

# Summary of Benefits 2021

Medicare Advantage Plan  
with Prescription Drugs

**AARP Medicare Advantage Plan 1 (HMO-POS)**  
H5253-104-000

Look inside to take advantage of the health services and drug coverages the plan provides.  
Call Customer Service or go online for more information about the plan.



**Toll-free 1-844-723-6473, TTY 711**  
8 a.m. - 8 p.m. local time, 7 days a week



**[www.AARPMedicarePlans.com](http://www.AARPMedicarePlans.com)**

**AARP** | Medicare Advantage  
from  **UnitedHealthcare**

# Summary of Benefits

## January 1st, 2021 - December 31st, 2021

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at [www.AARPMedicarePlans.com](http://www.AARPMedicarePlans.com) or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

### About this plan.

AARP Medicare Advantage Plan 1 (HMO-POS) is a Medicare Advantage HMOPOS plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed below, and be a United States citizen or lawfully present in the United States.

Our service area includes these counties in:

**North Carolina:** Franklin, Granville, Harnett, Lee, Nash, Sampson, Vance, Wayne, Wilson.

### Use network providers and pharmacies.

AARP Medicare Advantage Plan 1 (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network. With this plan, you have the freedom to enjoy nationwide access to care at in-network costs when you visit any provider participating in the UnitedHealthcare® Medicare National Network (exclusions may apply). If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to [www.AARPMedicarePlans.com](http://www.AARPMedicarePlans.com) to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

# AARP Medicare Advantage Plan 1 (HMO-POS)

## Premiums and Benefits

|                                                                       | In-Network                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Monthly Plan Premium                                                  | \$48                                                                                                                                                                                                                                                                                                                                                                                                 |
| Annual Medical Deductible                                             | This plan does not have a deductible.                                                                                                                                                                                                                                                                                                                                                                |
| Maximum Out-of-Pocket Amount<br>(does not include prescription drugs) | <p>\$4,900 annually for Medicare-covered services you receive from in-network providers.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and share of the cost for your Part D prescription drugs.</p> |

# AARP Medicare Advantage Plan 1 (HMO-POS)

## Benefits

|                                                                                                 |                                                       | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Hospital<sup>2</sup></b>                                                           |                                                       | \$345 copay per day: for days 1-5<br>\$0 copay per day: for days 6 and beyond<br>Our plan covers an unlimited number of days for an inpatient hospital stay.                                                                                                                                                                                                                                                                                                                           |
| <b>Outpatient Hospital</b><br><br>Cost sharing for additional plan covered services will apply. | Ambulatory Surgical Center (ASC) <sup>2</sup>         | \$0 copay for a diagnostic colonoscopy<br>\$195 copay otherwise (designated as Type 1 in the Provider Directory)                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                 | Outpatient Hospital, including surgery <sup>2</sup>   | \$0 copay for a diagnostic colonoscopy<br>\$295 copay otherwise (designated as Type 2 in the Provider Directory)                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                 | Outpatient Hospital Observation Services <sup>2</sup> | \$295 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Doctor Visits</b>                                                                            | Primary Care Provider                                 | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                 | Specialists <sup>2</sup>                              | \$35 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                 | Virtual Medical Visits                                | \$0 copay; Speak to network telehealth providers using your computer or mobile device.                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Preventive Care</b>                                                                          | Medicare-covered                                      | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                 |                                                       | Abdominal aortic aneurysm screening<br>Alcohol misuse counseling<br>Annual "Wellness" visit<br>Bone mass measurement<br>Breast cancer screening (mammogram)<br>Cardiovascular disease (behavioral therapy)<br>Cardiovascular screening<br>Cervical and vaginal cancer screening<br>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>Depression screening<br>Diabetes screenings and monitoring<br>Hepatitis C screening<br>HIV screening |

## Benefits

|                                                                 |                                                       | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-----------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                 |                                                       | <p>Lung cancer with low dose computed tomography (LDCT) screening</p> <p>Medical nutrition therapy services</p> <p>Medicare Diabetes Prevention Program (MDPP)</p> <p>Obesity screenings and counseling</p> <p>Prostate cancer screenings (PSA)</p> <p>Sexually transmitted infections screenings and counseling</p> <p>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</p> <p>Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</p> <p>“Welcome to Medicare” preventive visit (one-time)</p> |
|                                                                 |                                                       | <p>Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.</p>                                                                                                                                                                                                                                                                                                                                         |
|                                                                 | Routine physical                                      | \$0 copay; 1 per year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Emergency Care</b>                                           |                                                       | <p>\$90 copay (\$0 copay for worldwide coverage) per visit</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See the “Inpatient Hospital” section of this booklet for other costs.</p>                                                                                                                                                                                                                                                                                             |
| <b>Urgently Needed Services</b>                                 |                                                       | <p>\$30 - \$40 copay</p> <p>(\$0 copay for worldwide coverage)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b> | Diagnostic radiology services (e.g. MRI) <sup>2</sup> | <p>\$0 copay for each diagnostic mammogram</p> <p>\$110 copay otherwise</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                 | Lab services <sup>2</sup>                             | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                 | Diagnostic tests and procedures <sup>2</sup>          | \$20 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                 | Therapeutic Radiology <sup>2</sup>                    | \$60 copay per service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                 | Outpatient X-rays <sup>2</sup>                        | \$15 copay per service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

## Benefits

|                                                                              |                                                                            | In-Network                                                                                                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hearing Services</b>                                                      | Exam to diagnose and treat hearing and balance issues <sup>2</sup>         | \$0 copay                                                                                                                                         |
|                                                                              | Routine hearing exam                                                       | \$0 copay; 1 per year                                                                                                                             |
|                                                                              | Hearing aid <sup>2</sup>                                                   | \$375 - \$2,075 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every 2 years.                         |
| <b>Routine Dental Benefits</b><br><br>Covered in-network and out-of-network. | Preventive                                                                 | \$0 copay for exams, cleanings, x-rays, and fluoride *                                                                                            |
|                                                                              | Comprehensive <sup>2</sup>                                                 | \$0 copay or 50% coinsurance for comprehensive dental services *                                                                                  |
|                                                                              | Benefit limit                                                              | \$1,000 limit on all covered dental services *                                                                                                    |
| <b>Vision Services</b>                                                       | Exam to diagnose and treat diseases and conditions of the eye <sup>2</sup> | \$0 copay                                                                                                                                         |
|                                                                              | Eyewear after cataract surgery                                             | \$0 copay                                                                                                                                         |
|                                                                              | Routine eye exam                                                           | \$0 copay; 1 every year                                                                                                                           |
|                                                                              | Eyewear                                                                    | \$0 copay every 2 years; up to \$200 for frames or contact lenses. Standard single, bifocal, trifocal, or progressive lenses are covered in full. |
| <b>Mental Health</b>                                                         | Inpatient visit <sup>2</sup>                                               | \$345 copay per day: for days 1-5<br>\$0 copay per day: for days 6-90<br>Our plan covers 90 days for an inpatient hospital stay.                  |
|                                                                              | Outpatient group therapy visit <sup>2</sup>                                | \$15 copay                                                                                                                                        |
|                                                                              | Outpatient individual therapy visit <sup>2</sup>                           | \$25 copay                                                                                                                                        |
|                                                                              | Virtual Mental Health Visits                                               | \$0 copay; Speak to network telehealth providers using your computer or mobile device.                                                            |

## Benefits

|                                                                                                                        |                                 | In-Network                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Skilled Nursing Facility (SNF)<sup>2</sup></b>                                                                      |                                 | \$0 copay per day: for days 1-20<br>\$184 copay per day: for days 21-47<br>\$0 copay per day: for days 48-100<br><br>Our plan covers up to 100 days in a SNF. |
| <b>Physical therapy and speech and language therapy visit<sup>2</sup></b>                                              |                                 | \$35 copay                                                                                                                                                    |
| <b>Ambulance<sup>2</sup></b><br><br>Your provider must obtain prior authorization for non-emergency transportation.    |                                 | \$250 copay for ground<br>\$250 copay for air                                                                                                                 |
| <b>Routine Transportation</b>                                                                                          |                                 | \$0 copay; 24 one-way trips per year to or from approved locations                                                                                            |
| <b>Medicare Part B Drugs</b><br><br>Part B Drugs may be subject to Step Therapy. See Evidence of Coverage for details. | Chemotherapy drugs <sup>2</sup> | 20% coinsurance                                                                                                                                               |
|                                                                                                                        | Other Part B drugs <sup>2</sup> | 20% coinsurance                                                                                                                                               |

## Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                 |                      |                      |                      |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------|----------------------|
| <b>Stage 1: Annual Prescription (Part D) Deductible</b>                         | \$0 per year for Tier 1, Tier 2 and Tier 3; \$95 for Tier 4 and Tier 5 Part D prescription drugs.                                                                                                                                                                                                                                                               |                      |                      |                      |
| <b>Stage 2: Initial Coverage (After you pay your deductible, if applicable)</b> | <b>Retail</b>                                                                                                                                                                                                                                                                                                                                                   |                      | <b>Mail Order</b>    |                      |
|                                                                                 | <b>Standard</b>                                                                                                                                                                                                                                                                                                                                                 |                      | <b>Preferred</b>     | <b>Standard</b>      |
|                                                                                 | <b>30-day supply</b>                                                                                                                                                                                                                                                                                                                                            | <b>90-day supply</b> | <b>90-day supply</b> | <b>90-day supply</b> |
| Tier 1: Preferred Generic Drugs                                                 | \$2 copay                                                                                                                                                                                                                                                                                                                                                       | \$4 copay            | \$0 copay            | \$6 copay            |
| Tier 2: Generic Drugs <sup>3</sup>                                              | \$8 copay                                                                                                                                                                                                                                                                                                                                                       | \$16 copay           | \$0 copay            | \$24 copay           |
| Tier 3: Preferred Brand Drugs                                                   | \$47 copay                                                                                                                                                                                                                                                                                                                                                      | \$141 copay          | \$131 copay          | \$141 copay          |
| Select Insulin Drugs <sup>4</sup>                                               | \$35 copay                                                                                                                                                                                                                                                                                                                                                      | \$105 copay          | \$95 copay           | \$105 copay          |
| Tier 4: Non-Preferred Drugs                                                     | \$100 copay                                                                                                                                                                                                                                                                                                                                                     | \$300 copay          | \$290 copay          | \$300 copay          |
| Tier 5: Specialty Tier Drugs                                                    | 31% coinsurance                                                                                                                                                                                                                                                                                                                                                 | N/A <sup>5</sup>     | N/A <sup>5</sup>     | N/A <sup>5</sup>     |
| <b>Stage 3: Coverage Gap Stage</b>                                              | After your total drug costs reach \$4,130, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.                                                                                                                                                                      |                      |                      |                      |
| <b>Stage 4: Catastrophic Coverage</b>                                           | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of: <ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$3.70 copay for generic (including brand drugs treated as generic) and a \$9.20 copay for all other drugs.</li> </ul> |                      |                      |                      |

<sup>3</sup> Tier includes enhanced drug coverage.

<sup>4</sup> For 2021, this plan participates in the Insulin Senior Savings Program which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of \$35 for a 1-month supply of covered insulin during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your covered insulin in the catastrophic stage. Your cost maybe less if you receive Extra Help from Medicare.

<sup>5</sup> Limited to a 30-day supply

## Additional Benefits

|                                                             |                                                                      | In-Network                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acupuncture</b>                                          | Medicare-covered acupuncture <sup>2</sup>                            | \$0 copay for services provided by a primary care physician<br>\$35 copay for services provided by a specialist                                                                                                                                                                                                                                                                      |
| <b>Chiropractic Care</b>                                    | Manual manipulation of the spine to correct subluxation <sup>2</sup> | \$20 copay                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Diabetes Management</b>                                  | Diabetes monitoring supplies <sup>2</sup>                            | <p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p> |
|                                                             | Diabetes Self-management training                                    | \$0 copay                                                                                                                                                                                                                                                                                                                                                                            |
|                                                             | Therapeutic shoes or inserts <sup>2</sup>                            | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Durable Medical Equipment (DME) and Related Supplies</b> | Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>2</sup>   | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                      |
|                                                             | Prosthetics (e.g., braces, artificial limbs) <sup>2</sup>            | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Fitness program through Renew Active™</b>                |                                                                      | Renew Active provides a standard gym membership with access to an extensive nationwide network of fitness locations nationwide, plus a personalized fitness plan, online fitness classes, and an online brain health program all at no cost to you.                                                                                                                                  |

## Additional Benefits

|                                                      |                                                  | In-Network                                                                                                                                                                                                          |
|------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Foot Care (podiatry services)</b>                 | Foot exams and treatment <sup>2</sup>            | \$35 copay                                                                                                                                                                                                          |
|                                                      | Routine foot care                                | \$35 copay; for each visit up to 6 visits every year                                                                                                                                                                |
| <b>Home Health Care<sup>2</sup></b>                  |                                                  | \$0 copay                                                                                                                                                                                                           |
| <b>Hospice</b>                                       |                                                  | You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.                |
| <b>NurseLine</b>                                     |                                                  | Speak with a registered nurse (RN) 24 hours a day, 7 days a week                                                                                                                                                    |
| <b>Occupational Therapy Visit<sup>2</sup></b>        |                                                  | \$35 copay                                                                                                                                                                                                          |
| <b>Opioid Treatment Program Services<sup>2</sup></b> |                                                  | \$0 copay                                                                                                                                                                                                           |
| <b>Outpatient Substance Abuse</b>                    | Outpatient group therapy visit <sup>2</sup>      | \$15 copay                                                                                                                                                                                                          |
|                                                      | Outpatient individual therapy visit <sup>2</sup> | \$25 copay                                                                                                                                                                                                          |
| <b>Over-the-Counter (OTC) Products Catalog</b>       |                                                  | \$50 credit per quarter to use on approved OTC products. Order online, over the phone, or by mail through your Health & Wellness Products Catalog.                                                                  |
| <b>Personal Emergency Response System</b>            |                                                  | Help is only a button press away. A PERS monitoring device that can help provide you with the confidence of knowing that in any emergency situation you can get help quickly, 24 hours a day at no additional cost. |
| <b>Renal Dialysis<sup>2</sup></b>                    |                                                  | 20% coinsurance                                                                                                                                                                                                     |

Services with a 2 may require your provider to obtain prior authorization from the plan for in-network benefits.

\*Benefits are combined in and out-of-network

# Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the Benefits

- ✓ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Call us or go online to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✓ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✓ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

## Understanding Important Rules

- ✓ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ✓ Benefits, premiums and/or copays/coinsurance may change on January 1 of each year.
- ✓ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

## Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies. A Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans 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. You do not need to be an AARP member to enroll in a Medicare Advantage or Prescription Drug Plan. AARP and its affiliates are not insurers. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy 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.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY: 711)。

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

Esta información esta disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la cobertura de este libro.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-877-266-4832, TTY 711.

Participation in the Renew Active™ program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership. Equipment, classes, personalized fitness plans, and events may vary by location.

Certain services, classes and events are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in AARP® Staying Sharp and the Fitbit® Community for Renew Active is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. The Renew Active program varies by plan/area.

The Nurseline service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.