



# Summary of Benefits 2023

**AARP® Medicare Advantage Riverbank (PPO)**

H7404-014-000

Look inside to take advantage of the health services and drug coverages the plan provides.  
Call Customer Service or go online for more information about the plan.



**Toll-free 1-844-723-6473, TTY 711**

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



**AARPMedicarePlans.com**

**AARP® | Medicare Advantage**  
from  **UnitedHealthcare®**

Y0066\_SB\_H7404\_014\_000\_2023\_M

# Summary of Benefits

## January 1st, 2023 - December 31st, 2023

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can see it online at [myAARPMedicare.com](https://myAARPMedicare.com) or you can call Customer Service for help. When you enroll in the plan, you will get more information on how to view your plan details online.

## About this plan

AARP® Medicare Advantage Riverbank (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed below, and be a United States citizen or lawfully present in the United States.

Our service area includes these counties in:

**Minnesota:** Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright.

## Use network providers and pharmacies

AARP® Medicare Advantage Riverbank (PPO) has a network of doctors, hospitals, pharmacies, and other providers. With this plan, you have the freedom to enjoy nationwide access to care at in-network costs when you visit any provider participating in the UnitedHealthcare® Medicare National Network (exclusions may apply). Plus, you have the flexibility to visit any provider nationwide who accepts Medicare. You may pay a higher copay or coinsurance when you see an out-of-network provider. When looking at the following charts you'll see the cost differences for network vs. out-of-network care and services. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **[AARPMedicarePlans.com](https://AARPMedicarePlans.com)** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

# AARP® Medicare Advantage Riverbank (PPO)

## Premiums and Benefits

|                                                                       | In-Network                                                                                                                                                                                                                                                                                              | Out-of-Network                                                                |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Monthly Plan Premium                                                  | \$73                                                                                                                                                                                                                                                                                                    |                                                                               |
| Annual Medical Deductible                                             | This plan does not have a deductible.                                                                                                                                                                                                                                                                   |                                                                               |
| Maximum Out-of-Pocket Amount<br>(does not include prescription drugs) | \$2,900 annually for Medicare-covered services you receive from in-network providers.                                                                                                                                                                                                                   | \$5,100 annually for Medicare-covered services you receive from any provider. |
|                                                                       | <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and share of the cost for your Part D prescription drugs.</p> |                                                                               |

# AARP® Medicare Advantage Riverbank (PPO)

## Benefits

|                                                                                                 |                                                       | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Out-of-Network                                                  |
|-------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <b>Inpatient Hospital Care<sup>2</sup></b>                                                      |                                                       | \$150 copay per stay                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$200 copay per stay                                            |
|                                                                                                 |                                                       | Our plan covers an unlimited number of days for an inpatient hospital stay.                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |
| <b>Outpatient Hospital</b><br><br>Cost sharing for additional plan covered services will apply. | Ambulatory Surgical Center (ASC) <sup>2</sup>         | \$0 copay for a diagnostic colonoscopy<br>\$100 copay otherwise                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0 copay for a diagnostic colonoscopy<br>\$175 copay otherwise |
|                                                                                                 | Outpatient Hospital, including surgery <sup>2</sup>   | \$0 copay for a diagnostic colonoscopy<br>\$125 copay otherwise                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0 copay for a diagnostic colonoscopy<br>\$175 copay otherwise |
|                                                                                                 | Outpatient Hospital Observation Services <sup>2</sup> | \$125 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$175 copay                                                     |
| <b>Doctor Visits</b>                                                                            | Primary Care Provider                                 | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$0 copay                                                       |
|                                                                                                 | Specialists <sup>2</sup>                              | \$20 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$20 copay                                                      |
|                                                                                                 | Virtual Medical Visits                                | \$0 copay to talk with a network telehealth provider online through live audio and video                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |
| <b>Preventive Services</b>                                                                      | Medicare-covered                                      | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$0 copay                                                       |
|                                                                                                 |                                                       | Abdominal aortic aneurysm screening<br>Alcohol misuse counseling<br>Annual wellness visit<br>Bone mass measurement<br>Breast cancer screening (mammogram)<br>Cardiovascular disease (behavioral therapy)<br>Cardiovascular screening<br>Cervical and vaginal cancer screening<br>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>Depression screening<br>Diabetes screenings and monitoring<br>Hepatitis C screening<br>HIV screening |                                                                 |

## Benefits

|                                 |                  | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Out-of-Network         |
|---------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
|                                 |                  | Lung cancer with low dose computed tomography (LDCT) screening<br>Medical nutrition therapy services<br>Medicare Diabetes Prevention Program (MDPP)<br>Obesity screenings and counseling<br>Prostate cancer screenings (PSA)<br>Sexually transmitted infections screenings and counseling<br>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19<br>“Welcome to Medicare” preventive visit (one-time) |                        |
|                                 |                  | Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.                                                                                                                                                                                                                                                                                                               |                        |
|                                 | Routine physical | \$0 copay, 1 per year*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$0 copay, 1 per year* |
| <b>Emergency Care</b>           |                  | \$90 copay (\$0 copay for emergency care outside the United States) per visit<br>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency Care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.                                                                                                                                                                                                                                       |                        |
| <b>Urgently Needed Services</b> |                  | \$40 copay<br>(\$0 copay for urgently needed services outside the United States) per visit                                                                                                                                                                                                                                                                                                                                                                                                                                       |                        |

## Benefits

|                                                                 |                                                                    | In-Network                                                                                                                                                                                                         | Out-of-Network                                                   |
|-----------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| <b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b> | Diagnostic radiology services (e.g. MRI, CT scan) <sup>2</sup>     | \$0 copay for each diagnostic mammogram<br>\$140 copay otherwise                                                                                                                                                   | \$0 copay for each diagnostic mammogram<br>\$140 copay otherwise |
|                                                                 | Lab services <sup>2</sup>                                          | \$0 copay                                                                                                                                                                                                          | \$0 copay                                                        |
|                                                                 | Diagnostic tests and procedures <sup>2</sup>                       | \$20 copay                                                                                                                                                                                                         | \$20 copay                                                       |
|                                                                 | Therapeutic Radiology <sup>2</sup>                                 | \$60 copay per service                                                                                                                                                                                             | 40% coinsurance                                                  |
|                                                                 | Outpatient X-rays <sup>2</sup>                                     | \$15 copay per service                                                                                                                                                                                             | \$15 copay per service                                           |
| <b>Hearing Services</b>                                         | Exam to diagnose and treat hearing and balance issues <sup>2</sup> | \$0 copay                                                                                                                                                                                                          | \$20 copay                                                       |
|                                                                 | Routine hearing exam                                               | \$0 copay, 1 per year*                                                                                                                                                                                             | \$20 copay, 1 per year*                                          |
|                                                                 | Hearing aids <sup>2</sup>                                          | \$175 - \$1,225 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.*<br><br>Includes hearing aids delivered directly to you with virtual follow-up care (select models). |                                                                  |
| <b>Routine Dental Benefits</b>                                  | Preventive                                                         | \$0 copay for exams, cleanings, X-rays, and fluoride*                                                                                                                                                              | \$0 copay for exams, cleanings, X-rays, and fluoride*            |
|                                                                 | Comprehensive <sup>2</sup>                                         | \$0 copay for comprehensive dental services*                                                                                                                                                                       | \$0 copay for comprehensive dental services*                     |
|                                                                 | Benefit limit                                                      | \$2,000 combined limit on all covered dental services*<br>If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay                                           |                                                                  |

## Benefits

|                                                   |                                                                            | In-Network                                                                                                                                                                                                                                                                                             | Out-of-Network                                                                                      |
|---------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| <b>Vision Services</b>                            | Exam to diagnose and treat diseases and conditions of the eye <sup>2</sup> | \$0 copay                                                                                                                                                                                                                                                                                              | \$0 copay                                                                                           |
|                                                   | Eyewear after cataract surgery                                             | \$0 copay                                                                                                                                                                                                                                                                                              | \$0 copay                                                                                           |
|                                                   | Routine eye exam                                                           | \$0 copay, 1 per year*                                                                                                                                                                                                                                                                                 | \$0 copay, 1 per year*                                                                              |
|                                                   | Routine eyewear                                                            | \$0 copay<br>Plan pays up to \$300 every year for frames or contact lenses through UnitedHealthcare Vision. Standard single, bifocal, trifocal, or progressive lenses are covered in full.*<br><br>Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only). |                                                                                                     |
| <b>Mental Health</b>                              | Inpatient visit <sup>2</sup>                                               | \$150 copay per stay                                                                                                                                                                                                                                                                                   | \$200 copay per stay                                                                                |
|                                                   |                                                                            | Our plan covers 90 days for an inpatient hospital stay.                                                                                                                                                                                                                                                |                                                                                                     |
|                                                   | Outpatient group therapy visit <sup>2</sup>                                | \$0 copay                                                                                                                                                                                                                                                                                              | \$0 copay                                                                                           |
|                                                   | Outpatient individual therapy visit <sup>2</sup>                           | \$0 copay                                                                                                                                                                                                                                                                                              | \$0 copay                                                                                           |
|                                                   | Virtual Mental Health Visits                                               | \$0 copay to talk with a network telehealth provider online through live audio and video                                                                                                                                                                                                               |                                                                                                     |
| <b>Skilled Nursing Facility (SNF)<sup>2</sup></b> |                                                                            | \$0 copay per day: days 1-20<br>\$196 copay per day: days 21-35<br>\$0 copay per day: days 36-100                                                                                                                                                                                                      | \$150 copay per day: days 1-16<br>\$250 copay per day: days 17-18<br>\$0 copay per day: days 19-100 |
|                                                   |                                                                            | Our plan covers up to 100 days in a SNF.                                                                                                                                                                                                                                                               |                                                                                                     |

## Benefits

|                                                                                                                     |                                                                     | In-Network                                                       | Out-of-Network                                                   |
|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------|
| <b>Outpatient Rehabilitation Services</b>                                                                           | Physical therapy and speech and language therapy visit <sup>2</sup> | \$20 copay                                                       | \$20 copay                                                       |
|                                                                                                                     | Occupational Therapy Visit <sup>2</sup>                             | \$20 copay                                                       | \$20 copay                                                       |
|                                                                                                                     | Virtual Visit                                                       | \$0 copay                                                        | \$0 copay                                                        |
| <b>Ambulance<sup>2</sup></b><br><br>Your provider must obtain prior authorization for non-emergency transportation. |                                                                     | \$250 copay for ground<br>\$250 copay for air                    | \$250 copay for ground<br>\$250 copay for air                    |
| <b>Routine Transportation</b>                                                                                       |                                                                     | Not covered                                                      |                                                                  |
| <b>Medicare Part B Prescription Drugs</b>                                                                           | Chemotherapy drugs <sup>2</sup>                                     | 20% coinsurance                                                  | 40% coinsurance                                                  |
|                                                                                                                     | Other Part B drugs <sup>2</sup>                                     | \$0 copay for allergy antigens<br>20% coinsurance for all others | \$0 copay for allergy antigens<br>40% coinsurance for all others |

Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.

## Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                  |                       |                       |                       |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| <b>Stage 1: Annual Prescription (Part D) Deductible</b>                         | Since you have no deductible for Part D drugs, this payment stage doesn't apply.                                                                                                                                                                                                                                                                                 |                       |                       |                       |
| <b>Stage 2: Initial Coverage (After you pay your deductible, if applicable)</b> | <b>Retail</b>                                                                                                                                                                                                                                                                                                                                                    |                       | <b>Mail Order</b>     |                       |
|                                                                                 | <b>Standard</b>                                                                                                                                                                                                                                                                                                                                                  |                       | <b>Preferred</b>      | <b>Standard</b>       |
|                                                                                 | <b>30-day supply</b>                                                                                                                                                                                                                                                                                                                                             | <b>100-day supply</b> | <b>100-day supply</b> | <b>100-day supply</b> |
| Tier 1: Preferred Generic                                                       | \$0 copay                                                                                                                                                                                                                                                                                                                                                        | \$0 copay             | \$0 copay             | \$0 copay             |
| Tier 2: Generic <sup>3</sup>                                                    | \$8 copay                                                                                                                                                                                                                                                                                                                                                        | \$24 copay            | \$0 copay             | \$24 copay            |
| Tier 3: Preferred Brand                                                         | \$47 copay                                                                                                                                                                                                                                                                                                                                                       | \$141 copay           | \$131 copay           | \$141 copay           |
| Select Insulin Drugs <sup>4</sup>                                               | \$35 copay                                                                                                                                                                                                                                                                                                                                                       | \$105 copay           | \$95 copay            | \$105 copay           |
| Tier 4: Non-Preferred Drug                                                      | \$100 copay                                                                                                                                                                                                                                                                                                                                                      | \$300 copay           | \$290 copay           | \$300 copay           |
| Tier 5: Specialty Tier                                                          | 33% coinsurance                                                                                                                                                                                                                                                                                                                                                  | N/A <sup>5</sup>      | N/A <sup>5</sup>      | N/A <sup>5</sup>      |
| <b>Stage 3: Coverage Gap Stage</b>                                              | Tier 1 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach \$4,660, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap.                                                                                                                                    |                       |                       |                       |
| <b>Stage 4: Catastrophic Coverage</b>                                           | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,400, you pay the greater of: <ul style="list-style-type: none"> <li>□ 5% coinsurance, or</li> <li>□ \$4.15 copay for generic (including brand drugs treated as generic) and a \$10.35 copay for all other drugs.</li> </ul> |                       |                       |                       |

<sup>3</sup> Tier includes enhanced drug coverage.

<sup>4</sup> For 2023, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of \$35 for a 1-month supply of Part D select insulin drugs during the deductible, Initial Coverage and Coverage Gap or "Donut Hole" stages of your benefit. You will pay 5% of the cost of your insulin in the Catastrophic Coverage stage. This cost sharing only applies to members who do not qualify for a program that helps pay for your drugs ("Extra Help").

<sup>5</sup> Limited to a 30-day supply

## Additional Benefits

|                            |                                                                                                           | In-Network                                                                                                                                                                                                                                                                                                                                                                                                               | Out-of-Network                  |
|----------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| <b>Acupuncture</b>         | Routine acupuncture                                                                                       | \$10 copay, 12 visits per year*                                                                                                                                                                                                                                                                                                                                                                                          | \$20 copay, 12 visits per year* |
| <b>Chiropractic Care</b>   | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>2</sup> | \$10 copay                                                                                                                                                                                                                                                                                                                                                                                                               | \$20 copay                      |
|                            | Routine chiropractic care                                                                                 | \$10 copay, 12 visits per year*                                                                                                                                                                                                                                                                                                                                                                                          | \$20 copay, 12 visits per year* |
| <b>Diabetes Management</b> | Diabetes monitoring supplies <sup>2</sup>                                                                 | <p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch® Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p> | 50% coinsurance                 |
|                            | Diabetes self-management training                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                | \$0 copay                       |
|                            | Therapeutic shoes or inserts <sup>2</sup>                                                                 | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                          | 50% coinsurance                 |

## Additional Benefits

|                                                             |                                                                    | In-Network                                                                                                                                                                                                                     | Out-of-Network                 |
|-------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| <b>Durable Medical Equipment (DME) and Related Supplies</b> | Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>2</sup> | 20% coinsurance                                                                                                                                                                                                                | 50% coinsurance                |
|                                                             | Prosthetics (e.g., braces, artificial limbs) <sup>2</sup>          | 20% coinsurance                                                                                                                                                                                                                | 50% coinsurance                |
| <b>Fitness program</b>                                      |                                                                    | \$0 copay for Renew Active, which includes a free gym membership at a location you select from our nationwide network, plus a personalized fitness plan, online fitness classes, brain health challenges and 1 Fitbit® device. |                                |
| <b>Foot Care (podiatry services)</b>                        | Foot exams and treatment <sup>2</sup>                              | \$20 copay                                                                                                                                                                                                                     | \$20 copay                     |
|                                                             | Routine foot care                                                  | \$20 copay, 6 visits per year*                                                                                                                                                                                                 | \$20 copay, 6 visits per year* |
| <b>Meal Benefit<sup>2</sup></b>                             |                                                                    | \$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay.                                                                                                   |                                |
| <b>Home Health Care<sup>2</sup></b>                         |                                                                    | \$0 copay                                                                                                                                                                                                                      | 50% coinsurance                |
| <b>Hospice</b>                                              |                                                                    | You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.                           |                                |
| <b>NurseLine</b>                                            |                                                                    | Speak with a registered nurse (RN) 24 hours a day, 7 days a week.                                                                                                                                                              |                                |
| <b>Opioid Treatment Program Services<sup>2</sup></b>        |                                                                    | \$0 copay                                                                                                                                                                                                                      | \$0 copay                      |
| <b>Outpatient Substance Abuse</b>                           | Outpatient group therapy visit <sup>2</sup>                        | \$0 copay                                                                                                                                                                                                                      | \$0 copay                      |
|                                                             | Outpatient individual therapy visit <sup>2</sup>                   | \$0 copay                                                                                                                                                                                                                      | \$0 copay                      |

## Additional Benefits

|                                           | In-Network                                                                                                                                                                                   | Out-of-Network  |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| <b>Over-the-counter (OTC) credit</b>      | \$60 credit every quarter to buy covered OTC products. Shop at network retail locations or get home delivery by ordering online or by phone through your OTC catalog.                        |                 |
| <b>Personal Emergency Response System</b> | \$0 copay for a personal emergency response system (PERS).<br>Help is only a button press away. A PERS device can quickly connect you to the help you need, 24 hours a day in any situation. |                 |
| <b>Renal Dialysis<sup>2</sup></b>         | 20% coinsurance                                                                                                                                                                              | 20% coinsurance |

<sup>2</sup> May require your provider to get prior authorization from the plan for in-network benefits.

\* Benefits are combined in and out-of-network

## Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. You do not need to be an AARP member to enroll in a Medicare Advantage or Prescription Drug Plan. AARP and its affiliates are not insurers. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

UnitedHealthcare provides free services to help you communicate with us such as letters in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-844-867-3487 for additional information (TTY users should call 711). Hours are 24 hours a day, 7 days a week.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunice con nosotros. Por ejemplo, cartas en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-844-867-3487, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 24 horas del día, los 7 días de la semana.

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

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 100 day supply of your maintenance medication.

If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within five business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-877-266-4832, TTY 711.

Choose one device from approved select models every 2 years. Devices may vary by plan/area. Limitations and exclusions apply. Fitbit, the Fitbit logo, and related marks and logos are trademarks of Google LLC and/or its affiliates.

Participation in the Renew Active® program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership and other offerings. Fitness membership, equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Certain services, classes, events and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. AARP® Staying Sharp is the registered trademark of AARP. 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. The Renew Active program varies by plan/area. Access to gym and fitness location network may vary by location and plan.

The Nurseline service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health

information is kept confidential in accordance with the law. Access to this service is subject to terms of use.