Retiree Benefits SUMMARY

AARP® MedicareComplete® from SecureHorizons Retiree Plans

Benefits Effective January 1, 2009

AARP℠ | MedicareComplete®
from SecureHorizons

M0011_080512CG02

AARP® MedicareComplete® from SecureHorizons is a Medicare Advantage Retiree Plan offered by any of the following: UnitedHealthcare of Alabama, Inc., UnitedHealthcare of Arizona, Inc., UnitedHealthcare of Arkansas, Inc., UnitedHealthcare of Florida, Inc., UnitedHealthcare of Georgia, Inc., UnitedHealthcare of New England Inc., United HealthCare of New York, Inc., UnitedHealthcare of North Carolina, Inc., UnitedHealthcare of Ohio, Inc., UnitedHealthcare of Tennessee, Inc., UnitedHealthcare of the Midlands, Inc., United HealthCare of the Midwest, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Wisconsin, Inc., United HealthCare Insurance Company, United HealthCare Insurance Company of New York for New York residents.

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SECTION I: Introduction to AARP® MedicareComplete® from SecureHorizons,® a Medicare Advantage Retiree Plan

Overview of AARP® MedicareComplete® Retiree Plan

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

As you read this Retiree Benefits Summary and the Retiree Benefit Summary Insert for the AARP® MedicareComplete® Retiree Plan, you will learn important details about the benefits that this plan has been designed to offer you. If you have a question at any point while you are reading this information, please call the SecureHorizons Customer Service Department at **1-888-736-7440 (TTY 1-888-685-8480),** 8 a.m. to 8 p.m. local time, 7 days a week. A representative will be happy to assist you and answer any questions you may have.

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

Eligibility and Enrollment in the AARP® MedicareComplete® Retiree Plan

To be able to enroll in AARP® MedicareComplete® Retiree Plan:

1. You must be entitled to Medicare Part A and enrolled in Medicare Part B as of the Effective Date of your enrollment in an AARP® MedicareComplete® Retiree Plan.
2. You must meet the eligibility requirements of your former employer, union group or trust administrator (Plan Sponsor).
3. You must not currently have End-Stage Renal Disease (ESRD) or receive routine kidney dialysis. However, if either of these conditions applies to you, in some instances, you may still be eligible to enroll through a Plan Sponsored Medicare Advantage (MA) health plan or as an individual. You may be newly eligible for enrollment or able to continue your enrollment under the following circumstances:
   - Individuals with ESRD who age into Medicare can enroll in any Medicare Advantage Plan sponsored by their Plan Sponsor regardless of prior commercial coverage affiliation (your health plan coverage prior to you becoming eligible for Medicare).
   - If a Plan Sponsor offers a Medicare Advantage Plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, retirees with ESRD may select this new Medicare Advantage Plan option as the Plan Sponsor's open enrollment rules allow. You should contact your Plan Sponsor to determine what their rules allow.

- If a Plan Sponsor that has been offering a variety of coverage options consolidates its employee/retiree offerings (for example, it drops one or more plans), current enrollees of the dropped plans may be accepted into a Medicare Advantage Plan that is offered by the group.
- If a Plan Sponsor has contracted locally with a Medicare Advantage Organization (MAO) in more than one geographic area (for example, in two or more states), a retiree with ESRD who relocates permanently from one geographic location to another may remain with the Medicare Advantage Organization in the local Plan Sponsor Medicare Advantage Plan.
- Individuals with ESRD who are affected by the contract termination, non-renewal or service area reduction of another MAO may make one election to enroll in a Medicare Advantage Plan offered by a different Medicare Advantage Organization during the appropriate election period.
- Once enrolled in a Medicare Advantage Plan, an individual with ESRD may elect other Medicare Advantage Plans offered by the same Medicare Advantage Organization (within the same CMS contract) during an allowable election period. Standard Medicare Advantage eligibility rules apply.

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

4. You must permanently reside in the Service Area as defined in your Evidence of Coverage and Disclosure Information.
5. You must complete and sign an Enrollment Application Form or make an election through your Plan Sponsor. If another person assists you in completing the Enrollment Application Form, that person must also sign the form and state his or her relationship to you.
6. You must agree to abide by the AARP® MedicareComplete® Retiree Plan rules (included in this Retiree Benefits Summary book and Retiree Benefit Summary Insert, your Evidence of Coverage and Disclosure Information and throughout your member materials).

If you meet the above eligibility requirements, you cannot be denied membership in AARP® MedicareComplete® Retiree Plan on the basis of your health status, excluding end-stage renal disease as described above. AARP® MedicareComplete® is available to all eligible Medicare beneficiaries, including both members and non-members of AARP.

When You May Enroll in the AARP® MedicareComplete® Retiree Plan

Eligible individuals can enroll in the AARP® MedicareComplete® Retiree Plan at the following times:

- Open Enrollment — You may enroll in your Plan Sponsor's group plan when that plan is in open enrollment. This time period is typically around the end of the calendar year but it can vary. For more information regarding your open enrollment period, please contact your Plan Sponsor.

- Special Election Period (SEP) — Special periods of time in which you can discontinue enrollment in a Medicare Advantage Plan, and change your enrollment to another Medicare Advantage Plan or return to Original Medicare. In the event of the following circumstances, a Special Election Period is warranted: the Medicare Advantage Plan in which you are enrolled is discontinued in the Service Area in which you live; you move out of the Service Area of the Medicare Advantage Plan; the Medicare Advantage Organization offering the plan violated a material provision of its contract with you; or you meet such other material conditions as CMS may provide.

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

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

Note: Certain eligible Medicare beneficiaries, such as those who are institutionalized, those who receive Medicaid, or those eligible for a Medicare Savings Program, such as Medicaid Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual, may enroll in AARP® MedicareComplete® at any time during the Calendar Year.

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

From November 15, 2008 through December 31, 2008, anyone with Medicare may change the way they get their Medicare coverage for an effective date of **January 1, 2009.**

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

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage, such as AARP® MedicareComplete® Retiree Plan.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in Prescription Drug Plan and return to Original Medicare coverage.
- You may leave your current Prescription Drug Plan and enroll in another Prescription Drug Plan in addition to Original Medicare.

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

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in a "medical only" Medicare Advantage Plan, such as AARP® MedicareComplete® Retiree Plan, without Medicare Part D drug coverage.

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and return to Original Medicare.
- You may leave your current Prescription Drug Plan and continue with Original Medicare coverage.
- You may leave your current Prescription Drug Plan and enroll in a "medical only" Medicare Advantage Plan, such as AARP® MedicareComplete,® without Medicare Part D drug coverage.

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

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

From January 1, 2009 through March 31, 2009, Medicare beneficiaries (including Members of the AARP® MedicareComplete® Retiree Plan) have **one** chance to change the way they get their health care coverage. However, there are limits on when you may change benefit plans and the type of plan that you may join. **If you are not enrolled in a plan with Medicare Part D drug coverage, you may not use this time period to enroll in a plan with Medicare Part D drug coverage.**

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

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

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

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

Generally, Medicare beneficiaries cannot make any other changes during 2009 unless they meet special exceptions, including, but not limited to:

- the Medicare Advantage Plan in which the beneficiary is enrolled is discontinued in the Service Area in which the beneficiary lives
- the beneficiary moves out of the Service Area of the Medicare Advantage Plan
- the beneficiary meets such other material conditions as CMS may provide (as a result of unusual and/or out of the ordinary circumstances such as natural disasters, etc.)
- the beneficiary has Medicaid coverage
- the beneficiary receives assistance from a Medicare Savings Program
- the beneficiary is in a long-term care facility such as a nursing home

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

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

Medicare Part D Late Enrollment Penalty

If you don't join a Medicare Prescription Drug Plan when you are first eligible, and you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. This penalty amount changes every year, and you have to pay it as long as you have Medicare Prescription Drug coverage. However, if you qualified for extra help in 2006, 2007, or 2008, you may not have to pay a penalty.

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

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

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

- You received or are receiving extra help AND you enroll in a Medicare prescription drug plan by December 31, 2008, AND you stay in a Medicare prescription drug plan

Creditable Coverage

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

If your Plan Sponsor does not offer you Medicare Part D prescription drug coverage, but the prescription drug coverage you receive through your Plan Sponsor is at least as good as the standard Part D Medicare prescription drug coverage, it is considered to be *Creditable Coverage* and you will NOT incur a late enrollment penalty if you later decide, after May 15, 2006, to enroll in a standard Part D Medicare prescription drug coverage plan. Your plan administrator is responsible to notify you if your prescription drug coverage is or is not considered to be *Creditable Coverage.* If you have questions about your prescription drug coverage, please contact your Plan Sponsor.

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

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

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You 2008 (or 2009)" handbook. You'll get a copy of the handbook in the mail from Medicare in the fall. You can also get more information about Medicare prescription drug plans from these places:

- Visit *www.medicare.gov* for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call **1-800-MEDICARE (1-800-633-4227),** hearing impaired, **1-877-486-2048,** 24 hours a day, 7 days a week.

Your Enrollment Application Form

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

When Your AARP® MedicareComplete® Retiree Plan Coverage Begins

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

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

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

Our Liability Upon Your Initial Enrollment

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

About Your Medicare Supplement (Medigap) Policy

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

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

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

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

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

Some states provide additional Medigap protections. For State specific information, please call SecureHorizons Customer Service, your State's Department of Insurance or your State Health Insurance Assistance Program (SHIP).

Your Primary Care Physician (PCP)

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

How To Receive Covered Services From a Specialist

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

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

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

You may self-refer to an obstetrical and gynecological (OB/GYN) Specialist within your Contracted Medical Group/IPA or Network for routine and preventive services as described in Section II of this book. You may receive these Covered Services without Prior Authorization or a Referral from your Primary Care Physician. In all cases, however, you must receive Covered Services from an obstetrical and gynecological (OB/GYN) Specialist within your Contracted Medical Group/IPA or Network.

What Is an Emergency Medical Condition?

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

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

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

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

What To Do in an Emergency

Get medical help as quickly as possible. **Call 911 for help or go to the nearest emergency room, hospital, or urgent care center.** You don't need to get approval or a referral first from your PCP or other network provider. We will cover Emergency Services whether you are in or out of the Service Area. Do not wait to determine if a Physician or other provider is Contracted before you get help.

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

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

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

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

Post-Stabilization Care

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

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

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

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

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

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

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

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

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

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

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

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

If you need urgent medical care within your Service Area:

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

What Is the Difference Between a "Medical Emergency" and "Urgently Needed Care"?

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

SECTION II: Your AARP® MedicareComplete® Retiree Plan Benefits

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Health Plan Premium	In most cases, your Plan Sponsor is responsible for making payment of any applicable Health Plan Premium directly to UnitedHealthcare on behalf of its enrolled AARP® MedicareComplete® Retiree Plan Members and their eligible dependent(s). Your Plan Sponsor determines the amount of any retiree subscriber contribution toward Health Plan Premiums. Some Plan Sponsors, however, have made arrangements with UnitedHealthcare to bill you, the Member, directly for Health Plan Premiums. If this is the case, your monthly Health Plan Premium is due on the first day of each month for that month's coverage. Refer to your Retiree Benefit Summary Insert for your Monthly Health Plan Premium amount (if applicable).
Doctor and Hospital Choice	You must go to network doctors, specialists and hospitals. You need a referral to go to network specialists. You need prior authorization to go to non-network doctors, specialists or hospitals.
Physician Services, Including Doctor Office Visits Covered services include: ▪ Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center ▪ Consultation, diagnosis, and treatment by a specialist ▪ Hearing and balance exams, if your doctor orders it to see if you need medical treatment ▪ Telehealth office visits including consultation, diagnosis and treatment by a specialist	You may pay a copayment for each Primary Care Physician office visit. You may pay a copayment for each specialist office visit. You may pay a copayment or coinsurance❹ for physician services received at an Ambulatory Surgical Center. You may pay a copayment or coinsurance❹ for each Medicare-covered hearing service. You may pay a copayment or coinsurance❹ for each Medicare-covered visit for all other outpatient services.

❹ (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Physician Services, Including Doctor Office Visits (continued) ■ Second opinion by another network provider prior to surgery ■ Outpatient hospital services ■ Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)	
Emergency Department Services❶❷ (You may go to any hospital-based emergency department for emergency care.)	You pay a copayment for each Medicare-covered emergency room visit. Includes dialysis for acute kidney failure. You pay the emergency services copayment for covered services received in an inpatient hospital emergency department. If you are admitted to an inpatient hospital from an inpatient hospital emergency department for post-stabilization care or any other type of treatment, you only pay the inpatient hospital copayment. Post-stabilization services are included.❶ Worldwide coverage.

❶ Post-stabilization services are Medically Necessary, non-Emergency Services to ensure that you remain stabilized from the time a non-Network Medical Provider or facility requests authorization from UnitedHealthcare until: 1) you are discharged; or 2) a Network Medical Provider arrives and assumes responsibility for your care; or 3) the non-Network Medical Provider and UnitedHealthcare agree to other arrangements; or 4) a Contracting Medical Provider assumes responsibility for your care through the transfer to a contracting facility.

❷ Members should notify their Network Primary Care Physician or UnitedHealthcare within 48 hours, or as soon as possible after receiving emergency and Urgently Needed Services.

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Urgently Needed Care[1] [2] Urgently needed covered services include services provided when: a) you are temporarily absent from the area serviced by your network provider, and the services cannot be delayed until you return to the service area, or b) you are within the service area but your network provider or other contracted provider is unavailable or inaccessible.	You pay an office visit copayment for each Medicare-covered visit with your Primary Care Physician during regular office hours. You pay the urgently needed care copayment for each Medicare-covered visit with an in-area/in-network provider, other than your Primary Care Physician, or from your Primary Care Physician before or after regular office hours. You pay the emergency services copayment for each Medicare-covered visit with an in-area/non-network provider or from an out-of-area provider. Services received from an in-area/non-network provider are covered only under unusual and extraordinary circumstances, such as covered services provided when you are in your service area, but your network is temporarily unavailable or inaccessible, and when such services are medically necessary and immediately required: 1) as a result of unforeseen illness, injury or condition and 2) it is not possible, given the circumstances, to receive services through your network provider. Includes dialysis for acute kidney failure. Post-stabilization services are included.[1] Worldwide coverage.
Ambulance Services (Air, water or ground transportation.) Medical necessity limitations apply.	You may pay a copayment for each Medicare-covered ambulance trip. Covered services include ambulance services to free standing Renal Dialysis facilities when medically necessary, to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.

[1] Post-stabilization services are Medically Necessary, non-Emergency Services to ensure that you remain stabilized from the time a non-Network Medical Provider or facility requests authorization from UnitedHealthcare until: 1) you are discharged; or 2) a Network Medical Provider arrives and assumes responsibility for your care; or 3) the non-Network Medical Provider and UnitedHealthcare agree to other arrangements; or 4) a Contracting Medical Provider assumes responsibility for your care through the transfer to a contracting facility.

[2] Members should notify their Network Primary Care Physician or UnitedHealthcare within 48 hours, or as soon as possible after receiving emergency and Urgently Needed Services.

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Inpatient Care (Prior authorization by UnitedHealthcare or your network physician is required for inpatient admissions, except for admissions as a result of emergency and out-of-area urgent care.)	
Inpatient Hospital Care (Includes inpatient substance abuse and rehabilitation services.) Covered services include: ▪ Hospital room (private, if medically necessary) ▪ Meals, including special diets ▪ Regular nursing services ▪ Physician services ▪ Special care units, such as intensive care or coronary care units ▪ Medications while in a hospital ▪ Laboratory tests ▪ X-rays and other radiology services ▪ Necessary surgical and medical supplies ▪ Use of appliances, such as wheelchairs ▪ Operating room and recovery room ▪ Rehabilitation services, such as physical therapy, occupational therapy and speech pathology service ▪ All Medicare-approved solid organ transplants (including, but not limited to, kidney, heart, liver, lung and heart/lung, simultaneous pancreas/kidney and pancreas after kidney), when Medicare criteria are met	You may pay a copayment for each Medicare-covered hospital stay. Inpatient hospital care copayments are charged on a per admission or daily basis as specified in your Retiree Benefits Summary Insert. **Original Medicare hospital benefit periods do not apply. For inpatient hospital care, you are covered for an unlimited number of days, as long as the hospital stay is medically necessary and authorized by UnitedHealthcare or contracting providers.** When you are admitted to an inpatient hospital and then later transferred to another inpatient hospital, you pay the copayment charged for the first hospital admission. You do **not** pay a copayment for the second hospital admission. Once you are discharged from a hospital, any other hospital admissions, even for the same medical condition at the same hospital, will require a hospital copayment. In certain circumstances, you may be discharged from a hospital and transferred to a skilled nursing care unit or transitional care unit within the same hospital. If you are later re-admitted to the hospital from the skilled nursing care unit or transitional care unit, you will pay the hospital copayment. For professional fees and other transplant-related health services provided in a Medicare-certified transplant center, you may pay a copayment or coinsurance.❹

❹ (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Inpatient Hospital Care (continued) ■ Medicare-approved intestinal transplants performed at a contracting Medicare-certified transplant center ■ Bone marrow and stem cell transplants, when Medicare criteria are met ■ Blood and its administration	
Inpatient Mental Health Care	Inpatient mental health care copayments are charged on a per admission or daily basis as specified in your Retiree Benefits Summary Insert. The 190-day lifetime limit applies in a Medicare-approved, network psychiatric hospital upon referral of a network Primary Care Physician, contracting specialist or contracting mental health care provider, in accordance with Medicare guidelines. This benefit is limited by prior partial or complete use of the 190-day lifetime treatment in a free-standing psychiatric hospital or in the psychiatric unit of an acute care hospital that is separate and distinct from the rest of the hospital with a separate staff and administration. Psychiatric care in a general acute care hospital unit does not apply to the 190-day lifetime limit in a free-standing psychiatric hospital or in the psychiatric unit of an acute care hospital that is separate and distinct from the rest of the hospital with a separate staff and administration and is subject to the inpatient hospital benefits.

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Skilled Nursing Facility Care (In a Medicare-certified skilled nursing facility.) ▪ Semiprivate room (or a private room, if medically necessary) ▪ Meals, including special diets ▪ Regular nursing services ▪ Physical therapy, occupational therapy and speech therapy ▪ Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors) ▪ Blood — including storage and administration. Coverage of whole blood and packed red cells 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 services	You may pay a copayment each day for the number of days specified on your Retiree Benefits Summary Insert for Medicare-covered skilled nursing care per benefit period.❸ A 3-day prior hospital stay is ***not*** required. You are covered for up to the number of days specified on your Retiree Benefits Summary Insert per benefit period❸ for inpatient services in a skilled nursing facility (SNF), in accordance with Medicare guidelines.

❸ A Medicare benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row.

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Inpatient Services Inpatient Mental Health Care and Skilled Nursing Facility Care (When the inpatient stay itself is not or is no longer covered.) ▪ Physician services ▪ Diagnostic lab and X-ray services ▪ Radiation therapy ▪ Prosthetic devices, leg, arm, back and neck braces, as well as trusses ▪ Surgical dressings, splints and casts and accessories ▪ Physical therapy, occupational therapy and speech and language therapy	Inpatient hospital care copayments are charged on a per admission or daily basis as specified in your Retiree Benefits Summary Insert. **Original Medicare hospital benefit periods do not apply.** For inpatient hospital care, you are covered for an unlimited number of days, as long as the hospital stay is medically necessary and authorized by UnitedHealthcare, or contracting providers. While in a skilled nursing facility, these services and supplies continue to be covered, until a new benefit period❸ begins or until these services and supplies are no longer considered medically necessary or reasonably necessary for the diagnosis and treatment of your illness or injury. For inpatient mental health — No coverage beyond 190 days in a network or non-network facility, in accordance with Medicare guidelines. Psychiatric care in a general acute hospital is subject to regular Hospital benefits. (For more information on applicable copayments and coinsurance, please refer to your Retiree Benefits Summary Insert.)
Other Settings	
Home Health Agency Care ▪ Medically necessary part-time or intermittent skilled nursing care and home health aide services, in accordance with Medicare guidelines. This may include any number of days per week, up to 28 hours per week, of skilled nursing or home health aide services combined for less than 8 hours per day, based upon the reasonable need for such care.	You may pay a copayment or coinsurance❹ for all home health visits provided by a network home health agency when Medicare criteria are met. Other copayments or coinsurance❹ may apply. (See Durable Medical Equipment for applicable copayments or coinsurance.❹)

❸ A Medicare benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row.

❹ (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Home Health Agency Care (continued) ■ Medically necessary rehabilitation services (physical therapy, occupational therapy and speech and language pathology services) ■ Medical social services ■ Medical supplies ■ Durable Medical Equipment ■ Outpatient Injectable medications ■ Infusion equipment and medications	
Hospice You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include: ■ Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan ■ Home care	When you enroll in a Medicare certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage Plan. Hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Outpatient Medical Services and Supplies	
Outpatient Mental Health Care	You may pay a copayment or coinsurance[4] for each Medicare-covered individual/group therapy session.
Partial Hospitalization Psychiatric Program	You may pay a copayment each day for Medicare-covered benefits.
Outpatient Substance Abuse Services	You may pay a copayment for each individual/group visit for Medicare-covered benefits.
Outpatient Hospital Services (Services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital.) (Includes observation, medical and surgical care) Examples include, but are not limited to: infusion clinics for drugs or blood products, endoscopies, hyperbaric oxygen and wound care.	You may pay a copayment or coinsurance[4] for Medicare-covered benefits. You pay the emergency services copayment for covered services received in a hospital emergency department. If you are held for observation (up to 48 hours without being admitted) in an acute hospital or outpatient observation unit after receiving services in a hospital emergency department, you pay the outpatient hospital copayment or coinsurance,[4] instead of the emergency services copayment. You may pay a copayment or coinsurance[4] for covered pain management services, in connection with covered medical and surgical services.
Medicare-Covered Outpatient Rehabilitation Services (Comprehensive Outpatient Rehabilitation Facility (CORF), cardiac rehabilitation, pulmonary rehabilitation, occupational therapy, physical therapy and speech and language pathology services.)	You may pay a copayment or coinsurance[4] for each Medicare-covered visit.
Durable Medical Equipment (DME) Prosthetics, Orthotics (corrective appliances), Infusion Equipment and Supplies Used in Conjunction With the Above	You may pay a copayment or coinsurance[4] for Medicare-covered Durable Medical Equipment, prosthetic devices and medical supplies. The decision to rent or purchase a DME item is determined by your contracting medical group/IPA, Primary Care Physician or UnitedHealthcare.

[4] (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Diabetes Self-Management Training	You may pay a copayment or coinsurance[4] for Medicare-covered self-management training. An office visit copayment will apply.
Diabetes Monitoring Supplies (Includes coverage for glucose monitors, blood glucose test strips, ketone urine test strips, lancets, lancet injector devices and self-management training for insulin and non-insulin dependent diabetics.)	You may pay a coinsurance[4] for glucose monitors, blood glucose test strips, ketone urine test strips, lancets and lancet injector devices. Insulin and insulin syringes are covered on the Drug Formulary for a copayment.
Medical Nutrition Therapy (Provided by registered dieticians or other qualified nutrition professionals for people with diabetes and chronic renal disease and for post-transplant patients.)	You may pay a copayment or coinsurance[4] for Medicare-covered benefits. An office visit copayment will apply.
Imaging Procedures, X-rays and Portable X-rays Used in the Home	You may pay a copayment or coinsurance[4] for each Medicare-covered standard X-ray visit. You may pay a copayment or coinsurance[4] for covered complex radiology services and imaging procedures. These procedures 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, sonograms, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies). An office visit copayment may apply with your Primary Care Physician.
Laboratory Services	You may pay a copayment for Medicare-covered clinical and diagnostic laboratory services.
Radiation Therapy	You may pay a copayment or coinsurance[4] for each Medicare–covered radiation therapy visit. An office visit copayment may apply.

[4] (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Medical Supplies (Such as dressings, casts and splints.)	You may pay a copayment or coinsurance[4] for Medicare-covered benefits. An office visit copayment may apply.
Blood and Its Administration (Coverage begins with the first pint of blood.)	You may pay a copayment or coinsurance[4] for Medicare-covered benefits. An office visit copayment may apply.
Kidney Dialysis (Services, procedures, treatments and supplies rendered at non-Medicare-certified facilities within the United States will not be covered.) Covered services include: ▪ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2) ▪ Inpatient dialysis treatments (if you are admitted to a hospital for special care) ▪ Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) ▪ Home dialysis equipment and 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)	You may pay a copayment or coinsurance[4] for Medicare-covered services at a Medicare-certified facility within the United States.

[4] (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Preventive Services	
Bone Mass Measurement (For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years 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.)	You may pay a copayment or coinsurance[4] for Medicare-covered bone mass measurement every 24 months. An office visit copayment may apply.
Colorectal Screening Exams For members 50 and older, the following are covered: ▪ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months ▪ Fecal occult blood test, every 12 months For members at high risk of colorectal cancer, we cover: ▪ Screening colonoscopy (or screening barium enema as an alternative) every 24 months For members not at high risk of colorectal cancer, we cover: ▪ Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy	You may pay a copayment or coinsurance[4] for each Medicare-covered colorectal screening exam. You may pay a copayment or coinsurance[4] for colonoscopy and flexible sigmoidoscopy procedures that are provided in an outpatient hospital facility or at a Medicare-certified ambulatory surgical center. You may pay a copayment or coinsurance[4] for complex radiology services and imaging procedures, including barium enemas. An office visit copayment will apply with your Primary Care Physician.
Annual Screening Mammograms (Screening for women age 40 and older every 12 months. Baseline exam for women ages 35–39.)	You may pay a copayment or coinsurance[4] for Medicare-covered screening mammogram. No referral necessary for network providers. An office visit copayment will apply with your Primary Care Physician.

[4] (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Pap Smears and Pelvic Exams	You may pay a copayment or coinsurance❹ for a Medicare-covered Pap smear and pelvic exam annually. You may pay a copayment or coinsurance❹ for additional Pap smears, if medically necessary. An office visit copayment will apply. A laboratory services copayment related to routine screenings and exams may apply. No referral necessary for network providers.
Annual Prostate Cancer Screening Exams For men age 50 and older, covered services include the following — once every 12 months: ▪ Annual digital rectal exam ▪ Annual prostate-specific antigen (PSA) blood test	You may pay a copayment or coinsurance❹ for Medicare-covered screening exam. An office visit copayment will apply.
Cardiovascular Disease Testing (Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).)	Cardiovascular disease test offered once every 12 months. Cardiovascular screening blood tests are covered for all asymptomatic members for early detection of cardiovascular disease or abnormalities associated with an elevated risk of cardiovascular disease. The screening includes total cholesterol test, cholesterol test for high density lipoproteins and triglycerides test. You may pay a copayment or coinsurance❹ for each cardiovascular disease test.
Abdominal Aortic Aneurysm Screening	A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.

❹ (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Medicare-Covered Physical Exams (For members newly eligible for Medicare Part B benefits only.) If your coverage for Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first six months of your new Part B coverage. The one-time Medicare-covered physical exam will be in lieu of the routine physical exam. Members who receive the one-time Medicare-covered physical exam in a calendar year are not eligible for the routine physical exam until the following calendar year.	You may pay a copayment or coinsurance[4] for each Medicare-covered diagnostic radiological service or complex radiology service.
Immunizations	
Pneumococcal Pneumonia Vaccine	You may pay a copayment or coinsurance[4] for the Pneumococcal Pneumonia vaccine. No referral necessary for network providers. An office visit copayment will apply with your Primary Care Physician.
Flu Vaccine	You may pay a copayment or coinsurance[4] for the Influenza vaccine. No referral necessary for network providers. An office visit copayment will apply with your Primary Care Physician
Hepatitis B Vaccine (For members at intermediate or high risk.)	You may pay a copayment or coinsurance[4] for the Hepatitis B vaccine. An office visit copayment will apply with your Primary Care Physician.

[4] (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Part B Prescription Drugs Medicare Part B Prescription Drugs — Covered Under the Medical Benefit (Includes coverage for immunizing agents, biological sera, blood or blood plasma, or drugs (except insulin) prescribed for intravenous or intramuscular use or administration when authorized by your doctor and in accordance with Medicare guidelines.)	
Medicare Part B-Covered Immunosuppressive Drugs (Following a Medicare-approved organ transplant in accordance with Medicare guidelines.)	You may pay a coinsurance❹ for covered immunosuppressive drugs.
Medicare Part B-Covered Oral Chemotherapy Drugs Including Anti-nausea Drugs	You may pay a coinsurance❹ for self-administered Medicare-approved oral chemotherapy drugs, including anti-nausea drugs for up to a 30-day supply, when prescribed by your doctor as an anti-cancer chemo-therapeutic agent.
Medicare Part B-Covered Inhalation Solutions	You may pay a coinsurance❹ for inhalation solutions, such as Alupent, Isuprel, Metaprel, Proventil, etc. at a network pharmacy.
Outpatient Injectable Medications — Self-Administered	You may pay a coinsurance❹ for Medicare-covered benefits.
Outpatient Injectable Medications — Administered in a Physician's Office (Medicare-covered drugs that are not self-administered by the patient, and are injected while getting physician services (including chemotherapy, anti-emetics drugs and infusion medications).)	You may pay a coinsurance❹ for Medicare-covered benefits. An office visit copayment will apply.
Hemophilia Clotting Factors	You may pay a coinsurance❹ for Medicare-covered benefits.
Antigens (Treatment, including serum.)	You may pay a coinsurance❹ for Medicare-covered benefits.
Additional Benefits	
Routine Acupuncture	You pay 100% of the cost for acupuncture services. (Refer to your Retiree Benefits Summary Insert.) If covered, you may pay a copayment for each acupuncture visit.

❹ (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Chiropractic Services	
▪ **Medicare-Covered** (Manual manipulation of the spine to correct subluxation.)	You may pay a copayment for Medicare-covered benefits.
▪ **Routine** (non-Medicare covered)	You pay 100% of the cost for routine chiropractic services. (Your Plan Sponsor may have elected routine chiropractic services as a supplemental benefit. Refer to your Retiree Benefits Summary Insert.)
Dental Services	
▪ **Medicare-Covered** (Services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of cancer.)	You may pay a copayment or coinsurance❹ for Medicare-covered dental services when referred by your network Primary Care Physician.
▪ **Preventive** (non-Medicare covered)	You pay 100% of the cost for preventive dental services. (Your Plan Sponsor may have elected routine dental services as a supplemental benefit. Refer to your Retiree Benefits Summary Insert.)
Foot Care	
▪ **Medicare-covered foot care** (Includes only those services that meet Medicare criteria for the care of medical conditions affecting the lower limbs, including routine foot care.)	You may pay a copayment or coinsurance❹ for each Medicare-covered visit.
▪ **Routine** (non-Medicare covered)	You may pay a copayment or coinsurance❹ for each covered routine foot care visit. (For more information on applicable copayments and coinsurance, please refer to your Retiree Benefits Summary Insert.)

❹ (For CA, OR, WA) Coinsurance is based on the amount that Original Medicare would have covered. This may not necessarily reflect the actual cost to UnitedHealthcare. If there is no set Medicare amount for the service provided, the percentage will be based on UnitedHealthcare contractually negotiated rates. (For AZ, CO, NV, OK and TX) Coinsurance is based upon UnitedHealthcare contractually negotiated rates; if not available, Coinsurance is based on Medicare Allowable Cost (MAC).

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Hearing Services	
▪ **Medicare-Covered diagnostic hearing exam**	You may pay a copayment for each Medicare-covered hearing exam with a network provider.
▪ **Routine hearing test and hearing aids** (non-Medicare covered)	You are covered up to a specific credit amount (allowance) for a specific rate of occurrence toward the cost of purchase, fitting and repair of hearing aid unit(s). (For more information regarding your allowance, please refer to your Retiree Benefits Summary Insert.) You may pay a copayment or coinsurance[4] for covered routine hearing tests. (For more information on applicable copayments and coinsurance, please refer to your Retiree Benefits Summary Insert.) Call SecureHorizons Customer Service at **1-888-736-7440 (TTY 1-888-685-8480),** 8 a.m. to 8 p.m. local time, 7 days a week to locate a provider.
Vision Services	
Eye care — medical need	
▪ **Medicare-Covered eye exam**	You may pay a copayment for Medicare-covered diagnosis and treatment for diseases and conditions of the eye with a network provider. (Medicare-covered annual glaucoma screening included for members at high risk for glaucoma, members with a family history of glaucoma or members with diabetes.)
▪ **Medicare-Covered eyewear**	You may pay a copayment or coinsurance[4] for one pair of Medicare-covered lenses or contact lenses after each cataract surgery. Allowance for Medicare-covered frames may apply. (Refer to your Retiree Benefits Summary Insert for details.)
Routine Vision Services (non-Medicare covered)	
▪ **Routine eye exam** (refraction)	You may pay a copayment for a routine eye exam (refraction) visit.

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Vision Services (continued)

For members in California and Texas: If you belong to one of these contracting medical groups/IPAs, you will receive your routine eye exam (refraction) through your medical group/IPA listed below. Contact your medical group/IPA office to arrange an appointment. If you do not belong to any of these medical groups, you will receive your routine eye exam (refraction) through the provider listed below (see contact information below).

- Alamitos IPA
- Beaver Medical Group
- Encompass Medical Group
- Harriman Jones Medical Group
- Health Texas
- HealthCare Partners IPA/South Bay
- HealthCare Partners Medical Group/ East Los Angeles
- HealthCare Partners Medical Group/El Monte
- HealthCare Partners Medical Group/Glendale
- HealthCare Partners Medical Group/Los Angeles
- HealthCare Partners Medical Group/Montebello
- HealthCare Partners Medical Group/South Bay
- Lakewood Health Plan
- Leisure World Managed Care Medical Group
- Park Terrace Medical Associates
- Sharp Community Medical Group
- Sharp Community Medical Group/Graybill
- Sharp Community Medical Group/Chula Vista
- Sharp Community Medical Group/Coronado
- Sharp Community Medical Group/Grossmont
- Sharp Community/Inland North
- Sharp Rees-Stealy Medical Group Inc.
- WellMed

For all other members: Contact SecureHorizons Customer service at **1-888-736-7440 (TTY 1-888-685-8480),** 8 a.m. to 8 p.m., local time, 7 days a week to find a provider.

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Vision Services (continued)	
▪ **Routine eyewear or contact lenses**	You pay 100% of the cost for routine eyewear or contact lenses. (Your Plan Sponsor may have elected routine eye exams and/or eyewear or contact lenses as a supplemental benefit. Refer to your Retiree Benefits Summary Insert.)
Annual Routine Physical Examinations (non-Medicare covered)	You may pay a copayment for a routine physical exam, limited to one per calendar year.
Fitness Program	You may pay a monthly membership fee for a Fitness Program through Contracted fitness centers. There is no visit or use fee when you use Contracted service providers.
Optum® NurseLine	You pay $0 for calls to the NurseLine, available 24 hours a day, every day, to help you with health and medical questions or to find quality providers or assist you in scheduling appointments. Simply call **1-877-365-7949,** or for the hearing impaired, call the National Relay Center at **1-800-855-2880** and ask for the number above **(1-877-365-7949).**
Wellness Advising	You pay $0 for this program designed to help you address certain particular conditions (for example weight management or fall risk issues) associated with defined medical conditions or criteria. The program provides you with access to advisors who assist you in making lifestyle behavior changes, as well as understanding risk factors associated with your health issues. The advisors provide you either printed materials or telephonic support to achieve your goal.
Treatment Decision Support	You pay $0 for calls to the NurseLine to help you make effective treatment decisions, find a quality doctor, schedule appointments, work more effectively with your doctor, find a resource for a second opinion or answer questions about a number of medical conditions and treatment options (back pain, knee or hip replacements, benign prostate problems, prostate cancer, breast cancer, benign uterine conditions (fibroids, endometriosis, uterine bleeding), coronary disease, obesity (bariatric surgery)). Simply call **1-866-247-8292,** 7 a.m. to 10 p.m. (Central Time), Monday through Friday, or for the hearing impaired, call the National Relay Center at **1-800-855-2880** and ask for the number above **(1-866-247-8292).**

Your AARP® MedicareComplete® Retiree Plan Benefits (Through a network medical provider. Please refer to your Retiree Benefits Summary Insert for specific copayment and coinsurance amounts.)	
Access Support	You pay $0 for calls to the NurseLine to help you find a quality doctor and schedule appointments. Simply call **1-877-365-7949,** or for the hearing impaired, call the National Relay Center at **1-800-855-2880** and ask for the number above **(1-877-365-7949),** available 24 hours a day, every day.
Out-of-Pocket Maximum	The maximum amount members could pay for covered services during each calendar year. Expenses not covered by AARP® MedicareComplete® Retiree Plan do not count toward your annual out-of-pocket maximum. Please refer to the Retiree Benefits Summary Insert for the amount of your annual out-of-pocket maximum and list of services, if applicable. Members must retain receipts for copayments that apply to the annual out-of-pocket maximum, and submit them to UnitedHealthcare, once the annual out-of-pocket maximum has been reached.

SECTION III: General Exclusions

The purpose of this section is to tell you about medical care and services, items, and drugs that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services and items that aren't covered under any conditions, and some services that are covered only under specific conditions.

If you get services, items that are not covered, you must pay for them yourself. We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be services and items that we should have paid or covered.

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart in Section II or anywhere else in this booklet, **the following items and services aren't covered under the Original Medicare Plan or by our plan:**

1. Services not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. CMS will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to MA plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity *unless* medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, *unless* medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility, and items for the home such as air conditioners, air purifiers or other environmental equipment.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
9. Homemaker services.
10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.

12. Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Routine dental care (such as cleanings, fillings, or dentures) or other dental services, except as specifically described as a covered service in Section II of this Retiree Benefits Summary or on the Retiree Benefits Summary Insert. However, non-routine dental services received at a hospital may be covered. (Your Plan Sponsor may have elected routine Dental services as a supplemental benefit.)
15. Chiropractic care is generally not covered under the Plan (with the exception of manual manipulation of the spine), and is limited according to Medicare guidelines. (Your Plan Sponsor may have elected routine Chiropractic services as a supplemental benefit.)
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines, except as specifically described as a covered service in Section II of this Retiree Benefits Summary or in the Retiree Benefits Summary Insert, or in the Evidence of Coverage.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aids and routine hearing examinations, except as specifically described as a covered service in Section II of this Retiree Benefits Summary or on the Retiree Benefits Summary Insert. (Your Plan Sponsor may have elected routine Hearing services as a supplemental benefit.)
20. Eyeglasses (except after cataract surgery), routine eye examinations, except as specifically described as a covered service in Section II of this Retiree Benefits Summary or on the Retiree Benefits Summary Insert. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services. (Your Plan Sponsor may have elected routine Vision services as a supplemental benefit.)
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices; conception by artificial means, surrogate parenting.

23. Acupuncture, except as specifically described as a covered service in Section II of this Retiree Benefits Summary or on the Retiree Benefits Summary Insert. (Your Plan Sponsor may have elected routine Acupuncture services as a supplemental benefit.)
24. Naturopath services, complementary alternative medicine, tradition-based medicine and/or non-conventional medicine, except as covered by Medicare criteria for the treatment of an illness or disease.
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
26. Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
27. All services, procedures, treatments, medications and supplies related to Workers' Compensation claims.
28. Physical examinations or immunizations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearings, travel, dietary counseling, weight reduction programs or for premarital and pre-adoption purposes and/or other non-preventive reasons.
29. Abortion, except for cases resulting in pregnancies from rape or incest or that endanger the life of the mother.
30. Smoking cessation products and treatments, except as covered in accordance with Medicare guidelines.
31. Non-emergency transportation, except as described in Section II of this Retiree Benefits Summary or on the Retiree Benefits Summary Insert.
32. Health services received as a result of war or any act of war that occurs during the Member's term of Coverage under this Evidence of Coverage.
33. Health services for treatment of military service related disabilities provided by the Military Health Services System (including CHAMPUS or TRICARE) under which the federal government agrees to pay for the services and supplies.
34. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.
35. The following services and items are excluded from coverage under the UnitedHealthcare United Resource Network transplant program:
    - Unauthorized or not prior authorized organ procurement and transplant related services.
    - Transplants performed in a non-UnitedHealthcare United Resource Network facility, unless specifically authorized by the UnitedHealthcare Medical Director.

- Transplant services, including donor costs, when the transplant recipient is not a member.
- Artificial or non-human organs.
- Transportation services for any day a member is not receiving medically necessary transplant services.
- Transportation of any potential donor for typing and matching.
- Food and housing costs for any day a member is not receiving medically necessary transplant services.
- Storage costs for any organ or bone marrow, unless authorized by the UnitedHealthcare Transplant Medical Director.
- Services for which government funding or other insurance coverage is available.
- Bone marrow transplants or stem cell transplantation, except as a treatment for an appropriate diagnosis as specifically stated in the Medicare coverage guidelines or in this Evidence of Coverage.

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SecureHorizons Customer Service Department

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Sales Department

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