take you to a list of Part B Drugs that may be subject to Step Therapy: medicare.uhc.com/medicare/member/documents/part-b-step-therapy.html You or your doctor may need to provide more information about how a Medicare Part B		

Covered service	What you pay in-network	What you pay out-of-network
prescription drug is used in order to determine coverage. There may be effective, lower-cost drugs that treat the same medical condition. If you are prescribed a new Part B medication or have not recently filled the medication under Part B, you may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, you or your doctor can ask the plan to cover the Part B drug. (For more information, see Chapter 9.) Please contact Customer Service for more information. We also cover some vaccines under our Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	40% coinsurance for preventive obesity screening and therapy. You pay these amounts until you reach the out-of-pocket maximum.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:	$0 copayment for Medicare-covered opioid treatment program services.[††]	$0 copayment for Medicare-covered opioid treatment program services.

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Covered service	What you pay in-network	What you pay out-of-network
• U.S. Food and Drug Administration (FDA) -approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments		
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to:		
• X-rays	$30 copayment for each Medicare-covered standard X-ray service.[††] You pay these amounts until you reach the out-of-pocket maximum.	$50 copayment for each Medicare-covered standard X-ray service. You pay these amounts until you reach the out-of-pocket maximum.
• Radiation (radium and isotope) therapy including technician materials and supplies	20% coinsurance for each Medicare-covered radiation therapy service.[††] You pay these amounts until you reach the out-of-pocket maximum.	40% coinsurance for each Medicare-covered radiation therapy service. You pay these amounts until you reach the out-of-pocket maximum.
• Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations	20% coinsurance for each Medicare-covered medical supply.[††]	50% coinsurance for each Medicare-covered medical supply.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
• Note: There is no separate charge for medical supplies routinely used in the course of an office visit and included in the provider's charges for that visit (such as bandages, cotton swabs, and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown.	You pay these amounts until you reach the out-of-pocket maximum.	You pay these amounts until you reach the out-of-pocket maximum.
• Laboratory tests	$0 copayment for Medicare-covered lab services.††	$0 copayment for Medicare-covered lab services.
• Blood - including storage and administration (this means processing and handling of blood). Coverage begins with the first pint of blood that you need. • In addition, for the administration of blood infusion, you will pay the cost-sharing as described under the following sections of this chart, depending on where you received infusion services o Physician/practitioner services, including doctor's office visits o Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers	$0 copayment for Medicare-covered blood services.††	$0 copayment for Medicare-covered blood services.
• Other outpatient diagnostic tests - non-radiological diagnostic services	$50 copayment for Medicare-covered non-radiological diagnostic services.††Examples include, but are not	40% coinsurance for Medicare-covered non-radiological diagnostic services. Examples include, but are not limited to

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
	limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests.You pay these amounts until you reach the out-of-pocket maximum.	EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. You pay these amounts until you reach the out-of-pocket maximum.
• Diagnostic non-laboratory tests such as CT scans, MRIs, echocardiograms, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Other outpatient diagnostic tests - radiological diagnostic services, not including X-rays	$0 copayment for each diagnostic mammogram.†† $0 copayment for each vascular screening in your home or a nursing home in which you reside.†† $320 copayment for other Medicare-covered radiological diagnostic services, not including X-rays.†† You pay these amounts until you reach the out-of-pocket maximum. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but	40% coinsurance for Medicare-covered diagnostic services, not including X-rays. You pay these amounts until you reach the out-of-pocket maximum. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures

Covered service	What you pay in-network	What you pay out-of-network
	are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).	(myelogram, cystogram, angiogram, and barium studies).
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

Covered service	What you pay in-network	What you pay out-of-network
MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.		
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to:		
• Services in an emergency department	Please refer to Emergency Care.	Please refer to Emergency Care.
• Laboratory and diagnostic tests billed by the hospital	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
• Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it	Please refer to Outpatient mental health care.	Please refer to Outpatient mental health care.
• X-rays and other radiology services billed by the hospital	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
• Medical supplies such as splints and casts	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
• Certain screenings and preventive services	Please refer to the benefits preceded by the "Apple" icon.	Please refer to the benefits preceded by the "Apple" icon.
• Certain drugs and biologicals you can't give yourself	Please refer to Medicare Part B prescription drugs.	Please refer to Medicare Part B prescription drugs.
• Services performed at an outpatient clinic	Please refer to Physician/practitioner services, including doctor's office visits.	Please refer to Physician/practitioner services, including doctor's office visits.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
• Outpatient surgery or observation	Please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	Please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
• Outpatient infusion therapy For the drug that is infused, you will pay the cost-sharing as described in "Medicare Part B prescription drugs" in this benefit chart. In addition, for the administration of infusion therapy drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers" in this benefit chart) depending on where you received drug administration or infusion services.	Please refer to Medicare Part B prescription drugs and Physician/practitioner services, including doctor's office visits or Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	Please refer to Medicare Part B prescription drugs and Physician/practitioner services, including doctor's office visits or Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "outpatient observation" stay. If you aren't sure if you're an outpatient, you should ask the hospital staff.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Outpatient mental health care Covered services include:	$25 copayment for each Medicare-	$40 copayment for each Medicare-

Covered service	What you pay in-network	What you pay out-of-network
Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	covered **individual** therapy session.[††] $15 copayment for each Medicare-covered **group** therapy session.[††] You pay these amounts until you reach the out-of-pocket maximum.	covered **individual** therapy session. $30 copayment for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, physician offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$55 copayment for each Medicare-covered physical therapy and speech-language therapy visit.[††] You pay these amounts until you reach the out-of-pocket maximum. $35 copayment for each Medicare-covered occupational therapy visit.[††] You pay these amounts until you reach the out-of-pocket maximum.	$55 copayment for each Medicare-covered physical therapy and speech-language therapy visit. You pay these amounts until you reach the out-of-pocket maximum. $55 copayment for each Medicare-covered occupational therapy visit. You pay these amounts until you reach the out-of-pocket maximum.
Outpatient substance use disorder services Outpatient treatment and counseling for substance use disorder.	$25 copayment for each Medicare-covered **individual** therapy session.[††] $15 copayment for each Medicare-	$40 copayment for each Medicare-covered **individual** therapy session. $30 copayment for each Medicare-

Covered service	What you pay in-network	What you pay out-of-network
	covered **group** therapy session.[††] You pay these amounts until you reach the out-of-pocket maximum.	covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum.
Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers **Note**: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask your doctor or the hospital staff. If you receive any services or items other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost-sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received for the specific cost-sharing required. See "Colorectal cancer screening" earlier in this chart for screening and diagnostic colonoscopy benefit information.	$0 copayment for a colonoscopy at an ambulatory surgical center.[††] $440 copayment for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges.[††] You pay these amounts until you reach the out-of-pocket maximum.	40% coinsurance for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum.
	$0 copayment for a colonoscopy at an outpatient hospital.[††]	40% coinsurance for Medicare-covered surgery or other services provided to

Covered service	What you pay in-network	What you pay out-of-network
	$490 copayment for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.[††] You pay these amounts until you reach the out-of-pocket maximum. Outpatient surgical services that can be delivered in an available ambulatory surgery center must be delivered in an ambulatory surgery center unless a hospital outpatient department is medically necessary.	you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum.
	$490 copayment for each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.[††]	40% coinsurance for each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
	You pay these amounts until you reach the out-of-pocket maximum.	You pay these amounts until you reach the out-of-pocket maximum.
Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$55 copayment each day for Medicare-covered benefits.[††] You pay these amounts until you reach the out-of-pocket maximum.	$75 copayment for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.
Physician/practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical or surgical services you get in a physician's office.	$0 copayment for services from a primary care physician or under certain circumstances, treatment by a nurse	$0 copayment for services from a primary care physician or under certain circumstances, treatment by a nurse

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
	practitioner, physician's assistant or other non-physician health care professional in a primary care physician's office (as allowed by Medicare).	practitioner, physician's assistant or other non-physician health care professional in a primary care physician's office (as allowed by Medicare).
• Medically-necessary medical or surgical services you get in a certified ambulatory surgical center or hospital outpatient department.	See "Outpatient surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.	See "Outpatient surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.
• Consultation, diagnosis, and treatment by a specialist.	$55 copayment for services from a specialist or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare).††You pay these amounts until you reach the out-of-pocket maximum.	$55 copayment for services from a specialist or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare).You pay these amounts until you reach the out-of-pocket maximum.
• Basic hearing and balance exams performed by your specialist, if your	$0 copayment for each Medicare-covered exam.††	$55 copayment for each Medicare-covered exam.

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Covered service	What you pay in-network	What you pay out-of-network
doctor orders it to see if you need medical treatment.		You pay these amounts until you reach the out-of-pocket maximum.
• Medicare-covered including: -Telehealth for Medicare-covered telehealth services including consultation, diagnosis, and treatment by a physician or practitioner. -Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. -Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location. -Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location. -Telehealth services for diagnosis, evaluation, and treatment of mental health disorders -Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers. -Medicare-covered remote monitoring services. -Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:	$0 copayment for each Medicare-covered visit.[††]	You will pay the cost-sharing that applies to a Medicare-covered in-office visit.

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Covered service	What you pay in-network	What you pay out-of-network
• You're not a new patient **and** • The check-in isn't related to an office visit in the past 7 days **and** • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. -Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: • You're not a new patient **and** • The evaluation isn't related to an office visit in the past 7 days **and** • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment. -Consultation your doctor has with other doctors by phone, internet, or electronic health record.		
• Second opinion prior to surgery.	You will pay the cost-sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above).[††]	You will pay the cost-sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above).
• Monitoring services in a physician's office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as 'Coumadin Clinic' services).	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitione	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitione

Covered service	What you pay in-network	What you pay out-of-network
Medically-necessary services that are covered benefits and are furnished by a physician/non-physician health care professional in your home or a nursing home in which you reside.	r services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you receive services.†† $0 copayment for nurse practitioner, physician's assistant or other non-physician health care professional services.††For primary care provider services or specialist physician services, you will pay the cost sharing as applied in an office setting described above in this section of the benefit chart.††	r services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you receive services. You will pay the cost sharing that applies to primary care provider services or specialist physician services (as applied in an office setting, described above in this section of the benefit chart) depending on the type of physician that provides the services.
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	$45 copayment for each Medicare-covered visit in an office or home setting.†† For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient surgery and other medical services	$55 copayment for each Medicare-covered visit in an office or home setting. For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient surgery and other medical services provided at hospital

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
	provided at hospital outpatient facilities and ambulatory surgical centers.You pay these amounts until you reach the out-of-pocket maximum.	outpatient facilities and ambulatory surgical centers. You pay these amounts until you reach the out-of-pocket maximum.
Additional routine foot care We cover 6 in and out-of-network routine foot care visits every year. This benefit is in addition to the Medicare-covered podiatry services benefit listed above. Covered services include treatment of the foot which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails.	$45 copayment for each routine visit.*	$55 copayment for each routine visit.*
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.	40% coinsurance for members eligible for PrEP benefit. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test. Diagnostic PSA exams are subject to cost-sharing as described under Outpatient diagnostic tests and therapeutic services and supplies in this chart.	40% coinsurance for each Medicare-covered digital rectal exam. You pay these amounts until you reach the out-of-pocket maximum. 40% coinsurance for an annual PSA test. You pay these amounts until you reach the out-of-pocket maximum. Diagnostic PSA exams are subject to cost sharing as described under Outpatient diagnostic tests and therapeutic services and supplies in this chart.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a	20% coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies.[††]You pay these amounts until	50% coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies. You pay these amounts until you

Covered service	What you pay in-network	What you pay out-of-network
surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to Vision services later in this table for more detail.	you reach the out-of-pocket maximum.	reach the out-of-pocket maximum.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Medicare covers up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of pulmonary rehabilitation services.	$0 copayment for each Medicare-covered pulmonary rehabilitative visit.[††]	40% coinsurance for each Medicare-covered pulmonary rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening per year for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	40% coinsurance for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. You pay these amounts until you reach the out-of-pocket maximum.
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:	There is no coinsurance, copayment, or deductible for the Medicare-covered	40% coinsurance for members eligible for the Medicare-covered screening for the Hepatitis C virus.

Covered service	What you pay in-network	What you pay out-of-network
• You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	screening for the Hepatitis C virus.	You pay these amounts until you reach the out-of-pocket maximum.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. **For LDCT lung cancer screenings after the initial LDCT screening:** the member must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.	40% coinsurance for the Medicare-covered counseling and shared decision-making visit or for the LDCT. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	40% coinsurance for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. You pay these amounts until you reach the out-of-pocket maximum.
Services to treat kidney disease Kidney disease and dialysis services include:		
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime	$0 copayment for Medicare-covered benefits.	40% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	20% coinsurance for Medicare-covered benefits.[††] You pay these amounts until you reach the out-of-pocket maximum.	20% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for Medicare-covered benefits.	40% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient hospital care.	These services will be covered as described in the following sections: Please refer to Inpatient hospital care.
• Home dialysis equipment and supplies	Please refer to Durable medical equipment and related supplies.	Please refer to Durable medical equipment and related supplies.
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	Please refer to Home health agency care.	Please refer to Home health agency care.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 10. Skilled nursing facilities are sometimes called SNFs.) Covered services include, but are not limited to:	$0 copayment each day for Medicare-covered days 1-20 $221 copayment each day for Medicare-covered days 21-100.[††] You pay these	$250 copayment each day for Medicare-covered SNF care, up to 100 days. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
• Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech language therapy • Drugs administered to you as part of your plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/practitioner services A 3-day prior hospital stay is not required. Generally, you will get your SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)	amounts until you reach the out-of-pocket maximum. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
• A SNF where your spouse or domestic partner is living at the time you leave the hospital		
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	40% coinsurance for the Medicare-covered smoking and tobacco use cessation preventive benefits. You pay these amounts until you reach the out-of-pocket maximum.
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and have a referral from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising of a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits	$0 copayment for each Medicare-covered supervised exercise therapy (SET) visit.[††]	40% coinsurance for each Medicare-covered supervised exercise therapy (SET) visit. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP) /clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Urgently needed services outside of the United States or its territories is not covered by Original Medicare or the plan.	$40 copayment for each visit within the United States or its territories. You pay these amounts until you reach the out-of-pocket maximum.	

Covered service	What you pay in-network	What you pay out-of-network
Vision services Covered services include:		
• Outpatient physician services provided by an ophthalmologist or optometrist for the diagnosis and treatment of diseases and injuries of the eye, including diagnosis or treatment for age-related macular degeneration or cataracts. • Original Medicare doesn't cover routine eye exams (including eye refractions) for eyeglasses/contacts See Vision services - routine eye exam coverage below.	$0 copayment for each Medicare-covered exam.[††]	$55 copayment for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
• For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older	$0 copayment for each Medicare-covered glaucoma screening.	$55 copayment for each Medicare-covered glaucoma screening. You pay these amounts until you reach the out-of-pocket maximum.
• For people with diabetes or signs and symptoms of eye disease, eye exams to evaluate for eye disease are covered per Medicare guidelines. Annual examinations by an ophthalmologist or optometrist are recommended for asymptomatic diabetics. • For people with diabetes, screening for diabetic retinopathy is covered once per year	$0 copayment for Medicare-covered eye exams to evaluate for eye disease.[††]	$55 copayment for Medicare-covered eye exams to evaluate for eye disease. You pay these amounts until you reach the out-of-pocket maximum.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (additional pairs of eyeglasses or contacts are not covered by Medicare).	$0 copayment for one pair of Medicare-covered standard glasses or contact	40% coinsurance for one pair of Medicare-covered standard glasses or contact

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network
If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	lenses after cataract surgery.	lenses after cataract surgery. You pay these amounts until you reach the out-of-pocket maximum.
Vision services - routine eye exam We cover 1 in or out-of-network routine eye exam every year. Eye refraction is part of the routine eye exam benefit. You can get more information by viewing the Vendor Information Sheet at myAARPMedicare.com or by calling Customer Service to have a paper copy sent to you.	$0 copayment	$55 copay*
Vision services - routine eyewear • 1 pair of standard lenses and frames every 2 years or • Contact lenses instead of lenses and frames every 2 years Once contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Options that are not covered include (but are not limited to) non-prescription eyewear,	Provided by: UnitedHealthcare Vision® $0 copayment for 1 pair of eyeglasses (lenses/frames) or contact lenses with a retail value of up to $300. You are responsible for all	90% coinsurance on the first $300 of the retail value for 1 pair of eyeglasses (lenses/frames) or contact lenses. You are responsible for all costs over the retail value of $300.* Directions for submitting a

Covered service	What you pay in-network	What you pay out-of-network
contact lens fitting and evaluation fees or sales tax. You will be responsible for any charges for these items and services. This benefit may not be combined with any in-store promotional offer, such as a 2-for-1 sale, discount, or coupon. You can get more information by viewing the Vendor Information Sheet at myAARPMedicare.com or by calling Customer Service to have a paper copy sent to you.	costs over the retail value of $300.*	reimbursement request can be found in Chapter 7, Section 2.
"Welcome to Medicare" Preventive Visit Our plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this medical benefits chart. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. There is no coinsurance, copayment, or deductible for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to outpatient diagnostic tests and therapeutic services and supplies for other EKG's.	40% coinsurance for the "Welcome to Medicare" preventive visit. You pay these amounts until you reach the out-of-pocket maximum. 40% coinsurance for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" visit. Please refer to Outpatient diagnostic tests and therapeutic services and supplies for other EKG's. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered service	What you pay in-network	What you pay out-of-network

* Covered services that do not count toward your maximum out-of-pocket amount.
†† Covered services where your provider may need to request prior authorization.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered routine dental benefits included with your plan

- As part of your UnitedHealthcare Medicare Advantage plan you get a routine dental benefit that provides coverage for the non-Medicare covered dental services described in detail below.
- Any services not listed below are not covered.
- This dental plan offers access to the robust UHC Dental National Medicare Advantage Network. Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate for covered services within the limitations of the plan. Any fees associated with non-covered services are your responsibility.
- For assistance finding a provider, please use the dental provider search tool at myAARPMedicare.com. You may also call 1-866-272-1967 for help finding a provider or scheduling a dental appointment.
- This dental plan offers both in-network and out-of-network dental coverage, and all covered services have a $0 copayment. Out-of-network dentists are not contracted to accept plan payment as payment in full, so they might charge you for more than what the plan pays, even for services that have a $0 copayment. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.
- When you have covered dental services performed at a network dentist, the dentist will submit the claim on your behalf. When you see an out-of-network dentist, often the dentist will submit a claim on your behalf. If they do not, then you can submit it directly using the following instructions:
    - The claim submission must contain the following information:
        - Full member name and member ID number
        - Full provider name and address
        - List of dental services rendered with the corresponding ADA code(s)
        - Proof of payment in the form of a receipt, check copy, EOB, or a ledger statement from the provider showing a positive payment against the services rendered
    - Mail all required claim information within 365 days from the date of service to: **P.O. Box 30567, Salt Lake City, UT 84130**

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

- Payment will be sent to the address listed on your account. To update your address or for assistance with submitting claims, contact Customer Service at 1-866-272-1967 TTY 711.
- Claims are paid within 30 days and an Explanation of Payment (EOP) will accompany check payment.

- Dentists may ask you to sign an informed consent document detailing the risks, benefits, costs, and alternatives to all recommended treatments. If you would like to learn more about how your dental plan coverage relates to your proposed dental treatment and costs, you may ask your dentist to obtain a pre-treatment cost calculation from UHC Dental. If the provider has questions about how to obtain this information, they can contact UHC Dental using the number or website on the back of your member ID card.
- Coordination of Benefits (COB) – If you have a standalone dental plan in addition to the dental benefit offered with your UnitedHealthcare Medicare Advantage plan, it would be considered primary coverage and should be billed first. The dental coverage associated with your UnitedHealthcare Medicare Advantage plan would be considered secondary. If there is a remaining balance after the primary coverage has paid, your provider could bill UHC Dental for consideration of payment. UHC Dental will reduce their allowable amount (the amount the plan will pay for a covered service) by what the primary coverage/plan paid and is subject to any benefit maximums, limitations and/or exclusions.
- For all other questions or more information, please call 1-866-272-1967 TTY 711 or visit myAARPMedicare.com

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

American Dental Association (ADA) codes:	Description of dental procedure:	Frequency:	Criteria and exclusions:	Copayment
Covered dental procedures are listed by ADA code. These codes are used by dentists to submit dental claims.Categories provide easy reference.	Easy to interpret description of the dental procedure code	How often UnitedHealthcare will pay for the dental procedure	Conditions under which UnitedHealthcare would pay for this procedure and situations where UnitedHealthcare would NOT pay for the procedure	*$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay.
Exams				
D0120	Routine periodic exam completed during check-up	2 procedures per plan year	Covers periodic, limited, comprehensive, and detailed/extensive oral exams. Does not cover periodontal exams separate from periodic, limited, or comprehensive exams. Only 1 exam code covered per appointment.	$0*
D0150	Comprehensive exam (for a new patient, or an established patient after 3 or more years of inactivity from dental treatment)	2 procedures per plan year		$0*
X-rays				
D0210	Full-mouth/complete X-ray set for evaluation of the teeth and mouth	1 procedure every 3 plan years	Covers intraoral complete series of radiographs. Does not cover CTs, cephalograms, or MRIs.	$0*

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

American Dental Association (ADA) codes:	Description of dental procedure:	Frequency:	Criteria and exclusions:	Copayment
D0270, D0272, D0273, D0274, D0277	Bitewing X-rays for evaluation of the teeth and bone	1 procedure per plan year	Not covered in the same year as a full mouth set of X-rays (D0210)	$0*
D0330	Panoramic X-ray for evaluation of the teeth and mouth	1 procedure every 3 plan years	Covers panoramic radiographs. Does not cover CTs, cephalograms, or MRIs.	$0*
Cleanings				
D1110	Standard adult dental cleaning	2 procedures per plan year	Covers adult prophylaxis. Not covered on the same day as D4910 or D4355.	$0*
Other preventive services				
D1206, D1208	Fluoride	2 procedures per plan year	Covers topical application of fluoride (either varnish or excluding varnish).	$0*
D1310	Nutritional counseling	1 procedure every 3 plan years	Covers counseling on dietary habits as a part of treatment and control of gum disease and/or cavities.	$0*
D1354	Application of medication to a tooth to stop or inhibit cavity formation	2 procedures per plan year	Covers application of interim caries arresting medicament-per	$0*

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

American Dental Association (ADA) codes:	Description of dental procedure:	Frequency:	Criteria and exclusions:	Copayment
			tooth to a non-symptomatic carious tooth.	

Exclusions:

1. Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.
2. Dental services that are not necessary.
3. Hospitalization or other facility charges.
4. Any dental procedure performed solely for cosmetic and/or aesthetic reasons.
5. Any dental procedure not directly associated with a dental disease.
6. Any procedure not performed in a dental setting.
7. Reconstructive surgery of any type, including reconstructive surgery related to a dental disease, injury, or congenital anomaly.
8. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
9. Service for injuries or conditions covered by workmen's compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county, or other political subdivision. This exclusion does NOT apply to any services covered by Medicaid or Medicare.
10. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
11. Dental services rendered (including otherwise covered dental services) after the date on which individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date on which individual coverage under the policy terminates.
12. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice, sales tax, or duplicating/copying patient records.
14. Any services not listed above are not covered.

Disclaimer: Treatment plans and recommended dental procedures may vary. Talk to your dentist about treatment options, risks, benefits, and fees. CDT code changes are issued

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

annually by the American Dental Association. Procedure codes may be altered during the plan year in accordance with discontinuation of certain dental codes.

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

Section 2.1 Extra "optional supplemental" benefits you can buy

Our plan offers some extra benefits that aren't covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called **"Optional Supplemental Benefits."** If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

Adding Optional Supplemental Benefits to your plan

You must be enrolled in the plan in order to purchase an Optional Supplemental Rider. Purchasing an Optional Supplemental Rider is optional. You can purchase the rider at the time you enroll in your plan or within 3 months after the effective date of your plan.

Enrolling in Optional Supplemental Benefits

To enroll in an Optional Supplemental Rider, call Customer Service at the number listed on the cover. In general, completed requests to elect an Optional Supplemental Rider received by the last day of the month will be effective the first day of the following month.

Disenrolling from an Optional Supplemental Plan

If you wish to disenroll from an Optional Supplemental Rider, you may call Customer Service at the number listed on the cover.

Optional Supplemental Rider 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 Rider premium payment for the following month if the disenrollment request is received after the last day of the current month. Disenrollment from an Optional Supplemental Rider will not result in disenrollment from your health plan.

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

If you have a procedure in progress at the time of your termination of your Rider, your Dental Office will complete the procedure. If we cancel your Dental Office's contract, or if your Dental Office cancels their contract with us, it will be our responsibility to see that you receive your Dental Benefits at another Dental Office.

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 as necessary or upon request or disenrollment. We will refund any overpayments within 30 business

days of notification. We may apply your overpayment of Optional Supplemental benefit plan premiums to your monthly health plan premiums, if any.

Platinum Dental Rider

The Optional Supplemental Rider coverage described below applies only to members who are enrolled in the dental rider and are paying the associated monthly premium.

If you have not already enrolled into this Optional Supplemental Rider and you would like to enroll in it, you should call the Customer Service number listed on the back cover of this booklet. You can enroll into the Rider at the time you enroll in your plan or within 3 months after the effective date of your plan. For members who stay on a plan from year to year, your plan effective date is January 1 of the plan year, therefore you can enroll into the rider during AEP for a January 1 effective date or within the first 3 months of that plan year.

Introducing the Platinum Dental Rider

We know that having choices when selecting health care benefits is important to you. The Platinum Dental Rider is an optional supplemental benefit package that can be purchased to replace any dental benefits that may already be offered under your Medicare Advantage plan. **The Platinum Dental Rider cannot be combined with any other dental benefits that may be included in your plan. It is offered to you for a monthly premium of $54.** This is in addition to any monthly plan premium you may have for your Medicare Advantage plan.

Covered Platinum Dental Rider benefits:

Annual maximum: $1,500

- The Platinum Dental Rider includes:
  - –Exams
  - –Cleanings
  - –X-rays
  - –Fillings
  - –Crowns
  - –Bridges
  - –Root canals
  - –Extractions
  - –Partial dentures
  - –Complete dentures

- $0 copay for preventive and diagnostic dental care such as exams, routine cleanings, X-rays, and fluoride up to the annual maximum amount.
- A 50% coinsurance on all covered comprehensive services such as fillings, crowns, bridges, root canals, extractions and dentures up to the annual maximum amount.
- All covered services have applicable frequency limitations. Some covered services may consider prior tooth history and procedures in conjunction with frequency limitations. If you wish to discuss detailed information about your plan with your dentist or see the full list of covered dental services with associated frequency limitations, you can find it in the UHC Dental Medicare quick reference guide at uhcmedicaredentalproviderqrg.com.
- Procedures used for cosmetic-only reasons (tooth bleaching/whitening, veneers, gingival recontouring), orthodontics, space maintenance, implants and implant-related services, sales tax, charges for failure to keep appointments, dental case management, dental charges related to COVID-19 screening, testing and vaccination, and unspecified procedures by report are not covered by the plan.
- After the annual maximum is exhausted, any remaining charges are your responsibility. All covered dental services paid for by the plan count toward the annual maximum. Other limitations and exclusions listed below apply.
- This dental plan offers access to the robust UHC Dental National Medicare Advantage Network. Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate for covered services within the limitations of the plan. Any fees associated with non-covered services are your responsibility.
- For assistance finding a provider, please use the dental provider search tool at myAARPMedicare.com. You may also call 1-866-272-1967 for help finding a provider or scheduling a dental appointment.
- This dental plan offers both in-network and out-of-network dental coverage. Out-of-network dentists are not contracted to accept plan payment as payment in full, so they might charge you more than what the plan pays, even for services that have a $0 copayment. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.
- When you have covered dental services performed at a network dentist, the dentist will submit the claim on your behalf. When you see an out-of-network dentist, often the dentist will submit a claim on your behalf. If they do not, then you can submit it directly using the following instructions:
  - The claim submission must contain the following information:
    - Full member name and member ID number
    - Full provider name and address
    - List of dental services rendered with the corresponding ADA code(s)

- Proof of payment in the form of a receipt, check copy, EOB, or a ledger statement from the provider showing a positive payment against the services rendered

– Mail all required claim information within 365 days from the date of service to:

P.O. Box 30567, Salt Lake City, UT 84130

– Payment will be sent to the address listed on your account. To update your address or for assistance with submitting claims, contact Customer Service at 1-866-272-1967 TTY 711.

– Claims are paid within 30 days and an Explanation of Payment (EOP) will accompany check payment

- Dentists may ask you to sign an informed consent document detailing the risks, benefits, costs, and alternatives to all recommended treatments. If you would like to learn more about how your dental plan coverage relates to your proposed dental treatment and costs, you may ask your dentist to obtain a pre-treatment cost calculation from UHC Dental. If the provider has questions about how to obtain this information, they can contact UHC Dental using the number or website on the back of your member ID card.
- For all other questions or more information, please call 1-866-272-1967 TTY 711 or visit myAARPMedicare.com

Recovery of Payments

We reserve the right to deduct from any benefits properly payable under the Platinum Dental Rider the amount of any payment that has been made:

1. In error
2. Due to a misstatement contained in a claim
3. Due to a misstatement made to get coverage
4. With respect to an ineligible person; this deduction may be made against any claim for benefits under the Platinum Dental Rider by you if such payment is made with respect to you. No request for a refund of all or a portion of a payment of a claim to you or to a dentist will be made after 24 months from the claim payment date. The only exceptions to this are when the payment was made because of fraud committed by you or the dentist, or if you or the dentist has otherwise agreed to make a refund for overpayment of a claim.

Discharge of Liability

Any payment made in accordance with the provisions of the Platinum Dental Rider shall fully discharge our liability to the extent of such payment.

Exclusions:

1. Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.
2. Dental services that are not necessary.

3. Hospitalization or other facility charges.
4. Any dental procedure performed solely for cosmetic and/or aesthetic reasons.
5. Any dental procedure not directly associated with a dental disease.
6. Any procedure not performed in a dental setting.
7. Reconstructive surgery of any type, including reconstructive surgery related to a dental disease, injury, or congenital anomaly.
8. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
9. Service for injuries or conditions covered by worker's compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county, or other political subdivision. This exclusion does NOT apply to any services covered by Medicaid or Medicare.
10. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
11. Dental services rendered (including otherwise covered dental services) after the date on which individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date on which individual coverage under the policy terminates.
12. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice, sales tax, or duplicating/copying patient records.
14. Implants and implant-related services.
15. Tooth bleaching and/or enamel microabrasion.
16. Veneers.
17. Orthodontics.
18. Sustained release of therapeutic drug (D9613).
19. COVID-19 screening, testing, and vaccination.
20. Charges aligned to dental case management, case presentation, consultation with other medical professionals or translation/sign language services.
21. Space maintenance.
22. Any unspecified procedure by report (Dental codes: D##99).

Disclaimer: Treatment plans and recommended dental procedures may vary. Talk to your dentist about treatment options, risks, benefits, and fees. CDT code changes are issued annually by the American Dental Association. Procedure codes may be altered during the plan year in accordance with discontinuation of certain dental codes.

Section 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself, except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them.

The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital	Covered only when medically necessary
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Custodial care Custodial care is personal care that does not require the continuing attention of trained	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation	Not covered under any condition
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Chiropractic services (Medicare-covered)	Manual manipulation of the spine to correct a subluxation is covered. Excluded from Medicare coverage is any service other than manual manipulation of the spine for the treatment of subluxation.
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Home-delivered meals	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease. (As specifically described in the medical benefits chart in this chapter.)

Services not covered by Medicare	Covered only under specific conditions
Outpatient prescription drugs	Some coverage provided according to Medicare guidelines. (As specifically described in the medical benefits chart in this chapter.)
Elective hysterectomy, tubal ligation, or vasectomy, if the primary indication for these procedures is sterilization. Reversal of sterilization procedures, penile vacuum erection devices, or non-prescription contraceptive supplies.	Not covered under any condition
Acupuncture (Medicare-covered)	Available for people with chronic low back pain under certain circumstances. (As specifically described in the medical benefits chart in this chapter.)
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Physical exams that are for employment, licenses, insurance, court hearings, travel, dietary counseling, weight loss programs, premarital purposes, pre-adoption purposes or other non-preventive reasons	Not covered under any condition
Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport)	Services are only covered when the ambulance pick-up address is located in rural New York and applicable conditions are met. Members are responsible for all paramedic intercept service costs that occur outside of rural New York.

Services not covered by Medicare	Covered only under specific conditions
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to home and car remodeling or modification, and exercise equipment	Not covered under any condition
Immunizations for foreign travel purposes	Not covered under any condition
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs and their care, disposable or non-reusable items such as incontinence supplies, and other primarily non-medical equipment.	Not covered by Medicare under any condition
Any medical care or services received outside of the United States and the U.S. Territories, including emergency care and ambulance services. Travel or transportation expenses, including but not limited to air or land ambulance services, from a foreign country to the United States.	Not covered under any condition
Travel or transportation expenses, including but not limited to air or land ambulance services, from a foreign country to the United States.	Not covered under any condition
Transplant-related travel and lodging expenses Transplant-related travel and lodging expenses are not covered if you receive your transplant at any location in either your state of residence or a state adjacent to your state of residence, or you receive your transplant in the state with the nearest transplant center to you (for your required transplant type) regardless of distance.	There are limits on coverage for transplant-related travel and lodging expenses.

Services not covered by Medicare	Covered only under specific conditions
The following types of expenses are not reimbursable: • Vehicle rental, purchase, or maintenance/repairs • Auto clubs (roadside assistance) • Gas/fuel • Travel by air or ground ambulance (may be covered under your medical benefit – see "Ambulance services" in the Medical Benefits Chart) • Air or ground travel not related to medical appointments • Luxury car or limousine services • Premium, business class or first class air travel • Parking fees incurred other than at lodging or medical facility • Deposits or furniture rental charges • Utilities (if billed separate from the rent payment) • Phone calls, newspapers, movie rentals and gift cards • Expenses for lodging when staying with a relative or friend • Meals, snacks, food or beverages • Any eligible lodging expenses exceeding $125/day Transplant-related travel and lodging costs are not covered unless you are a UnitedHealthcare Medicare Advantage member at the time you receive your transplant and at the time the transplant-related expense is incurred. Transplant-related travel and lodging costs are not covered if you receive your transplant at a location that is not in the plan's Transplant Network for the type of transplant you need. Transplant-related travel and lodging costs are not covered for transplant donors.	When you are receiving covered transplant services at a location that is in the plan's transplant network for the type of transplant you need but that is outside the normal community pattern of care from your home, eligible travel and lodging expenses include: **Transportation:** Vehicle mileage, economy/coach airfare, taxi fares, rideshare services, tolls, parking and train, boat or bus fares. Eligible transportation services are not subject to a daily limit amount. **Lodging:** Costs for lodging or places to stay such as hotels, motels or short-term housing rentals. You can be reimbursed for eligible lodging costs up to $125 per day total. Because Medicare-approved transplant centers are not available for every type of transplant in every state, your local community pattern of care for transplants may require that you travel some distance in order to receive your transplant. Travel and lodging expenses are not reimbursable if you receive a transplant at any location in: • your state of residence • a state adjacent to your state of residence • the state with the nearest transplant center to you (for your required transplant type) regardless of distance. Please call the Customer Service number on your member ID card to confirm if you are eligible for transplant-related travel and lodging expenses.

Services not covered by Medicare	Covered only under specific conditions
	Any transplant-related travel and lodging expenses incurred more than 15 months after date of transplant is not reimbursable. Submission of the transplant travel reimbursement expense form must occur within 365 days of the date the travel or lodging expense was incurred.
Self-administered drugs in an outpatient hospital	Covered only under specific conditions

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

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safe and effective use 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.

Chapter 5:
Asking us to pay our share of a bill for covered medical services

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

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

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

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

1. **When you got medical care from a provider who's not in our plan's network**

   When you get care from a provider in the United States who is not part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.

   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.

- You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you already made.
  - If the provider is owed anything, we'll pay the provider directly.
  - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive.

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

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

- You only have to pay your cost-sharing amount when you get covered services. We don't allow network providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

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

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

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (**myAARPMedicare.com**) or call Customer Service and ask for the form.

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

Medical claims payment requests:
UnitedHealthcare
P.O. Box 31362
Salt Lake City, UT 84131-0362

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

Reimbursement process for supplemental benefits:

When using out-of-network providers for supplemental benefits, you'll need to pay out of pocket and submit a reimbursement request following the directions below for the applicable benefit.

Fitness program

You must submit your fitness reimbursement request to us within 60 calendar days of the date of service. If you are a member of an eligible UnitedHealthcare Medicare plan and choose to visit a fitness location outside the Renew Active fitness network, you may request reimbursement for an eligible individual day pass at a publicly available gym or fitness location. Reimbursement is limited to the member's actual out-of-pocket cost for an eligible day pass up to 10%.

Complete the reimbursement form to request payment and provide the information needed to process your request. You do not have to use the form, but it will help us process the information faster.

Download a copy of the request form from the fitness section of your member site or call Customer Service and ask them to send you the request form. Please attach proof of payment to the request form with the following information:

- Fitness location name, address, and phone number
- Amount paid for a day pass at a public gym or fitness location

- The name of individual who received services

If a printable reimbursement request form is not used, you must submit the following documentation:

- Member ID number, member first and last name, and member date of birth
- Member mailing address
- Written attestation that information provided is accurate
- Proof of payment, including the following:
  - Fitness location name, address, and phone number
  - Amount paid for a day pass at a public gym or fitness location
  - The name of individual who received services

Mail your request for payment along with a paid receipt to the following address:
One Pass Solutions Inc.
400 S. 4th St., STE 410 #269322
Minneapolis, MN 55415-1419

Exclusion criteria:

- Only an eligible individual day pass to a publicly available gym or fitness location is eligible for reimbursement. Proof of payment must show purchase on the date of service and must clearly include the gym or fitness location, name and address.
- Monthly memberships are not reimbursable.
- Packages of multiple visits, punch cards, or prepaid session bundles are not reimbursable.
- Initiation, registration, or annual fees are not reimbursable.
- Coaching costs, facility service fees and class fees are not reimbursable.
- Family passes are not reimbursable.
- Fitness equipment, clothing, or supplies are not reimbursable.
- Virtual/online fitness classes, apps, or digital subscriptions are not reimbursable.
- Spa, wellness, or recovery services such as massage, sauna, cryotherapy, or similar services are not reimbursable.
- Expenses at private clubs, country clubs, resort facilities, or private residential/community amenities are not reimbursable unless they are public gyms or fitness locations and the charge is for an eligible individual day pass.
- Late fees, cancellation fees, no-show fees, and penalties are not reimbursable.
- Taxes, shipping, handling, or convenience fees are not reimbursable.

- Duplicate, altered, incomplete, or illegible receipts will not be reimbursed.
- Reimbursement requests submitted after 60 calendar days of the date of service will not be reimbursed.
- Services or charges covered by another benefit, program, promotion, or third party are not eligible for reimbursement.
- Charges for guests, caregivers, dependents, or companions are not reimbursable.

Hearing services - Hearing aids

You must submit your reimbursement request within 365 days of the date of service. You can call UnitedHealthcare Hearing at 1-855-523-9355 to get the reimbursement form or follow the directions below. Requests for reimbursements are only eligible to be paid if the practice is out of network and not transacted through UnitedHealthcare Hearing. Sales tax is not reimbursable. Keep a copy of your submission and proof of payment. Original proof of payment should be included with your submission. Your submission must include:

- Member ID number, member first and last name, and member date of birth
    - Hearing device information
    - Date of service
    - Device costs
    - Any add-ons or upgrades
- Paid itemized receipt showing device(s) paid in full
- Copy of audiogram including provider's state and license number
- Signed bill of sale or delivery receipt showing:
    - Subscriber ID
    - Full name
    - Date of birth

Hearing aid claim submissions and proof of payment should be submitted to:
UnitedHealthcare Hearing
P.O. Box 740381
Atlanta, GA 30374
Email: **correspondence@uhchearing.com**

Once all materials are collected, UnitedHealthcare Hearing will process the claim within 60 calendar days and notify you of the outcome via letter.

Vision services – routine eyewear (UHC Vision)

You must submit your reimbursement request within 365 days of the date of service. You can use this reimbursement form https://memberforms.uhc.com/vision-reimbursement.html or follow the directions below. You must submit separate requests for each provider you paid. Sales tax is not reimbursable. Keep a copy of your submission and proof of payment. Original proof of payment should be included with your submission. Your submission must include:

- MemberID number, member first and last name, and member date of birth
- Member mailing address
- Provider name, provider address, and provider phone number
- Provider National Provider Identifier (NPI) number
- Receipts of services with dates of services (individual services, add-ons/upgrades)
- Amount to be reimbursed

UHC Vision claim submissions and proof of payment should be submitted to:
UnitedHealthcare I Spectera
P.O. Box 30978
Salt Lake City, UT 84130

Once all materials are collected, UHC Vision will process the claim within 30 calendar days and send you a letter with the outcome.

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

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

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

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

If you think we have made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a

formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7.

Chapter 6:
Your rights and responsibilities

Section 1 Our plan must honor your rights and cultural sensitivities

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

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

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service number at 1-866-272-1967 for additional information (TTY users should call 711).

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Se nos exige que le proporcionemos la información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener más información de nuestra parte de una forma que le resulte conveniente, llame al número de Servicio al Cliente al 1-866-272-1967 (los usuarios de TTY deben llamar al 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Customer Service (phone numbers are printed on the cover of this booklet). You

can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Se nos exige que le proporcionemos la información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener más información de nuestra parte de una forma que le resulte conveniente, llame al número de Servicio al Cliente al 1-866-272-1967 (los usuarios de TTY deben llamar al 711).

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service number at 1-866-272-1967 for additional information (TTY users should call 711).

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

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

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, consultar a un especialista en salud de la mujer o encontrar un

especialista de la red, llame a Servicio al Cliente para presentar una queja formal (los números de teléfono aparecen en la portada de esta guía). También puede presentar una queja ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

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

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount. You also have the right to choose an out-of-network provider that participates in Medicare.

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.

How to Receive Care After Hours

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

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we're required to get written permission from you or someone you've given legal power to make decisions for you first.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.

– We're required to release health information to government agencies that are checking on quality of care.

– Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

How is your health information shared and protected?

Sharing with your providers

We automatically share your health information with your network providers so they can work together on your care. This helps them coordinate your treatment, make faster treatment decisions, and improve your overall health experience.

We keep your health information safe with strong privacy and security protections. Only providers who have treated you and are part of our network can view your information.

And you're always in control – if you don't want to share your information, you can opt out at any time. And if you change your mind later, you can opt back in. Even if you choose to opt out, your provider may still access some information as allowed by law to make sure you get the right care.

Sharing with other health plans

If you have more than one health plan at the same time or change plans later, you can choose to allow us to request and share your health information with those plans. This helps keep your medical records complete and together in one place. It also helps with transitions in care and gives your health plans the information they need to best support you.

Your health information isn't shared automatically – you must give us permission to do so. You can change your mind at any time to start or stop sharing your health information. We'll only share your information with health plans you're enrolled in, and we'll be using privacy and security protections.

How to manage your sharing preferences

You can start or stop sharing your health information with your providers and other health plans whenever you like. To update your preferences, go to **myAARPMedicare.com**:

1. Sign in to your account
2. In the **My personal support network** section at the bottom left of the page, select **Manage access**
3. Under **Data sharing**, choose who you want to share your health information with

Or call us toll-free at **1-866-272-1967**, TTY **711**, 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept for help updating your preferences.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Customer Service at **1-866-272-1967** (TTY users call 711).

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

We[1] are required by law to protect the privacy of your health information. We are also required to provide 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 that is currently in effect.

The terms "information" or "health information" in this notice include 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. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

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 to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website. 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 Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that 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 confirm we are meeting our privacy obligations.

We may collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may collect, use, and disclose your health information:

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- **For Health Care Operations** 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. We may also de-identify health information in accordance with applicable laws.
- **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.
- **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. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes;** however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders,** we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help 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 interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **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** 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 federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Donation Purposes** 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 and pursuant to federal law, to protect the privacy of your information.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

    1. Alcohol and Substance Use Disorder
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

We will follow the more stringent and protective law, where it applies to us.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For information on how to revoke your authorization, contact the phone number listed on your health plan 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** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information 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. Any request for restrictions must be made in writing. **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 request for a restriction.**
- **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 in accordance

with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any 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 request to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may 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. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, 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. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request 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) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.
- **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. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, **please call the toll-free member phone**

number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-272-1967 (TTY/RTT 711).

- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at the following address:

  UnitedHealthcare

  Customer Service - Privacy Unit

  PO Box 740815

  Atlanta, GA 30374-0815

- **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.

[1]This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to **uhc.com/privacy/entities-fn-v1**.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means 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

Depending upon the product or service you have with us, we may 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, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

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. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-272-1967 (TTY 711).**

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

exceptions for HIPAA covered entities or health insurance products. For a current list of entities subject to this notice go to **uhc.com/privacy/entities-fn-v1**

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

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

If you want any of the following kinds of information, call **toll-free** at 1-866-272-1967 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.**

–You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.

- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

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

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

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

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

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

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

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

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

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

If your instructions aren't followed?

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

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do.

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

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

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

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

- Call Customer Service at **1-866-272-1967 (TTY users call 711)**
- **Call your local SHIP at 1-877-987-4463**.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

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

Get more information about your rights from these places:

- Call Customer Service at **1-866-272-1967 (TTY users call 711)**

- For information on the quality program for your specific health plan, call Customer Service. You can also access this information online at aarpmedicareplans.com/content/dam/shared/documents/Commitment_to_Quality.pdf.
- **Call your local SHIP at 1-877-987-4463**.
- Contact **Medicare**.

–Visit medicare.gov to read the publication **Medicare Rights & Protections** (available at: medicare.gov/publications/11534-medicare-rights-and-protections.pdf)

–Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

Section 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at **1-866-272-1967** (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this **Evidence of Coverage** to learn what's covered and the rules you need to follow to get covered services.

–Chapters 3 and 4 give details about medical services.

- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show your UnitedHealthcare member ID card whenever you get medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**

–To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.

–Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.

–If you have questions, be sure to ask and get an answer you can understand.

- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:

– You must continue to pay your Medicare Part B premium to stay a member of our plan.

– For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.

– **If you move outside our plan service area, you can't stay a member of our plan.**

– **If you move within our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.

– If you move, tell Social Security (or the Railroad Retirement Board).

Chapter 7:
If you have a problem or complaint (coverage decisions, appeals, complaints)

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

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints** (also called grievances).

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

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

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

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

Section 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call customer service at 1-866-272-1967 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

You can also contact Medicare for help.

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

Section 3 Which process to use for your problem

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

Yes.
Go to **Section 4, A guide to coverage decisions and appeals.**

No.
Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

Section 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as medical care. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage

decision if your doctor is unsure whether we'll cover a particular medical service or refuse to provide medical care you think you need. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

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

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

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to Section 5.4 of this chapter for more information about Level 2 appeals for medical care.

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

Section 4.1 Get help asking for a coverage decision or making an appeal

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

- **Call Customer Service at** 1-866-272-1967 (TTY **users call** 711)**.**

- Get free help from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Service at 1-866-272-1967 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)

– For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.

- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

– If you want a friend, relative, or another person to be your representative, call Customer Service at 1-866-272-1967 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available at

cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

– We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

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

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 7**: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (**Applies only to these services:** home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

- If you're not sure which information applies to you, call Customer Service at 1-866-272-1967 (TTY users call 711). You can also get help or information from your SHIP.

Section 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

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

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

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms	A coverage decision that involves your medical care is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

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

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

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

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

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

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

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

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

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

For standard coverage decisions we use the standard deadlines.

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

calendar days after we get your request. If your request is for a **Part B drug**, we'll give you an answer **within 72 hours** after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 9 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no.

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

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

Section 5.3 How to make a Level 1 appeal

Legal Terms	An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

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

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

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

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.

- If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
- If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your **health** condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- If our plan says no to part or all of your appeal, we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

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

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

If you don't agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

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

Section 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

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

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

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called **An Important Message from Medicare about Your Rights.** Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at **1-866-272-1967** (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - –Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - –Your right to be involved in any decisions about your hospital stay.
   - –Where to report any concerns you have about quality of your hospital care.
   - –Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - –You or someone who is acting on your behalf will be asked to sign the notice.
   - –Signing the notice shows **only** that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - –If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - –To look at a copy of this notice in advance, call Customer Service at 1-866-272-1967 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Service at 1-866-272-1967 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. West Virginia State Health Insurance Assistance Program (WV SHIP) 1-877-987-4463, TTY users call 711. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge.**

–**If you meet this deadline,** you can stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.

–**If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, **you may have to pay all the costs** for hospital care you get after your planned discharge date.

Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the

reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service at 1-866-272-1967 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the independent review organization says yes:

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

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.

- The notice you get will tell you in writing what you can do if you want to continue with the review process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

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

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, **we'll stop paying our share of the cost for your care.**

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

Section 7.1 We'll tell you in advance when your coverage will be ending

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got.** Signing the notice shows **only** that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

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

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

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

The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

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

How can you contact this organization?

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

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term	**"Detailed Explanation of Non-Coverage."** Notice that gives details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the review organization says no?

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

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 tells more about Levels 3, 4, and 5 of the appeals process.

Section 8 Taking your appeal to Level 3, 4, and 5

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

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

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

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

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

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

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

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

Making complaints

Section 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

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

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

Section 9.2 How to make a complaint

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

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

- **Calling Customer Service at 1-866-272-1967 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address and fax numbers for filing complaints are located in Chapter 2 under "How to contact us when you are making a complaint about your medical care."

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

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

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

Or

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

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

Chapter 8:

Ending membership in our plan

Section 1 Ending your membership in our plan

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

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

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

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

Section 2.1 You can end your membership during the Open Enrollment Period

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

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

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

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

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

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

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

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

- Usually, when you move.
- If you have Medicaid.
- If we violate our contract with you.
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE). * PACE is not available in all states. If you would like to know if PACE is available in your state, call Customer Service at 1-304-558-1700 (TTY users call 711).

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

Enrollment time periods vary depending on your situation.

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

- Another Medicare health plan with or without drug coverage.

- Original Medicare **with** a separate Medicare drug plan.
- Original Medicare **without** a separate Medicare drug plan.

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

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service at 1-866-272-1967 (TTY users call 711).**
- Find the information in the **Medicare & You** 2027 handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan • You'll automatically be disenrolled from our plan when your new plan's coverage starts.
• Original Medicare **with** a separate Medicare drug plan.	• Enroll in the new Medicare drug plan • You'll automatically be disenrolled from our plan when your new drug plan's coverage starts.
• Original Medicare **without** a separate Medicare drug plan.	• **Send us a written request to disenroll** or visit our website to disenroll online. Call Customer Service at 1-866-272-1967 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from our plan when your coverage in Original Medicare starts.

Note: If you also have creditable drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable drug coverage for 63 days or more in a row.

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

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

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you're discharged (even if you're discharged after your new health coverage starts).**

Section 5 We must end our plan membership in certain situations

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

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Customer Service at 1-866-272-1967 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen, or national, or an eligible noncitizen.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your UnitedHealthcare member ID card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Customer Service at 1-866-272-1967 (TTY users call 711).

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

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

What should you do if this happens?

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

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

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

Chapter 9:
Legal notices

Section 1 Notice about governing law

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

Section 2 Notice about non-discrimination

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

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

If you have a disability and need help with access to care, call us at Customer Service 711. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the

Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Section 4 Third party liability and subrogation

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

1) **Our payments are less than the recovery amount**. If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:

   a) **First:** Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).

   b) **Second:** Apply the ratio calculated above to our payment. The result is our share of procurement costs.

   c) **Third:** Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.

2) **Our payments equal or exceed the recovery amount.** If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.

3) **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:

   a) Our payments made on your behalf for services; or

   b) the recovery amount, minus the party's total procurement cost.

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

Section 5 Member liability

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

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

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

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

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

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

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

payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.

Section 8 Acts beyond our control

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

Section 9 Contracting medical providers and network hospitals are independent contractors

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

Section 10 Technology assessment

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

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

Section 11 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this

Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

Section 12 Information upon request

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

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

Section 13 2027 Enrollee Fraud & Abuse Communication

2027 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud

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

Here are some examples of potential Medicare fraud cases:

- A health care provider - such as a physician, 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, supplies or equipment;
- Someone bills for home medical equipment after it has been returned;
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare; or
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) Customer Service at 1-866-272-1967 (TTY 711), 7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept.

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

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

Section 14 Commitment of Coverage Decisions

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

Section 15 Fitness program Terms and Conditions

Renew Active Plan Year 2027 Disclaimers

The Renew Active® Program and its gym network varies by plan/area and may not be available on all plans. Participation in the Renew Active program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership at participating locations and other offerings. The participating locations and offerings may change at any time. Fitness membership equipment, classes and activities may vary by location. Certain services, classes, activities and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor.

Eligibility Requirements

Only members enrolled in a participating Medicare Plan offered by UnitedHealthcare Insurance Company ("UnitedHealthcare") and affiliates are eligible for the Renew Active program ("Program"), which includes, without limitation, access to standard fitness memberships at participating gyms/fitness locations, at no additional cost. By enrolling in the Program, you hereby accept and agree to be bound by these Terms and Conditions.

Enrollment Requirements

Membership and participation in the Program is voluntary. You must enroll in the Program according to the information provided on the member site or Customer Service. Once enrolled, you must obtain your confirmation code and provide it when requested to sign up for any Program services. Provide your confirmation code when requested when visiting a participating gym/fitness location to receive standard membership access at no additional cost. Please note, that by using your confirmation code, you are electing to disclose that you are a Renew Active member with a

participating UnitedHealthcare Medicare plan. Program enrollment is on an individual basis and the Program's waived monthly membership rate for standard membership services at participating gyms and fitness locations is only applicable to individual memberships. You are responsible for any and all non-covered services and/or similar fee-based products and services offered by Program service providers (including, without limitation, gym/fitness centers, in-person classes and other third party service offerings made available through the Program), including, without limitation, fees associated with personal training sessions, specialized classes and enhanced facility membership levels beyond the standard membership level. No reimbursements will be made for any fitness program offerings. Fitness membership offerings, including visits, hours, equipment, classes, personalized fitness plans, caregiver access and activities, can vary by location. Access to gym and fitness location network varies by plan/area and may not be available on all plans.

Community Resources, Classes and Activities Disclaimer

Information about classes and activities in your area is being made available so you will have an opportunity to learn about some community resources that may help your overall health and well-being. This information is provided solely as a convenience, and participation is voluntary. While the resources mentioned herein are at no additional cost, please note that charges may apply for other programs, classes, activities or services listed on a third-party website or otherwise offered by such third party. UnitedHealthcare does not endorse third-party organizations providing classes and activities and is not responsible for the information, products or services these organizations provide or the content on any linked site or any link contained in a linked site. These resources are not meant to replace professional health care and should not be used for emergency or urgent care needs. If you have health concerns, or before starting a new workout or diet program, please talk with your doctor. You and your health care provider must ultimately determine if you want to participate in these classes and activities. Be mindful that, if a resource is being offered on the internet, internet forums may contain misinformation.

Liability Waiver

Always seek the advice of a doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine.

Certain services and classes are provided by affiliates of UnitedHealthcare or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. UnitedHealthcare and its respective subsidiaries and affiliates do not endorse and are not responsible for the services or information provided by third parties, the content on any linked site, or for any injuries you may sustain while participating in any services and classes under the Program.

Other Requirements

You must verify that the individual gym/fitness location or service provider participates in the Program before enrolling. If a Program service provider you use, including a gym or fitness location, ceases to participate in the Program, your Program participation and waived monthly

membership rate with such service provider through the Program will be discontinued until you join another service offered by a participating service provider. You will be responsible for paying the standard membership rates of the such service provider should you elect to continue to receive services from a service provider once that service provider ceases to participate in our Program. If you wish to cancel your membership with such service provider, you can opt to do so per the cancellation policy of the applicable service provider, including the applicable gym or fitness location. You should review your termination rights with a service provider when you initially elect to sign up with such service provider.

Data Requirements

The Program administrator and/or your service provider will collect and electronically send and/or receive the minimum amount of your personal information required in order to facilitate the Program in accordance with the requirements of applicable laws, including privacy laws. Such required personal information includes, but is not limited to, program confirmation code, gym/fitness location/provider membership ID, activity year and month, and monthly visit count. By enrolling in the Program, you authorize the Program administrator and your service provider to request and/or provide such personal information.

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Optum Financial®

Privacy notice

Rev. 08/2025

Facts	What does Optum Bank do with your personal information?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Medicare Beneficiary Identifier or Member Identification Number and account balances • Payment history and transaction history • Purchase history and account transactions When you are no longer our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information, the reasons Optum Bank chooses to share and whether you can limit this sharing.

Reasons we can share your personal information	Does Optum Bank share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – information about your transactions and experiences, which is not used by affiliates to market their products to you	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	**Please call 1-866-234-8913 or visit us online at optumbank.com.**

What we do	
How does **Optum Bank** protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We also have additional safeguards to protect your information and we limit who can access it.
How does **Optum Bank** collect my personal information?	We collect your personal information, for example, when you: • Use your payment card or pay a bill • Update your contact information We also collect your personal information from others, such as affiliates or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • Our affiliates include companies within UnitedHealth Group and those companies that share the Optum name; financial companies such as Optum Financial, Inc. and UnitedHealthcare Insurance Company; and nonfinancial companies such as UHG Print Services.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • Optum Bank does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • Optum Bank does not engage in any joint marketing.

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Chapter 10:

Definitions

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

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO), you only have to pay our plan's allowed cost-sharing amounts when you get services covered by our plan. We don't allow network providers to "balance bill" or otherwise charge you more than the amount of cost-sharing our plan says you must pay.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods. For Inpatient Hospital Care, Medicare-defined hospital benefit periods do not apply. For inpatient hospital care, the cost-sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

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

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

final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

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

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

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

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

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

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

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

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care,

provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

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

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

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

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

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

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

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

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

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day/7 days a week.

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

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

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered Part A and Part B services received from in-network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. **Amounts you pay for your plan premiums and Medicare Part A and Part B premiums don't count toward the maximum out-of-pocket amount. Go to Chapter 4, Section 1.3 for information about your maximum out-of-pocket amount.**

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

Maximum Charge (Limiting Charge) – In the Original Medicare plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

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

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

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

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

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) does not offer Medicare prescription drug coverage.

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

Medicare Assignment – In Original Medicare, a doctor or supplier "accepts assignment" when he or she agrees to accept the Medicare-approved amount as full payment for covered services. For covered out-of-network services, it can save you money if your doctor or supplier accepts assignment. If a doctor or supplier accepts assignment, your cost-sharing is limited to your copayment or coinsurance amount for the covered service.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

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

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

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

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

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

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

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

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

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

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) **–** Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and

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

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

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

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

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from in-network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health coverage.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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

Prior Authorization – For medical services it means a process where your doctor or treating provider must receive approval in advance before certain medical services will be provided or payable. This approval is based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your costs-sharing responsibility is.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

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

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

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

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

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

AARP® Medicare Advantage Patriot No Rx WV-MA01 (PPO) Customer Service:

Download the **UnitedHealthcare app**

Visit **myAARPMedicare.com**

Call **1-866-272-1967**
Calls to this number are free.
7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept.
Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**
Calls to this number are free.
7 a.m.-10 p.m. CT, 7 Days Oct-Mar, M-F Apr-Sept.

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

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

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