Annual Notice of Changes 2021

Medicare Advantage Plan with Prescription Drugs

UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP)

Toll-free **1-866-944-4983,** TTY **711**
8am-8pm: 7 Days Oct-Mar; M-F Apr-Sept

www.myuhc.com/CommunityPlan

Do we have the right address for you?
If not, please let us know so we can keep you informed about your plan.

United Healthcare®

Y0066_ANOC_H2228_041_000_2021_M

Find updates to your plan for next year

This notice provides information about updates to your plan, but it doesn't include all of the details. Throughout this notice you will be directed to **www.myuhc.com/CommunityPlan** to review the details online. All of the below documents will be available online by **October 15, 2020.**

Provider Directory

Review the 2021 Provider Directory online to make sure your providers (primary care provider, specialists, hospitals, etc.) will be in the network next year.

Pharmacy Directory

Review the 2021 Pharmacy Directory online to see which pharmacies are in our network next year.

Drug List (Formulary)

You can look up which drugs will be covered by your plan next year and review any new restrictions on our website.

Evidence of Coverage (EOC)

Review your 2021 EOC for details about plan costs and benefits. The EOC is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. It also has information about the Quality Improvement Program, how medical coverage decisions are made and your Rights and Responsibilities as a member.

Would you rather get paper copies?

If you want a paper copy of what is listed above, please contact our Customer Service at 1-866-944-4983 (TTY users should call 711). Hours are 8am-8pm: 7 Days Oct-Mar; M-F Apr-Sept.

Would you rather get less paper?

Simplify your life with online delivery of plan materials. You can securely access your plan documents online anytime, anywhere. Register at **www.myuhc.com/CommunityPlan** to sign up for online delivery today.

UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP) offered by UnitedHealthcare

Annual Notice of Changes for 2021

You are currently enrolled as a member of UnitedHealthcare Dual Complete® (PPO D-SNP).

Next year, there will be some changes to the plan's costs and benefits. **This booklet tells about the changes.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 2 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

OMB Approval 0938-1051 (Expires: December 31, 2021)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP).
- If you want to change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in Section 3 to learn more about your choices.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you **don't join another plan by December 7, 2020**, you will be enrolled in UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP).
- If you **join another plan between October 15 and December 7, 2020**, your new coverage will start on January 1, 2021. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in other languages.
- Please contact our Customer Service number at 1-866-944-4983 for additional information (TTY users should call 711). Hours are 8am-8pm: 7 Days Oct-Mar; M-F Apr-Sept.
- Este documento está disponible sin costo en otros idiomas.

- Comuníquese con nuestro Servicio al Cliente al número 1-866-944-4983 para obtener información adicional (los usuarios de TTY deben llamar al 711). El horario es 8 a.m. a 8 p.m., los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.
- This document may be available in an alternate format such as Braille, larger print or audio. Please contact our Customer Service number at 1-866-944-4983, TTY: 711, 8am-8pm: 7 Days Oct-Mar; M-F Apr-Sept, for additional information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP)

- Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.
- The plan also has a written agreement with the Texas Medicaid program to coordinate your Medicaid benefits.
- When this booklet says "we," "us," or "our," it means UnitedHealthcare Insurance Company or one of its affiliates. When it says "plan" or "our plan," it means UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP) in several important areas. **Please note this is only a summary of changes.** A copy of the Evidence of Coverage is located on our website at www.myuhc.com/CommunityPlan. You may also call Customer Service to ask us to mail you an Evidence of Coverage. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2020 (this year)	2021 (next year)
Monthly Plan Premium* *Your premium may be higher or lower than this amount. (See Section 2.1 for details.)	$1.00	$17.20
Annual Medical Deductible	For 2020, your plan does not have a deductible.	For 2021, your plan has a $198 combined in and out-of-network deductible. Please see Chapter 4 of your Evidence of Coverage for details.
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From network providers: $6,700 From in-network and out-of-network providers combined: $10,000 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of- pocket amount for covered Part A and Part B services.	From network providers: $7,550 From in-network and out-of-network providers combined: $10,000 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of- pocket amount for covered Part A and Part B services.
Doctor Office Visits	Primary care visits:	Primary care visits:

Cost	2020 (this year)	2021 (next year)
	You pay a $0 copayment per visit (in-network). You pay 30% coinsurance per visit (out-of-network). Specialist visits: You pay a $0 copayment per visit (in-network). You pay 30% coinsurance per visit (out-of-network).	You pay a $0 copayment per visit (in-network). You pay 40% coinsurance per visit (out-of-network). Specialist visits: You pay $0 copayment - 20% of the total cost per visit (in-network). You pay 40% coinsurance per visit (out-of-network).
Inpatient Hospital Stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay a $0 copayment up to $1,300 copayment for each Medicare-covered hospital stay for unlimited days (in-network). You pay 30% coinsurance for each Medicare-covered hospital stay for unlimited days (out-of-network).	You pay a $0 copayment up to $1,400 copayment (or the 2021 Original Medicare amount, whichever is less) for each Medicare-covered hospital stay for unlimited days (in-network). You pay 40% coinsurance for each Medicare-covered hospital stay for unlimited days (out-of-network).
Part D prescription drug coverage (See Section 2.6 for details.)	If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts:	If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts:

Cost	2020 (this year)	2021 (next year)
	Deductible: □ $0 or □ $89 For generic drugs (including brand drugs treated as generic): □ $0 copayment or □ $1.30 copayment or □ $3.60 copayment or □ 15% of the total cost If the total amount you pay for copayments and coinsurance reaches $6,350, your cost sharing amounts will be: □ $0 copayment or □ $3.60 copayment For all other covered drugs: □ $0 copayment or □ $3.90 copayment or □ $8.95 copayment or □ 15% of the total cost If the total amount you pay for copayments and coinsurance reaches $6,350, your cost sharing amounts will be: □ $0 copayment or □ $8.95 copayment	Deductible: □ $0 or □ $0 For generic drugs (including brand drugs treated as generic): □ $0 copayment or □ $0 copayment or □ $0 copayment or □ 0% of the total cost If the total amount you pay for copayments and coinsurance reaches $6,550, your cost sharing amounts will be: □ $0 copayment or □ $0 copayment For all other covered drugs: □ $0 copayment or □ $0 copayment or □ $0 copayment or □ 0% of the total cost If the total amount you pay for copayments and coinsurance reaches $6,550, your cost sharing amounts will be: □ $0 copayment or □ $0 copayment
	If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs	

Cost	2020 (this year)	2021 (next year)
	Deductible: $435 You pay 25% of the total cost.	Deductible: $445 You pay 25% of the total cost.

Annual Notice of Changes for 2021
Table of Contents

Section 1: We Are Changing the Plan's Name

On January 1, 2021, our plan name will change from UnitedHealthcare Dual Complete® (PPO D-SNP) to UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP).

We will mail you a new UnitedHealthcare member ID card. If you have questions, or if your UnitedHealthcare member ID card is damaged, lost, or stolen, call Customer Service at 1-866-944-4983 (TTY users should call 711) right away and we will send you a new card.

You will see the new plan name reflected on future communications where the plan name is referenced.

Section 2: Changes to Benefits and Costs for Next Year

SECTION 2.1: Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly Premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	**$1.00**	**$17.20**

SECTION 2.2: Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
In-network maximum out-of-pocket amount Because our members also get assistance from Texas Medicaid Health and Human Services Commission (Medicaid), very few members ever reach this out-of-pocket maximum. If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Once you have paid $6,700 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	$7,550 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Once you have paid $7,550 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Because our members also get assistance from Texas Medicaid Health and Human Services Commission (Medicaid), very few members ever reach this out-of-pocket maximum. If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Cost	2020 (this year)	2021 (next year)
maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.		

SECTION 2.3: Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.myuhc.com/CommunityPlan. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

SECTION 2.4: Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered **only** if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.myuhc.com/CommunityPlan. You may also call Customer Service for updated pharmacy information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network.**

SECTION 2.5: Changes to Benefits and Costs for Medical Services

Please note that **the Annual Notice of Changes** only tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, **Medical Benefits Chart (what is covered and what you pay),** in your **2021 Evidence of Coverage.** A copy of the Evidence of Coverage is located on our website at www.myuhc.com/CommunityPlan. You may also call Customer Service to ask us to mail you an Evidence of Coverage.

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.

Cost	2020 (this year)	2021 (next year)
Medicare Cost Sharing Medicare cost sharing includes copayment, coinsurance, and deductibles. Part D cost sharing is always the responsibility of the member. Please contact Texas Medicaid Health and Human Services Commission	For Medicare covered services, you pay: $0 if you are enrolled in Medicaid as a Qualified Medicare Beneficiary (QMB). $0 if you are enrolled in Medicaid with full benefits (non-QMB), except for services that	For Medicare covered services, you pay: $0 if you are enrolled in Medicaid as a Qualified Medicare Beneficiary (QMB). $0 if you are enrolled in Medicaid with full benefits (non-QMB), except for services that

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
(Medicaid) at 1-512-424-6500 for more details.	are not covered by the state Medicaid program. If you do not have full Medicaid benefits or are not a QMB, you must pay your Medicare cost sharing, including copayments, deductibles, and coinsurance.	are not covered by the state Medicaid program. If you do not have full Medicaid benefits or are not a QMB, you must pay your Medicare cost sharing, including copayments, deductibles, and coinsurance. Please see your Evidence of Coverage for Medicare covered benefits.
Acupuncture for low back pain (Medicare-covered)	You pay a $0 copayment (in-network).	You pay a $0 copayment for services provided by a primary care physician (in-network). You pay $0 copayment - 20% of the total cost for services provided by a specialist (in-network). See Chapter 4 of the Evidence of Coverage for details.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Acupuncture for low back pain (Medicare-covered)	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost for services provided by a primary care physician (out-of-network). You pay 40% of the total cost for services provided by a specialist (out-of-network). See Chapter 4 of the Evidence of Coverage for details.
Routine Acupuncture Services	You pay a $0 copayment for a combination of 10 chiropractic and acupuncture visits. (in-network) You pay 30% coinsurance for a combination of 10 chiropractic and acupuncture visits. (out-of-network) Benefit is combined in and out-of-network.	You pay a $0 copayment for 6 acupuncture visits. (in-network) You pay 40% coinsurance for 6 acupuncture visits. (out-of-network) Benefit is combined in and out-of-network.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Additional Routine Foot Care	You pay a $0 copayment for 4 visits. (in-network) You pay 30% coinsurance for 4 visits. (out-of-network) Visits are combined in and out-of-network.	You pay a $0 copayment for 4 visits. (in-network) You pay 40% coinsurance for 4 visits. (out-of-network) Visits are combined in and out-of-network.
Annual Medical Deductible	For 2020, your plan does not have a deductible.	For 2021, your plan has a $198 combined in and out-of-network deductible. Please see Chapter 4 of your Evidence of Coverage for details.
Annual Routine Physical Exam	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Authorization	Your provider must obtain Prior Authorization for some services. Your Prior Authorization requirements include all Medicare-covered services except: Emergency Care, Urgently Needed Services, Emergency Ambulance Services, Opioid Treatment Program Services, and Medicare-covered Preventive Services.	The services for which your provider must obtain Prior Authorization have changed. Your Prior Authorization requirements include all Medicare-covered services except: Emergency Care, Urgently Needed Services, Emergency Ambulance Services, and Medicare-covered Preventive Services.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Blood	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Cardiac Rehabilitation	You pay a $0 copayment (in-network).	You pay $0 copayment - 20% of the total cost (in-network).
Cardiac Rehabilitation	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Chiropractic Services	You pay a $0 copayment (in-network).	You pay $0 copayment - 20% of the total cost (in-network).
Chiropractic Services	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Routine Chiropractic Services	You pay a $0 copayment for a combination of 10 chiropractic and acupuncture visits. (in-network) You pay a 30% coinsurance for a combination of 10 chiropractic and acupuncture visits. (out-of-network) Benefit is combined in and out-of-network.	You pay a $0 copayment for 6 chiropractic visits. (in-network) You pay a 40% coinsurance for 6 chiropractic visits. (out-of-network) Benefit is combined in and out-of-network.
Dental Services Comprehensive and Preventive Dental	You pay a $0 copayment for covered preventive and diagnostic services.	You pay a $0 copayment for covered preventive and diagnostic services.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
	You pay a $0 copayment for covered comprehensive dental services. You are covered for up to $3,500 per year. Benefit is combined in and out-of-network.	You pay a $0 copayment for covered comprehensive dental services. You are covered for up to $3,500 per year. Benefit is combined in and out-of-network. The list of services covered by your plan has changed, please see your Evidence of Coverage for a full list of covered services.
Diabetes Self-Management Training, Diabetic Services and Supplies	You pay a $0 copayment (in-network). We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio® Flex , Accu-Chek® Guide Me , Accu-Chek® Guide, and Accu-Chek® Aviva Plus. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, Accu-Chek® SmartView, and Accu-Chek® Compact Plus.	You pay a $0 copayment (in-network). We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan. If

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
	Other brands are not covered by your plan. If you use a brand of supplies that is not covered by your plan, you should speak with your doctor to get a new prescription for a covered brand.	you use a brand of supplies that is not covered by your plan, you should speak with your doctor to get a new prescription for a covered brand.
Diabetes Self-Management Training, Diabetic Services and Supplies	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Diabetes Self-Management Training, Diabetic Services and Supplies - Self-Management Training	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Diabetes Self-Management Training, Diabetic Services and Supplies - Therapeutic Shoes	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Durable Medical Equipment and Related Supplies	You pay 30% of the total cost (out-of-network).	You pay 50% of the total cost (out-of-network).
Hearing Services Additional Routine Hearing Exam	You pay a $0 copayment for 1 exam(s) every year. (in-network) You pay 30% coinsurance for 1 exam(s) every year. (out-of-network) Benefit is combined in and out-of-network.	You pay a $0 copayment for 1 exam(s) every year. (in-network) You pay 40% coinsurance for 1 exam(s) every year. (out-of-network) Benefit is combined in and out-of-network.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Hearing Services Medicare-Covered Hearing and Balance Exams	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Home Health Agency Care	You pay 30% of the total cost (out-of-network).	You pay 50% of the total cost (out-of-network).
Inpatient Hospital Care	You pay a $0 copayment up to $1,300 copayment. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days (in-network).	You pay a $0 copayment up to $1,400 copayment (or the 2021 Original Medicare amount, whichever is less) for each Medicare-covered hospital stay for unlimited days (in-network).
Inpatient Hospital Care	You pay 30% of the total cost for each Medicare-covered hospital stay for unlimited days (out-of-network).	You pay 40% of the total cost for each Medicare-covered hospital stay for unlimited days (out-of-network).
Inpatient Mental Health Care	You pay a $0 copayment up to $1,300 copayment. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days (in-network).	You pay a $0 copayment up to $1,400 copayment (or the 2021 Original Medicare amount, whichever is less) for each Medicare-covered hospital stay (in-network).
Inpatient Mental Health Care	You pay 30% of the total cost for each Medicare-covered hospital stay (out-of-network).	You pay a 40% of the total cost for each Medicare-covered hospital stay (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Kidney Disease Education Services	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Medicare-Covered Preventive Services Abdominal Aortic Aneurysm Screening	You pay 30% of the total cost (out-of-network).	You pay $0 copayment (out-of-network).
Medicare-Covered Preventive Services Annual Wellness Visit	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Bone-Mass Measurements	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Breast Cancer Screening (Mammograms)	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Cardiovascular Disease Testing	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Cervical and Vaginal Cancer Screening	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Barium Enema	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Medicare-Covered Preventive Services Colorectal Cancer Screening	You pay 30% of the total cost (out of network).	You pay a $0 copayment (out of network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Medicare-Covered Preventive Services Diabetes Screening	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services HIV Screening	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Screening for lung cancer with low dose computed tomography (LDCT)	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Intensive Behavioral Therapy to reduce Cardiovascular Disease risk	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Medical Nutrition Therapy	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Prostate Cancer Screening Exams – PSA test	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Screening and Counseling for Obesity	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Screening and Counseling to Reduce Alcohol Misuse	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Medicare-Covered Preventive Services Screening for Depression in Adults	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Medicare-Covered Preventive Services Screening for Sexually Transmitted Infections (STIs) and Counseling to Prevent STIs	You pay 30% of the total cost (out of network).	You pay a $0 copayment (out of network).
Medicare-Covered Preventive Services Smoking and Tobacco use Cessation	You pay 30% of the total cost (out of network).	You pay a $0 copayment (out of network).
Medicare-Covered Preventive Services **"Welcome to Medicare" physical exam**	You pay 30% of the total cost (out of network).	You pay a $0 copayment (out of network).
Medicare Part B Prescription Drugs	You pay 20% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Medicare Part B Prescription Drugs - Chemotherapy Drugs	You pay 20% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Meal Benefit	You pay a $0 copayment up to 14 meals for 7 days, two times per year. Benefit is combined in and out-of-network.	You pay a $0 copayment up to 42 meals for 21 days, two times per year. Benefit is combined in and out-of-network.
Opioid Treatment Program Services	You pay $0 copayment - 20% of the total cost (in-network).	You pay a $0 copayment (in-network).
Opioid Treatment Program Services	You pay 30% of the total cost (out-of-network).	You pay a $0 copayment (out-of-network).
Outpatient Diagnostic Tests and Therapeutic Services and Supplies – Medical Supplies	You pay 30% of the total cost (out-of-network).	You pay 50% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Outpatient Diagnostic Tests and Therapeutic Services and Supplies - Radiation Therapy	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Diagnostic Tests and Therapeutic Services and Supplies - X-rays	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Diagnostic Tests and Therapeutic Services and Supplies - Other Diagnostic tests - Non-Radiological Diagnostic Services	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Diagnostic Tests and Therapeutic Services and Supplies - Other Diagnostic tests - Radiological Diagnostic Service, not Including X-rays	You pay $0 copayment - 20% of the total cost (in-network).	You pay a $0 copayment for each diagnostic mammogram. You pay $0 copayment - 20% of the total cost otherwise (in-network).
Outpatient Diagnostic Tests and Therapeutic Services and Supplies - Other Diagnostic tests - Radiological Diagnostic Service, not Including X-rays	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Mental Health Care - Group Therapy Session	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Mental Health Care - Individual Therapy Session	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Rehabilitation Services - Occupational Therapy	You pay a $0 copayment (in-network).	You pay $0 copayment - 20% of the total cost (in-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Outpatient Rehabilitation Services - Occupational Therapy	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Rehabilitation Services - Physical Therapy and Speech Therapy	You pay a $0 copayment (in-network).	You pay $0 copayment - 20% of the total cost (in-network).
Outpatient Rehabilitation Services - Physical Therapy and Speech Therapy	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Substance Abuse Services - Group Therapy Sessions	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Substance Abuse Services - Individual Therapy Sessions	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Surgery - Ambulatory Surgical Center	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Surgery - Hospital Outpatient Facilities	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Outpatient Surgery- Hospital Outpatient Observation Services	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Health Products Benefit Card / Over-the-Counter (OTC) Products Card	$350 credit quarterly. Your credit amount expires at the end of the year. You can use your debit card at network retail locations or place an order online, over the phone, or by mail through your **Health Products Benefit Catalog** that will be sent to you. Benefit is combined in and out-of-network.	$300 credit quarterly. Your credit amount expires at the end of the year. You can use your debit card at network retail locations or place an order online, over the phone, or by mail through your **FirstLine Select+ Catalog** that will be sent to you. Benefit is combined in and out-of-network.
OTC - Healthy Food Benefit	Not Covered.	$25 credit per month to spend on healthy food items such as vegetables, fruit, grains, milk, meats and more. You can use your debit card at network retail locations. Your credit amount expires at the end of the month.
Partial Hospitalization	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Physician/Practitioner Services, Including Doctor's Office Visits - Medicare-Covered Hearing and Balance Exams	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Physician/Practitioner Services, Including Doctor's Office Visits - Non-Routine Dental Care	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Physician/Practitioner Services, Including Doctor's Office Visits - Primary Care Provider	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Physician/Practitioner Services, Including Doctor's Office Visits - Specialists	You pay a $0 copayment (in-network).	You pay $0 copayment - 20% of the total cost (in network).
Physician/Practitioner Services, Including Doctor's Office Visits - Specialists	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Podiatry Services	You pay a $0 copayment (in-network).	You pay $0 copayment - 20% of the total cost (in-network).
Podiatry Services	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Prostate Cancer Screening Exams – Digital Rectal Exams	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Prosthetic Devices and Related Supplies	You pay 30% of the total cost (out-of-network).	You pay 50% of the total cost (out-of-network).
Pulmonary Rehabilitation	You pay a $0 copayment (in-network).	You pay $0 copayment - 20% of the total cost (in-network).
Pulmonary Rehabilitation	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Skilled Nursing Facility (SNF) Care	You pay a $0 copayment up to the Original	You pay a $0 copayment up to the Original

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
	Medicare cost sharing amount for inpatient services. $0 copayment each day for days 1 to 20 (in-network). $176 copayment each day for days 21 to 100 (in-network).	Medicare cost sharing amount for 2021 which will be set by CMS in the fall of 2020. These are 2020 cost sharing amounts and may change for 2021. Our plan will provide updated rates as soon as they are released. $0 copayment each day for days 1 to 20 (in-network). $176 copayment each day for days 21 to 100 (in-network).
Skilled Nursing Facility (SNF) Care	You pay 30% of the total cost for each skilled nursing facility stay (out-of-network).	You pay the Original Medicare cost sharing amount for 2021 which will be set by CMS in the fall of 2020. These are 2020 cost sharing amounts and may change for 2021. Our plan will provide updated rates as soon as they are released. (out-of-network). $0 copayment each day for days 1 to 20 (out-of-network). $176 each day for days 21 – 100 (out-of-network).
Solutions for Caregivers	Covered.	Not Covered.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Supervised Exercise Therapy (SET)	You pay a $0 copayment (in-network).	You pay $0 copayment - 20% of the total cost (in-network).
Supervised Exercise Therapy (SET)	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Transportation (additional routine)	You pay a $0 copayment for 60 one-way trips per calendar year. (in-network) You pay 75% coinsurance for 60 one-way trips per calendar year. (out-of-network) Trips are combined in and out-of-network.	You pay a $0 copayment for 60 one-way trips per calendar year. (in-network) You pay 75% coinsurance for 60 one-way trips per calendar year. (out-of-network) Trips are combined in and out-of-network. Transportation services are provided by Comfort Care.
Vision Care Medicare-Covered Eye Exams to Evaluate for Eye Disease	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Vision Care Additional Routine Eye Exams	You pay a $0 copayment for 1 exam every year. (in-network) You pay 30% coinsurance for 1 exam every year. (out-of-network) Benefit is combined in and out-of-network.	You pay a $0 copayment for 1 exam every year. (in-network) You pay 40% coinsurance for 1 exam every year. (out-of-network) Benefit is combined in and out-of-network.
Vision Care Medicare-Covered Glaucoma Screening	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).
Vision Care Medicare-Covered Visits	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2020 (this year)	2021 (next year)
Vision Care Additional Routine Eyewear	You pay a $0 copayment for standard lenses; receive up to $300 toward your purchase of frames or contact lenses every 2 years. (in-network) You pay 50% coinsurance; receive up to $300 toward your purchase of frames or contact lenses every 2 years. (out-of-network) Credit is combined in and out-of-network.	You pay a $0 copayment for standard lenses; receive up to $300 toward your purchase of frames or contact lenses through a UnitedHealthcare Vision provider every 2 years. Home-delivered eyewear available nationwide through UnitedHealthcare Vision network providers (select products only). You are responsible for all costs for eyewear not purchased from a UnitedHealthcare Vision network provider.
"Welcome to Medicare" Preventive Visit - EKG following Welcome Visit	You pay 30% of the total cost (out-of-network).	You pay 40% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

SECTION 2.6: Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." **You can get the complete Drug List** by calling Customer Service (see the back cover) or visiting our website (www.myuhc.com/CommunityPlan).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
  - To learn what you must do to ask for an exception, see Chapter 9 of your **Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a drug that is not on the Drug List (Formulary) or when it is restricted in some way in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the **Evidence of Coverage.**) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you have obtained approval for a Drug List (Formulary) exception this year, please refer to the approved through date provided on your approval letter to determine when your approval expires. After the date of expiration on your approval letter, you may need to obtain a new approval in order for the plan to continue to cover the drug, if the drug still requires an exception and you and your doctor feel it is needed. To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage or call Customer Service.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. Because you receive “Extra Help” you will receive a “LIS Rider” by September 30, 2020. If you don’t receive it, please call Customer Service and ask for the "LIS Rider" to be sent to you.

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in.

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly (Part D) Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	Your deductible amount is either $0 or $89, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.) If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs, your deductible is $435.	Your deductible amount is either $0 or $0, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.) If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs, your deductible is $445.

Changes to Your Cost-sharing in the Initial Coverage Stage

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing.	Your cost for a one-month (30-day) supply filled at a network pharmacy with standard cost-sharing: **Generic drugs (including brand drugs treated as generic):** If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and	Your cost for a one-month (30-day) supply filled at a network pharmacy with standard cost-sharing: **Generic drugs (including brand drugs treated as generic):** If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and

Stage	2020 (this year)	2021 (next year)
	Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts: □ $0 copayment or □ $1.30 copayment or □ $3.60 copayment or □ 15% of the total cost **For all other covered drugs:** If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts: □ $0 copayment or □ $3.90 copayment or □ $8.95 copayment or □ 15% of the total cost	Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts: □ $0 copayment or □ $0 copayment or □ $0 copayment or □ 0% of the total cost **For all other covered drugs:** If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts: □ $0 copayment or □ $0 copayment or □ $0 copayment or □ 0% of the total cost
	If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs	
	For all covered drugs: You pay 25% of the total cost	**For all covered drugs:** You pay 25% of the total cost

Stage	2020 (this year)	2021 (next year)
	Once your total drugs costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Once your total drugs costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

Section 3: Deciding Which Plan to Choose

SECTION 3.1: If You Want to Stay in UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP).

SECTION 3.2: If You Want to Change Plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- **– OR–** You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read **Medicare & You 2021,** call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, UnitedHealthcare Insurance Company or one of its affiliates offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan,** enroll in the new plan. You will automatically be disenrolled from UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP).
- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - **– or –** Contact **Medicare,** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

Section 4: Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 to December 7.** The change will take effect on January 1, 2021.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year.

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2 of the **Evidence of Coverage.**

Section 5: Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Texas, the SHIP is called Texas Department of Aging and Disability Services (HICAP).

Texas Department of Aging and Disability Services (HICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Texas Department of Aging and Disability Services (HICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Texas Department of Aging and Disability Services (HICAP) at 1-800-252-9240**.**

For questions about your Texas Medicaid Health and Human Services Commission benefits, contact Texas Medicaid Health and Human Services Commission, at 1-512-424-6500, 8 a.m. - 5 p.m. CT, Monday - Friday. TTY users should call 1-512-424-6597. Ask how joining another plan or returning to Original Medicare affects how you get your Texas Medicaid Health and Human Services Commission coverage.

Section 6: Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas HIV State Pharmaceutical Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name

and phone numbers for this organization are in Chapter 2, Section 3 of your **Evidence of Coverage**).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP in your State. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP in your State. You can find your State's ADAP contact information in Chapter 2 of the **Evidence of Coverage.**

Section 7: Questions?

SECTION 7.1: Getting Help from UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP)

Questions? We're here to help. Please call Customer Service at 1-866-944-4983. (TTY only, call 711.) We are available for phone calls 8am-8pm: 7 Days Oct-Mar; M-F Apr-Sept. Calls to these numbers are free.

Read your 2021 Evidence of Coverage (it has details about next year's benefits and costs)

This **Annual Notice of Changes** gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 **Evidence of Coverage** for UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP). The **Evidence of Coverage** is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the Evidence of Coverage is located on our website at www.myuhc.com/CommunityPlan. You may also call Customer Service to ask us to mail you an Evidence of Coverage.

Visit our Website

You can also visit our website at www.myuhc.com/CommunityPlan. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary).

SECTION 7.2: Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read Medicare & You 2021

You can read the **Medicare & You 2021** Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 7.3: Getting Help from Medicaid

To get information from Texas Medicaid Health and Human Services Commission (Medicaid), you can call Texas Medicaid Health and Human Services Commission (Medicaid) at 1-512-424-6500. TTY users should call 1-512-424-6597.

UnitedHealthcare Dual Complete® Choice Premier (PPO D-SNP) Customer Service:

Call **1-866-944-4983**

Calls to this number are free. 8am-8pm: 7 Days Oct-Mar; M-F Apr-Sept. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**
Calls to this number are free. 8am-8pm: 7 Days Oct-Mar; M-F Apr-Sept.

Write P.O. Box 30769
Salt Lake City, UT 84130-0769

Website **www.myuhc.com/CommunityPlan**