Annual Notice of Changes 2025

AARP® Medicare Advantage from UHC NY-0013 (PPO)

myAARPMedicare.com

Toll-free **1-866-870-9604,** TTY **711**
8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept

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

AARP | Medicare Advantage
from UnitedHealthcare

Y0066_ANOC_H3418_002_000_2025_M

Here for you every step of the way

With more than 45 years of experience, we understand Medicare coverage is personal and changes to your coverage can affect your life. As America's most chosen Medicare Advantage brand, we're committed to delivering a 2025 plan that fits your needs, especially as some regulations change across the Medicare industry.

This Annual Notice of Changes will tell you what you need to know about your plan benefits, including what's new for 2025 and what's staying the same. You can continue to count on your easy-to-use UCard®, only from UnitedHealthcare, to open doors for your care, rewards and so much more.

The Annual Enrollment Period (AEP) is October 15–December 7. It's an opportunity to reflect on your health plan needs. And if your needs have changed, you can explore other plan options. With plans designed for all budgets, stages and ages, UnitedHealthcare has coverage you can count on for your whole life ahead.

A few important reminders:

1. You'll be automatically enrolled in this 2025 plan unless you take action during AEP
2. Your 2025 benefits will be effective January 1, whether you stay in your current plan or switch
3. Your current plan benefits end December 31, take advantage before it's too late

Visit uhc.care/next-year or scan the QR code to:

- Learn about Medicare industry changes
- View your 2025 Annual Notice of Changes online
- Review current year benefit usage

Expert guidance to support you

Questions? Contact your local licensed sales agent or call Customer Service at **1-866-870-9604**, TTY **711**, 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept

United Healthcare®

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 **myAARPMedicare.com** to review the details online. All of the below documents will be available online by **October 15, 2024.**

Provider Directory

Review the 2025 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 2025 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 2025 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 program, how medical coverage decisions are made and your Rights and Responsibilities as a member.

Reduce the clutter and get plan documents faster.

Visit **myAARPMedicare.com** to sign up for paperless delivery.

Would you rather get paper copies?

If you want a paper copy of what is listed above, please contact our Customer Service at 1-866-870-9604 (TTY users should call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

AARP® Medicare Advantage from UHC NY-0013 (PPO) offered by UnitedHealthcare

Annual Notice of Changes for 2025

You are currently enrolled as a member of AARP® Medicare Advantage from UHC NY-0013 (PPO).

Next year, there will be changes to the plan's costs and benefits. Please see page 8 for a Summary of Important Costs, including Premium. This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the Evidence of Coverage, which is located on our website at **AARPMedicarePlans.com**. You may also call Customer Service to ask us to mail you an Evidence of Coverage.

You have from October 15 until December 7 to make changes to your Medicare coverage for next year.

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.

- ☐ Review the changes to medical care costs (doctor, hospital).
- ☐ Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- ☐ Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2025 Drug List to make sure the drugs you currently take are still covered.

☐ Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

- ☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.
- ☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.
- ☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your Medicare & You 2025 handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
- ☐ 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, 2024, you will be enrolled in AARP® Medicare Advantage from UHC NY-0013 (PPO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with AARP® Medicare Advantage from UHC NY-0013 (PPO).
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.
- UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, braille, large print, audio, or you can ask for an interpreter. For more information, please call us toll-free at the number on your member ID card or the front of your plan booklet.
- UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llámenos al número gratuito que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

- **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 AARP® Medicare Advantage from UHC NY-0013 (PPO)

- Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. You do not need to be an AARP member to enroll. AARP encourages you to consider your needs when selecting products and does not make specific product or pharmacy recommendations for individuals.
- When this document says "we," "us," or "our," it means UnitedHealthcare Insurance Company or one of its affiliates. When it says "plan" or "our plan," it means AARP® Medicare Advantage from UHC NY-0013 (PPO).

Annual Notice of Changes for 2025
Table of Contents

Summary of important costs for 2025

The table below compares the 2024 costs and 2025 costs for AARP® Medicare Advantage from UHC NY-0013 (PPO) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. (See Section 1.1 for details.)	$0	$25.00
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 1.2 for details.)	From network providers: $7,550 From in-network and out-of-network providers combined: $13,300	From network providers: $9,350 From in-network and out-of-network providers combined: $14,000
Doctor office visits	Primary care visits: You pay a $0 copayment per visit from a Tier 1 provider (in-network). You pay a $20 copayment per visit from a Tier 2 provider (in-network). You pay 50% coinsurance per visit (out-of-network). Specialist visits: You pay a $40 copayment per visit from a Tier 1 provider (in-network). You pay a $55 copayment per visit from a Tier 2 provider (in-network). You pay 50% coinsurance per visit (out-of-network).	Primary care visits: You pay a $0 copayment per visit (in-network). You pay 50% coinsurance per visit (out-of-network). Specialist visits: You pay a $40 copayment per visit from a Tier 1 provider (in-network). You pay a $55 copayment per visit from a Tier 2 provider (in-network). You pay 50% coinsurance per visit (out-of-network).

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	You pay a $390 copayment each day for days 1 to 4 (in-network). $0 copayment for additional Medicare covered days (in-network). You pay 50% of the total cost for each Medicare-covered hospital stay for unlimited days (out-of-network).	You pay a $275 copayment each day for days 1 to 4 (in-network). $0 copayment for additional Medicare covered days (in-network). You pay 50% of the total cost for each Medicare-covered hospital stay for unlimited days (out-of-network).
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Tier 1 and Tier 2 $395 Tier 3, Tier 4 and Tier 5, except for covered insulin products and most adult Part D vaccines. Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage stage: - Drug Tier 1: Standard retail cost-sharing (in-network) $0 copayment - Drug Tier 2: Standard retail cost-sharing (in-network) $12 copayment - Drug Tier 3: Standard retail cost-sharing (in-	Deductible: $0 Tier 1 and Tier 2 $570 Tier 3, Tier 4 and Tier 5, except for covered insulin products and most adult Part D vaccines. Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage stage: - Drug Tier 1: Standard retail cost-sharing (in-network) $0 copayment - Drug Tier 2: Standard retail cost-sharing (in-network) $14 copayment - Drug Tier 3: Standard retail cost-sharing (in-

Cost	2024 (this year)	2025 (next year)
	network) $47 copayment You pay $35 per month supply of each covered insulin product on this tier[1] - Drug Tier 4: Standard retail cost-sharing (in-network) $100 copayment - Drug Tier 5: Standard retail cost-sharing (in-network) 27% of the total cost Catastrophic Coverage: - During this payment stage, the plan pays the full cost for your Medicare-covered Part D drugs. - You may have cost sharing for drugs that are covered under our enhanced benefit.	network) $47 copayment You pay $35 per month supply of each covered insulin product on this tier[1] - Drug Tier 4: Standard retail cost-sharing (in-network) $100 copayment - Drug Tier 5: Standard retail cost-sharing (in-network) 26% of the total cost Catastrophic Coverage: - During this payment stage, you pay nothing for your Medicare-covered Part D drugs. - You may have cost sharing for drugs that are covered under our enhanced benefit.

[1] You will pay a maximum of $35 in 2024 and 2025 for each 1-month supply of Part D covered insulin drugs through all drug payment stages, except the 2025 Catastrophic drug payment stage, where you pay $0.

Section 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$0**	**$25.00**
Platinum Dental Rider	You pay $56.00 a month for up to $1,500 per year for covered preventive and comprehensive dental services. Benefit is combined in and out-of-network. You pay a $0 copayment for covered preventive and diagnostic services. You pay 50% coinsurance for dentures and bridges. You pay a $0 copayment for all other covered comprehensive services. You may receive dental services from an out-of-network dentist. If an out-of-network dentist charges more than your plan pays, you may be billed for the difference, even for services listed as $0 copayment.	You pay $35.00 a month for up to $1,500 per year for covered preventive and comprehensive dental services. Benefit is combined in and out-of-network. You pay a $0 copayment for covered preventive and diagnostic services. You pay 50% coinsurance for dentures and bridges. You pay a $0 copayment for all other covered comprehensive services. You may receive dental services from an out-of-network dentist. If an out-of-network dentist charges more than your plan pays, you may be billed for the difference, even for services listed as $0 copayment.

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amounts

Medicare requires all health plans to limit how much you pay out-of-pocket for 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	2024 (this year)	2025 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) 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.	$7,550 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.	$9,350 Once you have paid $9,350 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 Your costs for covered medical services (such as copayments) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$13,300 Once you have paid $13,300 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.	$14,000 Once you have paid $14,000 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.

Section 1.3 Changes to the Provider and Pharmacy Networks

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.

Updated directories are located on our website at **myAARPMedicare.com**. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 Provider Directory (myAARPMedicare.com) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 Pharmacy Directory (myAARPMedicare.com) to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Acupuncture for chronic low back pain (Medicare-covered)	You pay a $0 copayment for Tier 1 providers or a $20 copayment for Tier 2 providers for services provided by a primary care physician (in-network). You pay a $40 copayment for Tier 1 providers or a $55 copayment for Tier 2 providers for services provided by a specialist (in-network). Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor. Your plan's network providers who provide these services are grouped into different tiers. These benefits and services can be identified with separate cost-shares based on the provider's "Tier". See Chapter 4 of the Evidence of Coverage for details.	You pay a $0 copayment for services provided by a primary care physician (in-network). You pay a $40 copayment for Tier 1 providers or a $55 copayment for Tier 2 providers for services provided by a specialist (in-network). Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor. Your plan's network providers who provide these services are grouped into different tiers. These benefits and services can be identified with separate cost-shares based on the provider's "Tier". See Chapter 4 of the Evidence of Coverage for details.
Dental services Comprehensive and preventive dental	You pay a $0 copayment for covered preventive and diagnostic services. Benefit is combined in and out-of-network.	You pay a $0 copayment for covered preventive and diagnostic services. You pay 50% coinsurance for dentures and bridges. You pay a $0 copayment for all

Cost	2024 (this year)	2025 (next year)
	You may receive dental services from an out-of-network dentist. If an out-of-network dentist charges more than your plan pays, you may be billed for the difference, even for services listed as $0 copayment.	other covered comprehensive services. You are covered for up to $1,000 per year. Benefit is combined in and out-of-network. You may receive dental services from an out-of-network dentist. If an out-of-network dentist charges more than your plan pays, you may be billed for the difference, even for services listed as $0 copayment. The list of services covered by your plan has expanded. See your Evidence of Coverage for more information.
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®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch®Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-	You pay a $0 copayment (in-network). We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch®Ultra 2, 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.

Cost	2024 (this year)	2025 (next year)
	Chek® Aviva Plus and Accu-Chek® SmartView. 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.	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.
Emergency care	You pay a $100 copayment.	You pay a $110 copayment.
Hearing services Hearing aids	You pay a $99 - $1,249 copayment for each OTC or prescription hearing aid, up to 2 hearing aids every year. Home-delivered hearing aids are available nationwide through network providers (select products only). You must use network providers to access this benefit.	You pay a $99 - $829 copayment for each OTC hearing aid. You pay a $199 - $1,249 copayment for each prescription hearing aid. You can purchase up to 2 hearing aids every year. Home-delivered hearing aids are available nationwide through network providers (select products only). You must use network providers to access this benefit.
Inpatient hospital care	You pay a $390 copayment each day for days 1 to 4 (in-network). $0 copayment for additional Medicare covered days (in-network).	You pay a $275 copayment each day for days 1 to 4 (in-network). $0 copayment for additional Medicare covered days (in-network).

Cost	2024 (this year)	2025 (next year)
Inpatient mental health care	You pay a $390 copayment each day for days 1 to 4 (in-network). $0 copayment each day for days 5 to 90 (in-network).	You pay a $275 copayment each day for days 1 to 4 (in-network). $0 copayment each day for days 5 to 90 (in-network).
Nurse Hotline	Covered	NurseLine is not covered. Your plan offers virtual care at no additional cost. You can talk to a network telehealth provider online through live audio and video. - $0 virtual visits from any network provider that offers virtual care - $0 virtual visits with Amwell, including 24/7 urgent care Access virtual care through the UnitedHealthcare app or myAARPMedicare.com.
Outpatient diagnostic tests and therapeutic services and supplies - radiation therapy	You pay a $0 copayment (in-network).	You pay 20% of the total cost (in-network).
Outpatient diagnostic tests and therapeutic services and supplies - X-rays	You pay a $50 copayment (out-of-network).	You pay a $55 copayment (out-of-network).
Outpatient diagnostic tests and therapeutic services and supplies - other diagnostic tests - non-radiological diagnostic services	You pay a $45 copayment (in-network).	You pay a $50 copayment (in-network).

Cost	2024 (this year)	2025 (next year)
Outpatient diagnostic tests and therapeutic services and supplies - other diagnostic tests - radiological diagnostic service, not including X-rays	You pay a $0 copayment for each diagnostic mammogram. You pay a $200 copayment otherwise (in-network).	You pay a $0 copayment for each diagnostic mammogram. You pay a $250 copayment otherwise (in-network).
Outpatient rehabilitation services - occupational therapy	You pay a $25 copayment (in-network).	You pay a $35 copayment (in-network).
Outpatient rehabilitation services - physical therapy and speech therapy	You pay a $25 copayment (in-network).	You pay a $50 copayment (in-network).
Outpatient surgery - ambulatory surgical center	You pay a $0 copayment for a diagnostic colonoscopy. You pay a $340 copayment otherwise for services provided to you at a Tier 1 ambulatory surgical center (in-network). You pay a $450 copayment otherwise for services provided to you at a Tier 2 ambulatory surgical center (in-network). Your plan's network providers who provide these services are grouped into different tiers. These benefits and services can be identified with separate cost-shares based on the provider's "Tier". Please see the Evidence of Coverage for more details.	You pay a $0 copayment for a diagnostic colonoscopy. You pay a $225 copayment otherwise for services provided to you at a Tier 1 ambulatory surgical center (in-network). You pay a $325 copayment otherwise for services provided to you at a Tier 2 ambulatory surgical center (in-network). Your plan's network providers who provide these services are grouped into different tiers. These benefits and services can be identified with separate cost-shares based on the provider's "Tier". Please see the Evidence of Coverage for more details.

Cost	2024 (this year)	2025 (next year)
Outpatient surgery - hospital outpatient facilities	You pay a $0 copayment for a diagnostic colonoscopy. You pay a $390 copayment otherwise (in-network).	You pay a $0 copayment for a diagnostic colonoscopy. You pay a $275 copayment otherwise (in-network).
Outpatient surgery - hospital outpatient observation services	You pay a $390 copayment (in-network).	You pay a $275 copayment (in-network).
Over-the-counter (OTC) credit	Covered	Not covered
Passport	Covered.	The following are changes in service area for the 2025 UnitedHealth Passport® benefit: Removal of Counties: **California:** Alameda, Amador, Contra Costa, El Dorado, Kings, Lake, Madera, Marin, Mendocino, Merced, Napa, Placer, Sacramento, San Benito, San Francisco, San Joaquin, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Yolo **Massachusetts:** Barnstable, Berkshire, Dukes, Nantucket **Minnesota:** Renville **North Carolina:** Carteret **North Dakota:** Stark, Ward, Williams **Vermont:** All counties in the state

Cost	2024 (this year)	2025 (next year)
		Addition of Counties: **Idaho:** Bear Lake, Benewah, Caribou, Clearwater, Custer, Franklin, Fremont, Lemhi, Lewis, Oneida, Teton **Illinois:** Effingham, Gallatin, Hardin, Johnson, Massac, Pope, Pulaski, Saline **Michigan:** Alcona, Allegan, Arenac, Charlevoix, Emmet, Huron, Iosco, Mecosta, Montcalm, Ogemaw, Ottawa, Roscommon, St. Joseph **Mississippi:** Grenada, Lamar **North Carolina:** New Hanover **Oklahoma:** Ellis, Harper, Washington, Woodward **Oregon:** Hood River **Utah:** Beaver, Emery, Garfield, Juab, Kane, Millard, San Juan **Washington:** Clallam, Jefferson, Mason
Physician/practitioner services, including doctor's office visits - primary care provider	You pay a $0 copayment from a Tier 1 provider (in-network). You pay a $20 copayment from a Tier 2 provider (in-network).	You pay a $0 copayment (in-network).
Urgently needed services	You pay a $40 copayment for each visit.	You pay a $45 copayment for each visit.

Cost	2024 (this year)	2025 (next year)
Vision care Additional routine eyewear	You pay a $0 copayment for standard lenses and receive up to $250 toward your purchase of frames or contact lenses through a network provider every year. Limited to 1 pair of standard lenses and frames every year. or Contact lenses instead of lenses and frames every year. Home-delivered eyewear is available nationwide through network providers (select products only). You are responsible for all costs for eyewear not purchased from a network provider.	You pay a $0 copayment for standard lenses or a copayment ranging from $40 to $153 for other covered lenses and receive up to $200 toward your purchase of frames or contact lenses through a network provider every 2 years. Limited to 1 pair of lenses and frames every 2 years. or Contact lenses instead of lenses and frames every 2 years. Home-delivered eyewear is available nationwide through network providers (select products only). You are responsible for all costs for eyewear not purchased from a network provider.

Section 1.5 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 (**myAARPMedicare.com**).

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

Starting in 2025, we may immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we may decide to keep the brand name drug or original biological product on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month's supply of your brand name drug or biological product at a network pharmacy. If you are taking the brand name drug or biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of the drug types that are discussed throughout this chapter, please see Chapter 12 of your Evidence of Coverage. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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. If you receive "Extra Help" you will receive a LIS Rider. If you don't receive it, please call Customer Service and ask for the "LIS Rider" to be sent to you.

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly (Part D) Deductible stage During this stage, **you pay the full cost** of your Tier 3, Tier 4 and Tier 5 drugs until you have reached the yearly deductible. The deductible does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	The deductible is $395. During this stage, you pay $0 for drugs on Tier 1 (in-network standard retail 30-day supply), $12 for drugs on Tier 2 (in-network standard retail 30-day supply), and the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.	The deductible is $570. During this stage, you pay $0 for drugs on Tier 1 (in-network standard retail 30-day supply), $14 for drugs on Tier 2 (in-network standard retail 30-day supply), and the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (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 chart are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your **Evidence of Coverage.** We changed the tier for some of the drugs on our Drug List. To see if your	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 - Preferred Generic**: You pay $0 per prescription. **Tier 2 - Generic:** You pay $12 per prescription. **Tier 3 - Preferred Brand:** You pay $47 per prescription. You pay $35 per month supply of each covered	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 - Preferred Generic:** You pay $0 per prescription. **Tier 2 - Generic:** You pay $14 per prescription. **Tier 3 - Preferred Brand:** You pay $47 per prescription. You pay $35 per month supply of each covered

Stage	2024 (this year)	2025 (next year)
drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you.	insulin product on this tier[1]. **Tier 4 - Non-Preferred Drug:** You pay $100 per prescription. **Tier 5 - Specialty Tier:** You pay 27% of the total cost. Your cost for a one-month mail-order prescription is 27%. ——— Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap stage).	insulin product on this tier[1]. **Tier 4 - Non-Preferred Drug[2]:** You pay $100 per prescription. Your cost for a one-month mail-order prescription is $100. **Tier 5 - Specialty Tier:** You pay 26% of the total cost. Your cost for a one-month mail-order prescription is 26%. ——— Once you have paid $2,000 out-of-pocket for Medicare-covered Part D drugs, you will move to the next stage (the Catastrophic Coverage stage).

[1] You will pay a maximum of $35 in 2024 and 2025 for each 1-month supply of Part D covered insulin drugs through all drug payment stages, except the 2025 Catastrophic drug payment stage, where you pay $0.

[2] In 2025, prescriptions on Tier 4 of the Formulary are limited to a one-month supply at both retail and mail-order pharmacies.

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage stage, you pay nothing for your Medicare-covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your **Evidence of Coverage**.

Section 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year (January – December)**. To learn more about this payment option, please contact us at 1-866-870-9604 or visit Medicare.gov.
Rewards administration	Rewards did not expire 1 month after your plan ended.	Rewards expire 1 month after your plan ends.

Section 3 Deciding Which Plan to Choose

Section 3.1 If You Want to Stay in AARP® Medicare Advantage from UHC NY-0013 (PPO)

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 AARP® Medicare Advantage from UHC NY-0013 (PPO).

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 plans for 2025 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the **Medicare & You 2025 handbook,** call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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 AARP® Medicare Advantage from UHC NY-0013 (PPO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from AARP® Medicare Advantage from UHC NY-0013 (PPO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll or visit our website to disenroll online. Contact Customer Service if you need more information on how to do so.
  - **– 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.

Section 4 Deadline for 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, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2025, 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Section 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York, the SHIP is called New York Health Insurance Information Counseling and Assistance Program (HIICAP).

It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. New York Health Insurance Information Counseling and Assistance Program (HIICAP) 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 New York Health Insurance Information Counseling and Assistance Program (HIICAP) at 1-800-701-0501.

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.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, 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 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office.

- **Help from your state's pharmaceutical assistance program.** New York has a program called New York State EPIC Program 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.
- **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. To be eligible for the ADAP operating in your State, 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, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, please contact the ADAP in your state. You can find your state's ADAP contact information in Chapter 2 of the **Evidence of Coverage.** Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-866-870-9604 or visit Medicare.gov.

Section 7 Questions?

Section 7.1 Getting Help from AARP® Medicare Advantage from UHC NY-0013 (PPO)

Questions? We're here to help. Please call Customer Service at 1-866-870-9604. (TTY only, call 711.) We are available for phone calls 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. Calls to these numbers are free.

Read your 2025 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 2025. For details, look in the 2025 **Evidence of Coverage** for AARP® Medicare Advantage from UHC NY-0013 (PPO). 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 **myAARPMedicare.com**. 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 **myAARPMedicare.com**. 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read Medicare & You 2025

Read the **Medicare & You 2025** handbook. Every fall, this document 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 document, you can get it at the Medicare website (medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, please call us using the toll-free number on your member identification card. Someone who speaks your language can help you. This is a free service.

Spanish: Contamos con servicios gratuitos de intérprete para responder cualquier pregunta que pudiera tener sobre nuestro plan de salud o de medicamentos. Para obtener los servicios de un intérprete, llámenos al número de teléfono gratuito que figura en su tarjeta de identificación de miembro. Una persona que habla su idioma podrá ayudarle. Es un servicio gratuito.

Chinese Mandarin: 我们提供免费口译服务，解答您对我们的健康或药物计划的任何疑问。如需寻找一名口译员，请使用您的会员身份证上的免费电话号码联系我们。一名与您讲相同语言的人可以为您提供帮助。这是一项免费服务。

Chinese Cantonese: 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打您的會員識別卡上的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

Tagalog: Mayroon kaming libreng serbisyo ng interpreter para sagutin anumang tanong na maaaring mayroon ka tungkol sa kalusugan o plano ng gamot. Para makakuha ng interpreter, pakitawagan kami gamit ang libreng numero sa iyong kard ng pagkakakilanlan ng kasapi. Sinumang nagsasalita ng wika mo ay puwedeng makatulong sa iyo. Ang serbisyong ito ay libre.

French: Nous disposons de services d’interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser sur notre régime d’assurance maladie ou d’assurance-médicaments. Pour recevoir l’aide d’un interprète, veuillez nous appeler en composant le numéro gratuit figurant sur votre carte d’identification de membre. Quelqu’un parlant votre langue peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi mà bạn có về chương trình sức khoẻ hay thuốc của chúng tôi. Để gặp thông dịch viên, vui lòng gọi cho chúng tôi theo số điện thoại miễn phí trên thẻ nhận dạng thành viên của bạn. Người nói cùng ngôn ngữ với bạn có thể giúp bạn. Đây là dịch vụ miễn phí.

German: Wir verfügen über kostenlose Dolmetscherdienste, um alle Fragen zu beantworten, die Sie über unseren Gesundheits- oder Medikamentenplan haben mögen. Um einen Dolmetscher zu erhalten, rufen Sie uns bitte unter der kostenfreien Nummer auf Ihrem Mitgliedsausweis an. Jemand, der Ihre Sprache spricht, kann Ihnen helfen. Dies ist eine kostenlose Dienstleistung.

Korean: 건강 또는 의약품 플랜에 관한 질문에 답변해드리기 위해 무료 통역 서비스를 제공합니다. 통역 서비스를 이용하려면, 가입자 ID 카드에 있는 수신자 부담 전화번호로 전화해 주십시오. 한국어를 사용하는 통역사가 도움을 드릴 수 있습니다. 이 서비스는 무료입니다.

Russian: Если у Вас возникнут какие-либо вопросы о нашем плане медицинского страхования или плане по приобретению препаратов, мы предоставим Вам бесплатные услуги устного перевода. Для того чтобы воспользоваться услугами устного перевода, пожалуйста, свяжитесь с нами по бесплатному номеру телефона, указанному на Вашей идентификационной карте участника плана. Сотрудник, который говорит на Вашем языке, сможет Вам помочь. Данная услуга предоставляется бесплатно.

Arabic: لدينا خدمات ترجمة فورية للرد على أي أسئلة قد تكون لديك حول الخطة الصحية أو خطة الأدوية الخاصة بنا. للحصول على مترجم، اتصل بنا باستخدام رقم الهاتف المجاني على بطاقة تعريف عضويتك. سيساعدك شخص ما يتحدث لغتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा प्लान के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं मौजूद हैं। दुभाषिया पाने के लिए, कृपया अपने सदस्य पहचान पत्र पर टोल-फ्री नंबर का उपयोग करके हमें कॉल करें। आपकी भाषा बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Italian: Mettiamo a disposizione un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per avvalersi di un interprete, si prega di chiamare il numero verde riportato sulla tessera identificativa. Una persona che parla italiano potrà fornire l’assistenza richiesta. Il servizio è gratuito.

Portuguese: Dispomos de serviços de intérprete gratuitos para esclarecer quaisquer dúvidas que tenha sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número gratuito no seu cartão de identificação de membro. Alguém que fala a sua língua pode ajudá-lo(a). Este é um serviço gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou gendwa genyen konsènan plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, tanpri rele nou apati nimewo apèl gratis ki sou kat idantifikasyon kòm manm ou an. Yon moun ki pale lang ou ka ede ou. Sa se yon sèvis gratis.

Polish: Oferujemy bezpłatne usługi tłumaczeniowe, aby odpowiedzieć na wszelkie pytania dotyczące naszego planu ubezpieczenia zdrowotnego lub planu refundacji leków. Aby skorzystać z pomocy tłumacza, proszę zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej członka planu. Osoba posługująca się Pana/Pani językiem Panu/Pani pomoże. Usługa ta jest bezpłatna.

Japanese: 当社の医療または処方薬プランに関する質問にお答えするために、無料の通訳サービスをご利用いただけます。通訳が必要な場合には、会員IDカードに記載されているフリーダイヤル番号を使用して、当社までお問い合わせください。お客様の言語を話す通訳者がお手伝いいたします。これは無料のサービスです。

For more information, please call customer service at:

AARP® Medicare Advantage from UHC NY-0013 (PPO) Customer Service:

Call **1-866-870-9604**

Calls to this number are free. 8 a.m.-8 p.m.: 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.
8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

Write: **P.O. Box 30770**
Salt Lake City, UT 84130-0770

myAARPMedicare.com

AANY25LP0231099_000