

Benefit Highlights

AARP® Medicare Advantage from UHC DE-0001 (PPO)

This is a short description of your 2024 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

| Plan costs | | |
|--|--|---|
| Monthly plan premium | \$0 | |
| Medical benefits | | |
| | In-network | Out-of-network |
| Annual Medical Deductible | No deductible in or out-of-network | |
| Annual out-of-pocket maximum (The most you may pay in a year for covered medical care) | \$5,900 In-network | \$9,550 combined in and out-of-network |
| Doctor's office visit | | |
| Primary care provider (PCP) | \$0 copay | \$45 copay |
| Specialist | \$35 copay (no referral needed) | \$70 copay (no referral needed) |
| Virtual visits | \$0 copay to talk with a network telehealth provider online through live audio and video | |
| Preventive services | \$0 copay | \$0 copay - 40% coinsurance (depending on the service) |
| Inpatient hospital care | \$295 copay per day: days 1-6 \$0 copay per day: days 7 and beyond | \$500 copay per day: days 1-20 \$0 copay per day: days 21 and beyond |
| Skilled nursing facility (SNF) | \$0 copay per day: days 1-20 \$203 copay per day: days 21-100 | \$225 copay per day: days 1-43 \$0 copay per day: days 44-100 |

| Medical benefits | | |
|--|--|-------------------------------|
| | In-network | Out-of-network |
| Outpatient hospital, including surgery (Cost sharing for additional plan services will apply) | \$295 copay | 40% coinsurance |
| Outpatient mental health | | |
| Group therapy | \$15 copay | \$30 copay |
| Individual therapy | \$25 copay | \$40 copay |
| Virtual visits | \$0 copay to talk with a network telehealth provider online through live audio and video | |
| Diabetes monitoring supplies | \$0 copay for covered brands | 50% coinsurance |
| Diagnostic radiology services (such as MRIs, CT scans) | \$210 copay | 40% coinsurance |
| Diagnostic tests and procedures (non-radiological) | \$30 copay | 40% coinsurance |
| Lab services | \$0 copay | \$0 copay |
| Outpatient x-rays | \$15 copay | \$30 copay |
| Ambulance | \$275 copay for ground or air | \$275 copay for ground or air |
| Emergency care | \$120 copay (\$0 copay for emergency care outside the United States) per visit | |
| Urgently needed services | \$40 copay (\$0 copay for urgently needed services outside the United States) per visit | |

| Benefits and services beyond Original Medicare | | |
|--|---|------------------------------|
| | In-network | Out-of-network |
| Routine physical | \$0 copay, 1 per year* | 40% coinsurance, 1 per year* |
| Routine eye exams | \$0 copay, 1 per year* | \$70 copay, 1 per year* |
| Routine eyewear | \$0 copay Plan pays up to \$250 every year toward your purchase of frames (with standard lenses covered in full) or contact lenses (fitting) | |

Benefits and services beyond Original Medicare

| | In-network | Out-of-network |
|--------------------------------------|--|--|
| | and evaluation may be an additional cost) through UnitedHealthcare Vision.* | |
| | Home delivered eyewear available through UnitedHealthcare Vision (select products only). You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network. | |
| Dental - preventive | \$0 copay for exams, cleanings, X-rays, and fluoride* | \$0 copay for exams, cleanings, X-rays, and fluoride* |
| Dental - comprehensive | 50% coinsurance on dentures and bridges \$0 copay for all other covered comprehensive services* | 50% coinsurance on dentures and bridges \$0 copay for all other covered comprehensive services* |
| Dental - benefit limit | \$1,000 combined limit on all covered dental services* If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay | |
| Hearing - routine exam | \$0 copay, 1 per year* | \$70 copay, 1 per year* |
| Hearing aids | \$99 to \$1,249 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.* Includes hearing aids delivered directly to you with virtual follow-up care (select models). | |
| Fitness program | \$0 copay for Renew Active®, which includes a free gym membership, plus online fitness classes and brain health content. | |
| Foot care - routine | \$35 copay, 6 visits per year* | \$70 copay, 6 visits per year* |
| Over-the-counter (OTC) credit | \$40 credit every quarter to buy covered OTC products | |
| Meal benefit | \$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay. | |
| Nurse Hotline | Speak with a registered nurse (RN) 24 hours a day, 7 days a week. | |

*Benefits are combined in and out-of-network

Prescription drug payment stages

| | | |
|---------------------------------------|---|--|
| Annual Prescription Deductible | \$0 for Part D prescription drugs | |
| Initial Coverage | Standard Retail (30-day supply) | Preferred Mail Order (100-day supply) |
| Tier 1: Preferred Generic | \$0 copay | \$0 copay |
| Tier 2: Generic¹ | \$10 copay | \$0 copay |
| Tier 3: Preferred Brand | \$47 copay | \$131 copay |
| Tier 3: Covered Insulin Drugs | \$35 copay | \$95 copay |
| Tier 4: Non-Preferred Drug | \$100 copay | \$290 copay |
| Tier 5: Specialty Tier | 33% coinsurance | N/A ³ |
| Coverage Gap (Donut hole) | After your total drug cost reaches \$5,030, the plan continues to pay its share of the cost of your Tier 1 drugs and you pay your copay or coinsurance. For all other tiers, you pay 25% of the negotiated price for covered drugs. You may pay less if your plan has additional coverage in the gap. | |
| Catastrophic Coverage | After your total out-of-pocket drug cost reaches \$8,000, you won't pay anything for Medicare Part D covered drugs for the rest of the plan year. | |

¹ Tier includes enhanced drug coverage

³ Limited to a 30-day supply



This information is not a complete description of benefits. Contact the plan for more information.

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