2025 UnitedHealthcare Medicare Advantage copay guidelines

Frequently asked questions

Overview

Copays and coinsurance may vary depending on the member's plan. A member's cost share should not exceed the provider's reimbursement rate. Please use the following cost sharing information when treating and servicing UnitedHealthcare Medicare Advantage members.

Notes:

- **Preventive services:** All of our Medicare Advantage plans cover Medicare-covered preventive services for a $0 copay with a network provider
- **Modifier 26:** Any professional component billed with a 26 modifier is covered with no additional member copay in and out of network on all HMO and PPO plans.
- **Employer group plans:** These plans may have custom cost sharing that differs from this guide as outlined in their Evidence of Coverage (EOC)

If you have questions, contact your provider advocate or visit **UHCprovider.com/contactus** for chat options and contact information.

Coding guidelines and coverage summaries

- We follow the Centers for Medicare & Medicaid Services (CMS) Medicare coverage and coding guidelines for all network services. See the **CMS Medicare Coverage Database (NCD/LCD Lookup)**.
- For more information on Medicare-covered preventive services, see the CMS **Medicare Preventive Services Educational Tool**
- To review UnitedHealthcare Medicare Advantage policies and guidelines, visit **UHCprovider.com** > Coverage and payments > Policies and protocols > For Medicare Advantage Plans

Benefit	Copay and coinsurance guidelines
Alcohol misuse counseling	Medicare covers 1 annual alcohol misuse screening for adults who misuse alcohol but aren't alcohol dependent. Coverage is limited to 1 screening per year. People who screen positive can receive up to 4 brief face-to-face counseling sessions per year (if they're competent and alert during counseling). A primary care provider (PCP) must provide the counseling in a primary care setting.

Benefit	Copay and coinsurance guidelines
Alcohol misuse counseling (cont.)	All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.
Allergy testing and treatment	A non-radiological diagnostic procedure and test copay or coinsurance applies for allergy testing. There's no cost share for professional services for allergen immunotherapy, including provision of the allergen extracts.
Ambulance transportation	A cost share applies for every one-way ambulance trip, according to Medicare guidelines. If a provider group starts a transfer between facilities and arranges for transportation, cost sharing will be included either on the transferring hospital claim or the receiving hospital claim and will be factored into the inpatient or ambulatory reimbursement. Covered ambulance services include air and ground services to the nearest facility that can provide care only if the member's health would be endangered by other means of transportation or if authorized by the plan. The member's condition must require both the ambulance transportation and the level of service provided for the billed service to be considered medically necessary. Nonemergency transportation by ambulance is appropriate only if it's documented that the member's condition is such that other means of transportation could endanger their health – regardless if another form of transportation is available – and that transportation by ambulance is medically necessary. Transportation back to the United States from another country is not covered. If a member was alive at the time the ambulance was called, but passed away before the ambulance arrived, no member cost sharing applies (i.e., no member benefit was used).
Annual wellness visit	There's no coinsurance, copay or deductible for an annual wellness visit. • If the member has had Medicare Part B for more than 12 months, they're entitled to an annual wellness visit with a PCP to develop or update a personalized prevention plan, based on their current health and risk factors • The annual wellness visit is covered once every calendar year. Visits don't need to be 12 months apart.

Benefit	Copay and coinsurance guidelines
Annual wellness visit (cont.)	• Visits do not include lab tests, drugs, radiological diagnostic tests or non-radiological diagnostic tests. Additional applicable cost share may apply to any lab or diagnostic testing performed during the visit. If ordered and performed during the preventive visit, these additional services will be billed separately, according to Medicare guidelines, and the applicable cost share may apply depending on the member's filed benefit. • The member's first annual wellness visit can't take place within 12 months of their Welcome to Medicare preventive visit. However, a Welcome to Medicare visit isn't required if they've had Medicare Part B for 12 months.
Annual routine physical exam	All of our Medicare Advantage plans cover an annual routine physical examination with no cost share. The exam includes a comprehensive physical exam and evaluates the status of chronic diseases. • The annual routine physical exam doesn't include any other services such as lab tests, drugs, radiological diagnostic tests or non-radiological diagnostic tests. Additional applicable cost share may apply to any lab or diagnostic testing performed during the visit. If ordered and performed during the preventive visit, these additional services will be billed separately, according to Medicare guidelines, and the applicable cost share may apply depending on the member's filed benefit. • The annual routine physical exam is covered once every calendar year. Visits don't need to be 12 months apart.
Behavior therapy for cardiovascular disease	Coverage extends to 1 visit a year for members with high-risk factors to help lower risk for cardiovascular disease. All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.
Breast cancer screening	The following services are covered: • One baseline mammogram for women ages 35–39 • One screening mammogram every year for women ages 40 and older • Clinical breast exams once every 2 years A screening mammogram is used for early detection of breast cancer in women who have no signs or symptoms of the disease. We cover both 2D and 3D mammograms. All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.

Benefit	Copay and coinsurance guidelines
Breast cancer screening (cont.)	Women with a history of breast cancer or any signs or symptoms of breast cancer are not eligible for a screening mammogram, but may be eligible for a diagnostic mammogram, which is typically subject to a radiologic diagnostic cost share under Original Medicare. • However, in 2025, most of our Medicare Advantage plans have a $0 copayment for diagnostic mammograms. (Exception: Institutional Special Needs Plans (SNPs) and employer group plans may apply radiologic diagnostic cost sharing.) • Breast biopsies such as fine needle aspiration (FNA) biopsy, core needle biopsy and open (surgical) biopsy are surgical procedures and subject to outpatient surgery cost sharing
Cervical and vaginal cancer screening (Pap test and pelvic exam)	Covered once a year for high-risk women and every 2 years for all other women. All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.
Colorectal cancer screening	We follow Medicare coverage coding guidelines to determine whether a colonoscopy is screening or diagnostic. For members ages 45 and older, we cover the following services: • Guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) once a year • Screening colonoscopy once every 10 years or every 2 years for members at high risk of colorectal cancer, but not within 4 years of a screening sigmoidoscopy • Flexible sigmoidoscopy or screening barium enema once every 4 years • Cologuard® multitarget stool DNA test once every 3 years All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible. No cost share will be applied to a screening colonoscopy, including when a colonoscopy that started as a screening procedure turns into a diagnostic procedure because of the discovery of an abnormality requiring further surgery during the same operative session. Under Original Medicare, diagnostic colonoscopies and therapeutic colonoscopies and sigmoidoscopies are typically subject to cost sharing. However, in 2025, all of our Medicare Advantage plans have a $0 copayment for diagnostic colonoscopies and therapeutic colonoscopies and sigmoidoscopies, in addition to $0 copayment for preventive services.

Benefit	Copay and coinsurance guidelines
Colorectal cancer screening (cont.)	(Exception: Employer group plans may apply outpatient surgery cost sharing.) This includes the following scenarios: • Members who have a history of colon cancer, or have had polyps removed during a previous colonoscopy, are not eligible for a screening colonoscopy, but may be eligible for a diagnostic colonoscopy • A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy
COVID-19 monoclonal antibody therapy	Covered services include the following, administered in accordance with current Medicare coverage guidelines published by CMS: • Monoclonal antibody COVID-19 infusion There is no copay, coinsurance or deductible in or out of network. Drugs for treatment of COVID symptoms are not covered by Medicare but may be covered under the Medicare Part D prescription drug benefit or the member's prescription drug plan.
Depression screening	We cover 1 screening for depression per year in a primary care setting that can provide follow-up treatment and referrals. Annual depression screenings may be performed separately by a PCP and can take place during a scheduled office visit. All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible. The Welcome to Medicare visit and first annual wellness visit include an annual depression screening. If a member needs further evaluation to diagnose their condition, or if they need mental health treatment, refer them to a mental health professional.
Diabetes screening (fasting plasma glucose)	Diabetes screening is covered when provided, according to Medicare coverage guidelines: • The member has any of the following risk factors: – High blood pressure (hypertension) – History of abnormal cholesterol and triglyceride levels (dyslipidemia) – Obesity – History of high blood sugar (glucose) – Overweight with a family history of diabetes • The member may be eligible for up to 2 diabetes screenings a year based on test results All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.

Benefit	Copay and coinsurance guidelines
Diabetes self-management training	• Up to 10 hours of training per year in 30-minute group sessions. This includes education about how to monitor blood sugar, diet, exercise, medication and reducing risks. We cover individual sessions if no group sessions are available or if you believe special needs prevent the member from participating in a group setting. • May also qualify for up to 2 hours of follow-up training each year when ordered by you or another provider as part of the patient's care plan. The follow-up training must take place in a calendar year after the date the initial training was received. All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.
Diabetes monitoring supplies	Covered services are subject to the diabetic supplies cost share and include supplies to monitor blood glucose: • Blood glucose monitor • Blood glucose test strips • Lancet devices and lancets • Glucose-control solutions for checking the accuracy of test strips and monitors Continuous glucose monitors (CGMs) are subject to the same cost share as the diabetic-monitoring supplies, not the durable medical equipment (DME) cost share. Coverage is in accordance with Medicare guidelines; CGMs not covered by Medicare will be denied. **Insulin and insulin syringes** Insulin, insulin syringes and disposable insulin pumps may be separately covered under the Medicare Part D prescription drug benefit or the member's prescription drug plan. On UnitedHealthcare individual Medicare Advantage plans, external insulin pumps are DME and subject to the DME cost share. All members of Medicare Advantage plans have a maximum $35 cost share for a 30-day supply and a $105 cost share for a 90-day supply of Part B insulin drugs.
Dialysis	The outpatient dialysis treatment cost share applies for dialysis and all related services performed in a dialysis facility, whether in or out of the service area. • A separate Medicare Part B drug cost share is assessed for medications administered and billed separately from the dialysis service • For dialysis performed in an inpatient hospital, the inpatient hospital cost share applies • For home dialysis equipment and supplies, the DME and related supplies cost share applies

Benefit	Copay and coinsurance guidelines
DME and related supplies	The DME cost share applies to all medically necessary, Medicare-covered DME and related supplies including, but not limited to: • Walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers or hospital beds
Emergency services	Cost share for emergency services, including worldwide emergency coverage, varies by benefit plan. • The ER copay is all-inclusive of all services provided in an ER setting. For example, if an MRI is performed while a member is in the ER (i.e., the MRI is included on the ER claim), only the ER cost share should apply • Cost sharing for medically necessary emergency services is the same for both network and out-of-network providers • The ER copay is waived if the ER visit results in admission within 24 hours; please refer to the member's EOC for details • If ER and observation are billed together, only the ER cost share applies
HIV PrEP	FDA-approved Pre-Exposure Prophylaxis (PrEP) using antiretroviral drugs to prevent HIV in patients at increased risk of getting HIV • Administration of injectable PrEP using antiretroviral drugs to prevent HIV - $0 copay with both network and out-of-network providers • Individual counseling, including HIV risk assessment, HIV risk reduction and medication adherence – $0 copay with network providers, applicable cost sharing out of network • HIV screenings: Up to 8 times per year using FDA-approved lab tests and point-of-care tests – $0 copay with network providers All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible
Immunizations and vaccinations	Vaccines covered under Medicare Part B are covered for a $0 cost share, including both administration and vaccine for both network and out-of-network providers. Covered services include: • COVID-19 vaccination • Pneumonia • Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine for members at high or intermediate risk • Other vaccines if members are at risk and they meet Medicare Part B coverage rules

Benefit	Copay and coinsurance guidelines
Immunization and vaccinations (cont.)	All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible. There's no office visit cost share if the immunization or vaccination was the only reason for the visit. The office visit cost share may apply if services that would incur a cost share were provided during the same visit as the immunization or vaccination. Other vaccinations and immunizations not covered by Medicare may be covered under Medicare Part D or the member's prescription drug plan. Members who do not have Part D or other prescription drug coverage do not have coverage for any vaccines not covered by Medicare Part B.
Inpatient hospital admissions and care	Inpatient hospital copays are all-inclusive; no cost sharing applies other than the per-day or per-stay flat cost sharing amount, depending on the plan. Once the member reaches the copay maximum, or their out-of-pocket maximum, there are no additional copays that apply. • If the member's plan has a flat per-stay copay, the member is responsible for one (1) copay for the admission, even if the member is transferred to another hospital (same facility type) as part of the same stay • If the member's plan has a coinsurance, the coinsurance amount applies per admission for each hospital stay. If the member is transferred to another hospital, coinsurance also applies to the stay at the receiving hospital. The coinsurance also applies to any services, such as professional services, that are provided to the member during the inpatient hospital stay. • Some plans cover unlimited days for each hospital stay, while other plans follow Original Medicare coverage and limit inpatient hospital stays to 90 days per benefit period • Transfer to a separate facility type, such as an inpatient rehabilitation hospital, is considered a new admission and the member is responsible for the applicable cost sharing • For mental health admissions, some benefit plans may apply a different inpatient acute hospital cost share: either a different per-day copay or different maximum number of days

Benefit	Copay and coinsurance guidelines
Laboratory services	The laboratory cost share applies per day per provider, not per laboratory test. To prevent multiple lab cost shares for a single visit, all lab services must be billed by the same provider on the same date of service on a single claim. If a member has blood drawn or a specimen collected at the physician's office, cost sharing is not assessed for venipuncture or labs billed with an office place of service: • An additional cost share for the physician office visit isn't assessed if the blood draw or specimen collection was the primary reason for the member's visit • An additional cost share for the physician office visit may apply if other physician services are rendered If a member goes to an outpatient hospital or freestanding lab for lab services only, the lab cost share applies. If a redraw is required, members will not be assessed an additional lab cost share. Additional lab cost shares may apply for labs performed on later dates. Lab tests associated with the following Medicare-covered preventive services will not be assessed a cost share, including, but not limited to: • Pap smear • Colorectal cancer screening • Prostate cancer screening (a digital rectal exam (DRE) is covered for a $0 copayment with network providers on non-SNPs and may be subject to cost sharing on SNPs, depending on the plan • Cardiovascular screenings (subject to member cost sharing – in most plans, one time only when provided during the Welcome to Medicare visit)
Medical nutrition therapy	Medical nutrition therapy is covered for members with diabetes or renal disease, or after a kidney transplant when referred by their doctor, including: • Three hours of individual counseling during their first year and 2 hours each year after that • If the member's condition, treatment or diagnosis changes, the member may receive additional hours of treatment All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.

Benefit	Copay and coinsurance guidelines
Medicare Part B: Outpatient injectable and infusion medications	Physician-administered outpatient injectable and infusion medication policies: • The Medicare Part B drug cost share applies, per drug per day, for covered outpatient injectable drugs when administered at the physician's office • If the injectable medication is given in the physician's office and an office visit is billed, cost sharing for both the physician office visit and the injectable drug may apply • There is no separate cost share, other than the office visit cost share, for administering the injection • Refer to "Immunizations and vaccinations" on **page 7** for more information on cost sharing • When an injectable medication is administered in an outpatient hospital setting, cost sharing for both the outpatient hospital services and the injectable drug may apply **Home health injectable and infusion drug policies:** • Medically necessary medications dispensed for home infusion therapy that are administered through an infusion pump may be covered under either Medicare Part B or the Part D prescription drug benefit, depending on the medication • Medically necessary medications dispensed for home infusion therapy that are administered as injectables may be covered under Medicare Part D or the member's prescription drug plan • To authorize these services, continue using the established protocol based on your contract with UnitedHealthcare Medicare Advantage or its affiliates. If you have questions, check out our **contact resources** for chat options and contact information. • A cost share for DME and components may apply when the medications are administered in a home setting **Self-administered outpatient injectable and infusion medications** • Self-administered outpatient injectable and infusion medications may be covered under the Medicare Part D prescription drug benefit **Chemotherapy** • Chemotherapy drugs are Medicare Part B drugs when administered in an outpatient or office setting, regardless of the method of administration • The chemotherapy drug cost share applies to the chemotherapy drug and its administration • Chemotherapy drugs administered in the home by infusion may be either Part B or Part D **Immunosuppressive drugs** The Medicare Part B cost share applies to all members for covered immunosuppressive drugs provided post-transplant.

Benefit	Copay and coinsurance guidelines
Mental health – inpatient	Some benefit plans have a different inpatient acute hospital admissions cost share for mental health services – either a different per-day amount or different maximum number of days. Covered services include: • Mental health services that require a hospital stay for inpatient services in a psychiatric hospital (190-day lifetime limit). The 190-day limit doesn't apply to mental health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services
Non-radiological diagnostic tests	A non-radiological diagnostic cost share applies to the following common tests: • ECG • EKG • Holter monitor • Pulmonary function testing • Sleep studies • Stress tests: – Treadmill – Stationary bicycle – Continuous electrocardiographic monitoring – Pharmacological stress
Obesity screening and counseling	Medicare covers body mass index (BMI) screenings and behavioral counseling in a primary care setting for members who meet the clinical definition of obese: BMI 30 or higher. Obesity screening is covered once per year. Obesity counseling coverage includes: • One in-person visit every week for the first month • One in-person visit every other week during months 2–6 • One in-person visit every month during months 7–12, if they lose at least 6.6 pounds within the first 6 months All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.
Observation care	Observation billed with an outpatient hospital place of service is subject to the outpatient hospital cost share. If emergency room and observation are billed together, only the emergency room cost share applies.

Benefit	Copay and coinsurance guidelines
Observation care (cont.)	Observation services shouldn't be billed concurrently with diagnostic or therapeutic services that include active monitoring. A separate cost share applies to diagnostic or therapeutic services billed with observation, when appropriate. Any observation copay that's applied is limited to one copay per day.
Opioid treatment program services	Opioid use disorder treatment services are covered under Medicare Part B. Members receive coverage for these services through the plan. Covered services are subject to an outpatient opioid treatment services cost share ($0 copay with network and out-of-network providers on all Medicare Advantage plans) and include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments While office-based opioid treatment (OBOT) programs and opioid treatment programs (OTP) provide the same types of counseling and support services for opioid treatment, there are differences in how medications are administered, as well as the applicable cost sharing: Members can visit an OBOT and receive a prescription medication for a specified number of days. An outpatient cost share is applied to each OBOT visit and a separate prescription drug copay is applied to each prescription medication received. OTP: Members are seen daily and medication is dispensed and ingested on site. The cost share that applies is the amount filed for the OTP benefit on the member's plan.
Outpatient hospital services	Medically necessary services provided in an outpatient facility or outpatient department of a hospital for diagnosis or treatment are covered and may be subject to applicable cost sharing. When members receive services for multiple benefit categories during the same visit, a separate cost share may apply for each service received. The following benefit categories may incur a separate cost share including, but not limited to: • Medicare Part B drugs, including chemotherapy and chemotherapy administration • Blood

Benefit	Copay and coinsurance guidelines
Outpatient hospital services (cont.)	• Physical, occupational, speech and pulmonary therapy • Mental health and psychiatric services • Renal dialysis • Lab • Radiological services • Non-radiological test • Observation • Cardiac rehabilitation • Pulmonary rehabilitation • Surgery
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	Outpatient surgery is not all-inclusive and could be subject to additional cost shares based on the services provided. • If the plan has a flat copayment, the copayment includes surgery; anesthesia; any other physician/nonphysician professional services rendered during the visit; and observation (one copay per day of observation). Additional services that are separately billed/payable are subject to cost sharing, including: diagnostic tests, therapeutic services, prosthetics, orthotics, supplies and Part B drugs. • If the plan has coinsurance, the coinsurance is applied to the costs for the surgery; anesthesia; any other physician/nonphysician professional services rendered during the visit; and observation. Additional services provided during the visit (as outlined above) are subject to separate cost sharing specific to that separate benefit category. Please refer to the appropriate section in the member's EOC for additional information.
Physician office visits	**Primary care** • Cost sharing applies to any covered professional services rendered by a PCP type: family practice, general practice, internist, pediatrician. The same cost sharing applies to all PCPs regardless of whether the provider is the member's assigned PCP. • Cost sharing is not all-inclusive to all services rendered during a visit. If during a visit, other services are provided (e.g., labs, diagnostic tests, part B drugs, etc.), the cost sharing for that benefit category applies in addition to the office visit cost share. • Some plans have $0 cost sharing for primary care services rendered in a home setting. If this benefit category has cost sharing and the plan does not call out services in the home as having a $0 cost share, then the same cost sharing should apply to the home visit as would apply in an office setting.

Benefit	Copay and coinsurance guidelines
Physician office visits (cont.)	**Specialist services** • Specialist cost sharing applies to all professional physician services that are not included in a more specific benefit category – There are separate benefit categories for primary care, eye care (optometrist/ophthalmologist), foot care (podiatrist), mental health, chiropractic care, radiology and hearing care • Cost sharing is not all-inclusive to all services rendered during a visit. If a physician provides other services during the visit, such as diagnostic tests, Part B drugs etc., the cost sharing for that benefit category also applies to those specific services. **Other physician office visit information** For physician house calls, the physician office visit cost share applies to evaluation and management services done in the member's home. For monitoring anticoagulation medications such as Coumadin®, heparin and warfarin, the physician office visit cost share will be only if the monitoring is provided during an office visit. To qualify, the physician must: • Personally perform an initial evaluation of the member • Order and supervise the anticoagulation monitoring • Be physically present in the immediate office at the time of service A Doctor of Pharmacy can provide services at a Coumadin clinic or facility as long as they are: • Licensed by the state and performing within the scope of practice • Performing under the supervision of a Doctor of Medicine or osteopathy, who must be in the office to offer assistance if needed Separate surgery-related office visits performed during the global post-operative period aren't included in the office visit cost share provision, since these services are already included in the surgical allowance.
Preventive care	We follow Medicare coverage and coding guidelines for network preventive services. If the member is treated or monitored for an existing medical condition during the preventive visit, a cost share may apply for the existing medical condition. The following preventive services are covered for a $0 copay with a network provider at the same frequency as with Original Medicare and should be billed according to Medicare guidelines:

Benefit	Copay and coinsurance guidelines
Preventive care (cont.)	• Abdominal aortic aneurysm screening ultrasound • Alcohol misuse screening and counseling • Annual routine physical exam (not Medicare-covered) • Annual wellness visit • Bone mass measurements (bone density) • Breast cancer screening (2D and 3D mammograms) • Cardiovascular disease risk reduction visit (behavioral therapy) • Cardiovascular disease screening • Cervical cancer screening with human papillomavirus (HPV) test • Colorectal cancer screening • COVID-19, flu, pneumonia and hepatitis B vaccines • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma tests for those at high risk • Hepatitis B screening • Hepatitis C screening • HIV PrEP using antiretroviral therapy • HIV screening • Lung cancer screening with low-dose computed tomography • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Obesity screening and counseling to promote sustained weight loss • Pap tests and pelvic examinations • Prostate-specific antigen test screening • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling • Welcome to Medicare preventive visit All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service.
Prostate cancer screening	For men ages 50 and older, covered services include the following once per year: • Prostate-specific antigen test: There is no copay, coinsurance or deductible • Digital rectal exam: Subject to cost sharing per the member's evidence of coverage – Cost sharing applies to this preventive service according to Medicare guidelines. However, many UnitedHealthcare Medicare Advantage plans do not charge member cost sharing for this service. All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service.

Benefit	Copay and coinsurance guidelines
Prosthetic devices and related supplies (including orthotics)	The DME prosthetics and orthotics cost share applies for each medically necessary, Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices and related supplies. Coverage includes, but is not limited to: • Devices including, but not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy) • Certain supplies related to prosthetic devices and repair or replacement of prosthetic devices • Some prosthetic devices following cataract removal or cataract surgery
Radiation therapy	A therapeutic radiology cost share per procedure or per visit applies: • For members with coinsurance, members will pay a percentage of the amount paid to the provider for all covered procedures • For members with a copay, members will pay the applicable copay per visit Examples include, but are not limited to: • Brachytherapy • Radioactive implants (separate outpatient surgery cost share may be applied for placement of an interstitial device) • Conformal proton beam radiation • Therapeutic radiology or radiation (radium and isotope) therapy **Note:** Gamma knife and stereotactic procedures are covered as outpatient surgery with the applicable cost share.
Radiology services	Radiology cost sharing may vary for the following separate cost sharing categories: • Medicare-covered breast cancer screening mammography and bone mass measurement are Medicare-covered preventive benefits with no cost share. These services are covered at the same frequency as covered under Original Medicare and can be provided any time during the calendar year in which the member is eligible to receive the service. • Flat-film X-rays, or a conventional X-ray that produces a 2 dimensional planar image, may be subject to a cost share for each Medicare-covered standard X-ray view, in addition to any applicable office visit cost share billed

Benefit	Copay and coinsurance guidelines
Radiology services (cont.)	For other radiological diagnostic services, not including X-rays or separately identified preventive services: • The applicable cost share applies • Radiology services that require specialized equipment beyond standard X-ray equipment performed by specially trained or certified personnel, including: – Specialized scans: CT, SPECT, PET, MRI, MRA – Nuclear studies – Radiopharmaceuticals – Ultrasounds – Diagnostic mammograms (for cost share details, see Breast Cancer Screening on **page 3**) – Interventional radiological procedures, such as myelogram, cystogram, angiogram and barium studies
Rehabilitation services: Medicare-covered outpatient rehabilitation, including cardiac and pulmonary rehabilitation, and physical, speech and occupational therapies	Applicable cost sharing may apply per session for Medicare-covered outpatient rehabilitation services, including: • Cardiac and pulmonary rehabilitation • Physical, speech and occupational therapies
Sexually transmitted infection (STI) and high-intensity behavioral counseling to prevent STIs	Medicare covers STI screening for chlamydia, gonorrhea, syphilis or hepatitis B when tests are ordered by a PCP for members who are pregnant or have an increased risk for an STI. These tests are covered once every year or at certain times during pregnancy. Medicare also covers counseling sessions to prevent members from contracting an STI if they're considered at increased risk, according to Medicare guidelines. Up to 2 individual 20- to 30-minute in-person counseling sessions are covered each year as a preventive service if they're provided by a PCP and take place in a primary care setting. All Medicare-covered preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible.

Benefit	Copay and coinsurance guidelines
Supervised exercise therapy (SET)	SET is covered for members who have symptomatic peripheral artery disease (PAD) and have a referral from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. A SET copay or coinsurance applies per session.
Urgent services	**Urgent services** Cost share for urgently needed services varies by benefit plan. • The copay for urgently needed services, covered nationwide, is not all-inclusive and could be subject to additional cost shares based on services provided, similar to how copays are applied in a physician office. For example, an X-ray rendered in an urgent care center is subject to the X-ray cost share in addition to the urgent care copay. • Urgently needed services obtained at a retail walk-in clinic are subject to the urgent care cost share
Vision benefits	**Medicare-covered vision exams** • Examinations for medical care, evaluation of a complaint or follow-up for an existing medical condition should be billed to the member's medical insurance plan **Routine vision exams** • Routine vision exams, screening for disease or updating prescriptions should be billed to the member's routine vision insurance benefit **Medicare-covered vision** • Medicare-covered eye exams may be subject to cost sharing as set forth in the member's EOC • Separate cost sharing may apply to other services received during the same visit, including a medical office visit, routine eye exam, Part B drugs or diagnostic radiology (excluding diagnostic images of the eye) • Medicare-covered, medically necessary vision care includes: – For plans with a flat copay for Medicare-covered vision services, a single copayment covers: ° Medical exams for the diagnosis and treatment of diseases and injuries of the eye, including diagnosis or treatment for age-related macular degeneration or cataracts ° Diagnostic tests done as part of the vision exam ° For people with diabetes or signs and symptoms of eye disease, eye exams to evaluate for eye disease

Benefit	Copay and coinsurance guidelines
Vision benefits (cont.)	° For people with diabetes, screening for diabetic retinopathy is covered once per year – For plans with coinsurance, the coinsurance applies to all billed charges for the medically necessary vision services set forth above • All UnitedHealthcare Medicare Advantage plans to cover the following at $0 cost sharing with a network provider: – Glaucoma screening: Once per year for members at high risk of glaucoma, such as family history of glaucoma, diabetes, African Americans (ages 50 and older) and Hispanic Americans (ages 65 and older). The glaucoma screening can be provided any time during the calendar year in which the member is eligible to receive the service. There is no copay, coinsurance or deductible. **Medicare-covered eyewear includes:** • One standard pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens • Corrective lenses or frames and replacements needed after a cataract removal without a lens implant **Routine vision benefits (not available on all plans)** • Routine eye exam: Vision screening and vision refraction performed by an ophthalmologist or optometrist: – For members receiving vision screening services during an office visit, 1 copay applies – If vision refraction is performed in addition to vision screening during an office visit, only 1 copay applies Limited to 1 exam every year. Refer to the member's EOC for details. • **Routine eye wear:** Credit toward lenses and frames or contact lenses once every 1 or 2 years, depending on the member's plan, up to the allowed amount. Refer to the member's EOC for details.

PCA-1-25-00641-M&R-QRG_04212025

UnitedHealthcare®