2016 UnitedHealthcare Medicare Advantage Copayment Guidelines for Plans Administered on UHCWest.com

The following is guidance on cost sharing to assist you when completing your transactions on UHCWest.com for our Medicare Advantage members. While copayments and coinsurance vary depending on the benefit plan, all UnitedHealthcare Medicare Advantage plans feature an annual maximum out-of-pocket amount for all Medicare-covered medical benefits.

Group Retiree plans may have different copayments and coinsurance than the standard cost sharing described on the following pages.

We follow the Centers for Medicare & Medicaid Services (CMS) Medicare coverage and coding guidelines for all in-network preventive services. If a UnitedHealthcare Medicare Advantage member is treated or monitored for a medical condition during the preventive service visit, a copayment applies for the care received for the medical condition. For coding information, please go to cms.gov > Medicare.

For additional details on the information in this document, please visit UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries.

Please contact Provider Services at 888-866-8297 if you have questions regarding specific copayment, coinsurance or maximum out-of-pocket information.

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Benefit	Copayment/Coinsurance Guidelines
Alcohol Misuse Counseling	Medicare covers one annual alcohol misuse screening for adults who misuse alcohol but aren't alcohol dependent and are competent and alert during counseling. Limited to one screening per year. People who screen positive can receive up to four face-to-face counseling sessions per year. A primary care doctor must provide the counseling in a primary care setting. For more information, please click the following link: Alcohol, Chemical and/or Substance Abuse – Detoxification and Rehabilitation

Allergy Testing/Treatment	A copayment or coinsurance applies for allergy testing and/or administration of allergy serum. Refer to "Physician Office Visits including Telephonic/Online Consults/Anticoagulation Monitoring" on page 11 of this document for a list of health care professionals who may collect an office visit copayment for allergy serum injections. For more information, please click the following link: Allergy Testing and Allergy Immunotherapy.

Ambulance Transportation	A cost-share applies per one-way ambulance trip per Medicare guidelines. If a provider group initiates a transfer between facilities and arranges for transportation to facilitate the transfer, that trip is part of the clinical case management services and not subject to a cost-share. Covered ambulance services include helicopters and ground ambulance services to the nearest facility that can provide care only if the member's health could be endangered by other means of transportation. 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. Non-emergency transportation by ambulance is appropriate only if it is documented that the member's condition is such that other means of transportation could endanger the person's health - regardless of whether another form of transportation is available - and that transportation by ambulance is medically required. For more information, please click the following link: Ambulance Services

Annual Wellness Visit	There is no coinsurance, copayment or deductible for the Annual Wellness Visit. • If the member has had Medicare Part B for more than 12 months, they are entitled to an Annual Wellness Visit with a primary care provider 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 do not need to be 12 months apart. • 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 is not required to be covered for Annual Wellness visits if they've had Medicare Part B for 12 months. For more information, please click the following link: Preventive Health Services and Procedures

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 evaluation of chronic diseases. • The annual routine physical exam does not include any other services such as lab, x-ray or non-radiological services. When ordered and performed during the preventive visit, these additional services will be billed separately according to Medicare guidelines and a cost share will apply. • The annual routine physical exam is covered once every calendar year. Visits do not need to be 12 months apart. For more information, please click the following link: Preventive Health Services and Procedures

Behavior Therapy for Cardiovascular Disease	One visit per year for members with high-risk factors is covered. For more information, please click the following link: Preventive Health Services and Procedures

Breast Cancer Screening	The following services are covered: • One baseline mammogram for women between the ages of 35 and 39 • One screening mammogram every year for women 40 and older Note: Both 2D and 3D mammograms are covered. A screening mammogram is used for early detection of breast cancer in women who have no signs or symptoms of the disease. No cost share will be applied when a mammogram that started as a screening procedure turns into a diagnostic procedure during the same session. Women with a history of breast cancer and/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 subject to a cost share. For more information, please click the following link: Preventive Health Services and Procedures

Cervical and vaginal cancer screening (Pap test and pelvic exam)	Covered annually for women in a high risk category and every two years for all other women. For more information, please click the following link: Preventive Health Services and Procedures

Colonoscopy	We follow Medicare coverage coding guidelines to determine whether a colonoscopy is a screening or diagnostic. For members 50 and older, the following services are covered: • Fecal occult blood test limited to once a year • Screening colonoscopy once every 10 years or every two years for members at high risk of colorectal cancer, but not within four years of a screening sigmoidoscopy • Flexible sigmoidoscopy or screening barium enema once every four years • Cologuard™ multitarget stool DNA test once every three years No cost share will be applied 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. For more information, please click the following link Preventive Health Services and Procedures

Depression Screening	We cover one 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 primary care doctor and can take place during a scheduled office visit. 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, a cost share may be applied. For more information, please click the following link: Preventive Health Services and Procedures

Diabetes Outpatient Self-Management Training	Diabetes Outpatient Self-Management Training: • Up to 10 hours of training per year in 30-minute group sessions. Includes education about how to monitor blood sugar, diet, exercise and medication. Individual sessions are covered 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 two hours of follow-up training each year when ordered by you or another provider as part of the patient's plan of care. The follow-up training must take place in a calendar year after the date the initial training was received. For more information, please click the following links: • Preventive Health Services and Procedures • Diabetes Management, Equipment and Supplies

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) or a family history of diabetes. • Based on the results of these tests, the member may be eligible for up to two diabetes screenings a year. For more information, please click the following link: Preventive Health Services and Procedures

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 in the dialysis facility and billed separately from the dialysis service. • For dialysis performed in an inpatient hospital, the inpatient hospital cost-share applies. • For dialysis (peritoneal or hemodialysis) in a member's home and for home support services such as visits by trained dialysis workers, the home health cost-share applies. • For home dialysis equipment and supplies and for certain drugs for home dialysis, the durable medical equipment and related supplies cost-share applies. For more information, please click the following link: Dialysis Services

Enhanced Counterpulsation (ECP)/Enhanced External Counterpulsation (EECP)	ECP treatment may consist of up to 35 one-hour individual treatment sessions. Members diagnosed with disabling angina who are not candidates for surgical intervention are covered. A cost-share may apply for each treatment session depending on the place of service. For more information, please click the following link: Cardiac Pacemakers and Defibrillators.

Emergency and Urgent Services	The cost-share for emergency and urgently needed services, including worldwide emergency coverage, varies by benefit plan. • An emergency room copayment applies but may be waived if the emergency room visit results in admission to inpatient care. Please refer to plan details. • Urgent care – Non-contracted and contracted cost shares apply when members receive urgent care from a non-contracted or contracted urgent care center. For more information, please click the following link: Emergent/Urgent Services, Post-stabilization Care and Out-of-Area Services.

Immunizations/ Vaccinations	The physician office visit cost-share will not be assessed if the immunization or vaccination was the only reason for the visit. The office visit cost share will 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. For more information, please click the following link: Preventive Health Services and Procedures.

Inpatient Hospital Admissions and Care	Depending on the member's benefit plan, an inpatient hospital cost-share may apply in one of the following ways: • If the member's coverage plan requires a per-day copayment up to a maximum, the member incurs a copayment for each day of the hospital stay and each hospital admitted to during the same stay. After the member reaches the copayment maximum for the stay or their maximum out-of-pocket expense, they no longer incur an additional copayment. • If the member's coverage plan requires a per-admission copayment, the member is responsible for one copayment for the admission, even if they are transferred to another hospital during the same stay. • Coverage is for unlimited days for each hospital. • Transfer to a separate facility type such as an acute inpatient rehabilitation hospital is considered a new admission. • For mental health admissions, some benefit plans may have a different per-day copayment or different maximum number of days. For more information, please click the following link: Hospital Services (Inpatient and Outpatient).

Medical Nutritional Therapy	Medical nutritional 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 two hours each year after that. • If the member's condition, treatment or diagnosis changes, the member may be able to receive additional hours of treatment. For more information, please click the following links: • Preventive Health Services and Procedures • Diabetes Management, Equipment and Supplies.

Medicare Part B: Outpatient Injectable/Infusion Medications	Physician-administered outpatient injectable/infusion medication policies: • The Part B drug cost share applies per drug per day for Medicare covered outpatient injectable drugs including chemotherapy when administered at the physician's office. • If the injectable medication is given in the physician's office and an office visit is billed, the cost sharing for both the physician office visit and the injectable will be assessed. • There is no separate cost-share other than the office visit cost-share for administering the injection. • See "Immunizations/Vaccinations" in this document 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 will be assessed. **Home Health Injectable/Infusion Drugs policies:** • Most medications dispensed for home infusion therapy are covered under the prescription drug benefit (Part D), not under the medical benefit (Part C). To authorize these services, continue using the established protocol based on your contract with UnitedHealthcare Medicare Solutions and/or its affiliates or call the Provider Services phone number listed on the back of the member's identification card. • A cost-share for the DME components of an infusion pump may apply when the medications are administered in a home setting. **Self-Administered Outpatient Injectable/Infusion Medications** • The Part D drug cost share applies to Medicare covered self-administered injectable medications up to a 30 day supply. **Chemotherapy** • Chemotherapy Drugs are Medicare Part B drugs when administered in an outpatient or office setting, regardless of the method of administration, such as subcutaneous injection, intramuscular injection or intravenous infusion. • The Part B 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 Medicare covered immunosuppressive drugs provided post-transplant. For more information, please click the following links: • Medications/Drugs (Outpatient/Part B), • Chemotherapy, and Associated Drugs and Treatments • Transplants – Organ and Tissue Transplants

Medications: Outpatient Pharmacy Benefit – Insulin	Insulin and insulin syringes are covered under the Medicare Part D prescription drug benefit. Insulin pumps worn outside the body are subject to the Durable Medical Equipment cost share. For more information, please click the following link: Diabetes Management, Equipment and Supplies.

Mental Health – Inpatient	Some benefit plans have a different inpatient acute hospital cost-share for mental health admissions: either a different per day amount or different maximum number of days. Covered services include: • Mental health services that require a hospital stay with a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services. For more information, please click the following link: Mental Health Services and Procedures.

Non-Radiological Diagnostic Tests	A cost share applies to the following common non-radiological diagnostic tests, among others: • ECG • EKG • Holter monitor • Pulmonary testing • Sleep studies • Stress test For more information, please click the following links: • Cardiovascular Diagnostic Procedures • Sleep Apnea – Diagnosis and Treatment • Respiratory Therapy, Pulmonary Rehabilitation and Pulmonary Services.

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 coverage: one screening per year Obesity counseling coverage: • 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 lbs. within the first six months For more information, please click the following link: Preventive Health Services and Procedures.

Hospital Observation	Hospital observation billed with an emergency room place of service is subject to the emergency services cost-share. 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. Observation services should not be billed concurrent with diagnostic or therapeutic services that include active monitoring. A separate cost-share applies to diagnostic or therapeutic services billed with observation when appropriate. For more information, please click the following link: Observation Care (Outpatient Hospital).

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 cost sharing. When members receive services for multiple benefit categories during the same visit, a separate cost-share applies for each service received. The following benefit categories may incur a separate cost-share: • Outpatient surgery • Medicare Part B drugs, including chemotherapy and chemotherapy administration • DME, prosthetics, corrective appliances/non-foot orthotics, ostomy/colostomy supplies and medical supplies • Blood • Physical, occupational, speech and pulmonary therapy • Mental health and psychiatric services • Renal dialysis • Lab • Radiological services • Non-radiological tests For more information, please click the following link: Hospital Services (Inpatient and Outpatient).

Outpatient Surgery, including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers	Outpatient surgery and procedures may be subject to cost sharing to the provider at the time of service according to the following policies: 1. The facility or physician's office must be licensed by the state as an ambulatory surgery center or outpatient hospital facility. 2. The copayment is applied per admission. 3. Part B drug cost-share will be applied separately to outpatient injectable and infusion medications, including chemotherapy administered in an outpatient hospital and billed separately from the procedure. 4. Separate cost sharing applies for any radiological or non-radiological diagnostic testing or lab work billed along with outpatient procedures. 5. For minor surgeries such as wart removal performed in the physician's office within the scope of their practice, only the physician office visit cost-share applies. If cost-share is applied under the member's benefit plan, the cost-share is applied to the entire allowable cost of the outpatient procedure, including both facility and professional charges.

Physician Office Visits, including Telephonic/Online Consults/Anticoagulation Monitoring	The physician office visit copayment may apply when services, including evaluation and management services, are received in an office setting from any of the following providers: Doctors of Medicine, Doctors of Osteopathy, Doctors of Optometry, Doctors of Philosophy, Doctors of Chiropractic, Physicians' Assistants, Doctors of Podiatric Medicine, Nurse Practitioners or Family Nurse Practitioners. Primary care physician house calls: The physician office visit cost-share applies to services, including evaluation and management services, by a physician in the member's home. For monitoring anticoagulation medications such as Coumadin, Heparin and Warfarin, the physician office visit cost-share will be assessed only if the monitoring is provided during a contracted physician's office visit. To qualify, the contracted physician must: 1. Have personally performed an initial evaluation of the member; 2. Have ordered and supervised the anticoagulation monitoring; and 3. Be physically present in the immediate office at the time of service. A Doctor of Pharmacy can provide services at a Coumadin Clinic/Facility as long as they are: 1. Licensed by the state and performing within the scope of practice; and 2. Performing under the supervision of a Doctor of Medicine or Osteopathy who must be in the office to offer assistance if needed When an injectable medication is administered in the physician's office, only the outpatient injectable drugs cost-share is assessed. The cost-share for the physician office visit is not assessed if the injection was the primary reason for the member's visit, except a separate office visit cost-share applies if the member receives an injection that specifically requires a physician to administer it. The physician office visit cost-share does not apply to telephone/online consultation because the cost-share can only be assessed when the health care professional sees the member in person. The physician office visit cost-share does not apply to office visits provided during the post-operative period timeframe. For more information, please click the following link: Physician Services.

Laboratory Services	• If the plan calls for a laboratory cost-share, the cost-share applies per visit or per claim, not per laboratory test. To prevent multiple lab cost-shares for a single visit, all lab services must be billed on a single claim. • If a member has blood drawn/specimen collected at the physician's office and other physician services are rendered, only the physician office visit cost-share applies. The lab provider is responsible for billing and collecting the lab cost-share. • If a member goes to the physician's office for the blood draw/specimen collection specifically, neither the office visit cost-share nor lab cost-share applies. The lab provider is responsible for billing and collecting the lab cost-share. • If a member goes to an outpatient hospital or freestanding lab for lab services only, only the lab-cost share applies. • If a re-draw is required, members will not be assessed an additional lab cost-share. • Additional lab cost-shares apply for labs performed on later dates. • The lab cost-share assessed cannot exceed the total contracted/payable amount of the lab charges per visit. For example, lab cost-share = $7, total payable to lab charge = $4.50. Therefore, the lab cost-share assessed cannot exceed $4.50. • Lab tests associated with the following Medicare-covered services will not be assessed a cost-share: pap smear and colorectal, prostate and cardiovascular screenings. For more information, please click the following link: Laboratory Tests and Services.

Preventive Care	We follow Medicare coverage and coding guidelines for in-network preventive services. If the member is treated or monitored for an existing medical condition during the preventive visit, a cost-share applies for the care received for the existing medical condition. The following preventive services are covered at a $0 cost-share at the same frequency as with original Medicare and should be billed according to Medicare guidelines: • Abdominal aortic aneurysm screening • 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 and vaginal cancer screening (Pap test and pelvic exam)

Preventive Care (continued)	• Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Flu, pneumonia, and hepatitis B vaccines • Glaucoma tests for those at high risk • Hepatitis C screening • HIV screening • Lung cancer screening with Low Dose Computed Tomography • Medical nutrition therapy services • Obesity screening and counseling to promote sustained weight loss • Prostate-specific antigen test • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling • "Welcome to Medicare" preventive visit For more information, please click the following link: Preventive Health Services and Procedures.

Prostate Cancer Screening	We follow Medicare coverage and coding guidelines for in-network preventive services. If the member is treated or monitored for an existing medical condition during the preventive service visit, cost sharing applies for the care received for the existing medical condition. For men 50 and older, covered services include: • Digital Rectal Exam – subject to cost sharing per the member's explanation of coverage. It is not a $0 preventive service under Medicare guidelines. • Prostate Specific Antigen test cost sharing is explained in our Preventive Health Services and Procedures. For more information, please click the following link: Preventive Health Services and Procedures.

Radiation Therapy	A cost-share per procedure or per visit applies. Examples include, but are not limited to: brachytherapy, radioactive implants and conformal proton beam radiation. Gamma knife and stereotactic procedures are covered as outpatient surgery with the applicable cost-share. • For members with coinsurance, coinsurance will be assessed against all covered procedures in the form of a percentage of the amount paid to the provider. • For members with a copayment instead of coinsurance, the copayment is assessed per visit and per procedure billed. Therapeutic radiology or radiation (radium and isotope) therapy For more information, please click the following link: Radiologic Therapeutic Procedures.

Radiology Services - Basic and Complex	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.
	• Flat film X-rays, or a conventional X-ray that produces a two-dimensional planar image, are subject to a cost-share applied in addition to any applicable office visit cost-share billed.
	
	For other radiological diagnostic services not including X-rays or separately identified preventive services:
	• A copayment/coinsurance applies per procedure to the vendor or facility
	• 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
	  ○ Ultrasounds
	  ○ Diagnostic mammograms
	  ○ Interventional radiological procedures such as myelogram, cystogram, angiogram and barium studies
	
	Screening mammograms are covered as preventive services per Medicare guidelines and are generally not subject to cost sharing, depending on the benefit plan.
	• The Part B cost-share applies to injectable or infused drugs such as contrast material dye/radioactive tracer and other cardiac medications given in conjunction with an imaging procedure such as nuclear stress test and CT scan.
	• Per procedure means per CPT procedure code billed
	
	For more information, please click the following links:
	• Radiologic Diagnostic Procedures
	• Radiologic Therapeutic Procedures

Rehabilitation Services: Medicare-covered Outpatient Rehabilitation, including Cardiac and Pulmonary Rehabilitation, and Physical, Speech and Occupational Therapies	Cost sharing may apply per session for Medicare-covered outpatient rehabilitation services including cardiac and pulmonary rehabilitation and physical, speech and occupational therapies. For more information, please click the following links: • Rehabilitation - Medical Rehabilitation (OT, PT and ST, including Cognitive Rehabilitation) • Rehabilitation - Cardiac Rehabilitation Services (Outpatient)

Sexually Transmitted Infection (STI) and High Intensity Behavioral Counseling to prevent STIs	Medicare covers STI screening for chlamydia, gonorrhea, syphilis and/or Hepatitis B when tests are ordered by a primary care provider for members who are pregnant and/or have an increased risk for an STI. Medicare also covers counseling sessions to prevent members from contracting an STI if they are considered at increased risk according to the following: • Have had multiple sex partners • Use condoms inconsistently • Have sex under the influence of alcohol or drugs • Have sex in exchange for money or drugs • Pregnant women 24 or younger and sexually active (for chlamydia and gonorrhea only) • Have had an STI within the past year • Have engaged in IV drug use (for hepatitis B only) • Are a man who has sex with men and engages in high risk sexual behavior, regardless of age • Live in an area with a high rate of STIs STI counseling: • Up to two individual 20-30 minute in-person counseling sessions annually for adults at increased risk of STI to prevent STIs through education and advice about minimizing risky sexual behavior. For more information, please click the following link: Preventive Health Services and Procedures.

Vision Benefits	Examinations for medical care, evaluation of a complaint or following up on an existing medical condition should be billed to the member's medical insurance plan. Examinations for checking vision, screening for disease, or updating prescriptions should be billed to the member's routine vision insurance benefit if you participate in the plan. **Medicare-covered medically necessary vision care:** A high percentage of groups are capped for office services, so please refer to the Division of Financial Responsibility to determine how the claim will be paid. • Outpatient physician services for eye care screening exams are not covered by Medicare. Medical exams for non-screening diagnosis codes are covered. • Glaucoma screening once per year for members at high risk of glaucoma such as family history of glaucoma, diabetes and African-Americans 50 and older ○ Glaucoma screening is a Medicare-covered preventive benefit not subject to a copay, however, cost sharing may apply to other services received during the same visit including a medical or routine eye exam • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens • Corrective lenses/frames and replacements needed after a cataract removal without a lens implant **Additional benefits – routine vision** Vision screening and vision refraction • For members receiving vision screening services during a physician office visit, one copayment applies. • If vision refraction is performed in addition to vision screening during an office visit, only one copayment applies. • Routine vision benefits are not available on all plans. **Routine Eye Exam:** • Limited to one exam every one or two years depending on the member's benefits. Please refer to the member's explanation of coverage for details. **Routine Eye Wear** • Pair of standard lenses and frames or contact lenses once every one or two years depending on the member's plan. For more information, please click the following link: Vision Services, Therapy and Rehabilitation.