

Benefit Highlights

AARP® Medicare Advantage from UHC NC-0013 (HMO-POS)

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 |
| Part B Premium Reduction | Up to \$50 |
| Medical benefits | |
| Annual Medical Deductible | No deductible |
| Annual out-of-pocket maximum (The most you may pay in a year for covered medical care) | \$8,300 |
| Doctor's office visit | |
| Primary care provider (PCP) | \$0 copay |
| Specialist | \$50 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 |
| Inpatient hospital care | \$430 copay per day: days 1-5 \$0 copay per day: days 6 and beyond |
| Skilled nursing facility (SNF) | \$0 copay per day: days 1-20 \$203 copay per day: days 21-100 |
| Outpatient hospital, including surgery (Cost sharing for additional plan services will apply) | \$430 copay |
| Outpatient mental health | |
| Group therapy | \$15 copay |
| Individual therapy | \$25 copay |

Medical benefits

| | |
|--|--|
| 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 |
| Diagnostic radiology services (such as MRIs, CT scans) | \$150 copay |
| Diagnostic tests and procedures (non-radiological) | \$45 copay |
| Lab services | \$0 copay |
| Outpatient x-rays | \$15 copay |
| Ambulance | \$290 copay for ground or air |
| Emergency care | \$100 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

| | |
|---|--|
| Routine physical | \$0 copay, 1 per year |
| Routine eye exams | \$0 copay, 1 per year |
| Routine eyewear | <p>\$0 copay Plan pays up to \$200 every year toward your purchase of frames (with standard lenses covered in full) or contact lenses (fitting and evaluation may be an additional cost) through UnitedHealthcare Vision.</p> <p>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.</p> |
| Dental - preventive (covered in-network and out-of-network) | <p>\$0 copay for exams, cleanings, X-rays, and fluoride*</p> <p>If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay</p> |
| Hearing - routine exam | \$0 copay, 1 per year |

Benefits and services beyond Original Medicare

| | |
|----------------------------|---|
| 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 | \$50 copay, 6 visits per year |
| 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 Tier 1 and Tier 2 Part D prescription drugs; \$435 for Tier 3, Tier 4, Tier 5 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 | \$0 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 | 26% 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. | |

Prescription drug payment stages

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

Optional riders available – See the Summary of Benefits or Evidence of Coverage for information



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

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