

# Benefit Highlights

## AARP® Medicare Advantage from UHC VA-0007 (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)	\$7,500 In-network	\$10,000 combined in and out-of-network
Doctor's office visit		
Primary care provider (PCP)	\$0 copay	\$0 copay
Specialist	\$50 copay (no referral needed)	\$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	\$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	\$410 copay per day: days 1-7 \$0 copay per day: days 8 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 1-45 \$0 copay per day: days 46-100

Medical benefits		
	In-network	Out-of-network
<b>Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)</b>	\$295 copay	\$410 copay
<b>Outpatient mental health</b>		
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	
<b>Diabetes monitoring supplies</b>	\$0 copay for covered brands	50% coinsurance
<b>Diagnostic radiology services (such as MRIs, CT scans)</b>	\$225 copay	40% coinsurance
<b>Diagnostic tests and procedures (non-radiological)</b>	\$45 copay	40% coinsurance
<b>Lab services</b>	\$0 copay	\$0 copay
<b>Outpatient x-rays</b>	\$15 copay	\$30 copay
<b>Ambulance</b>	\$290 copay for ground or air	\$290 copay for ground or air
<b>Emergency care</b>	\$100 copay (\$0 copay for emergency care outside the United States) per visit	
<b>Urgently needed services</b>	\$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
<b>Routine physical</b>	\$0 copay, 1 per year*	40% coinsurance, 1 per year*
<b>Routine eye exams</b>	\$0 copay, 1 per year*	\$50 copay, 1 per year*
<b>Routine eyewear</b>	\$0 copay Plan pays up to \$250 every 2 years toward your purchase of frames (with standard lenses covered in full) or contact lenses	

## Benefits and services beyond Original Medicare

	In-network	Out-of-network
	(fitting 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.	
<b>Dental - preventive</b>	\$0 copay for exams, cleanings, X-rays, and fluoride*	\$0 copay for exams, cleanings, X-rays, and fluoride* If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay
<b>Hearing - routine exam</b>	\$0 copay, 1 per year*	\$50 copay, 1 per year*
<b>Hearing aids</b>	\$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).	
<b>Fitness program</b>	\$0 copay for Renew Active®, which includes a free gym membership, plus online fitness classes and brain health content.	
<b>Foot care - routine</b>	\$50 copay, 6 visits per year*	\$50 copay, 6 visits per year*
<b>Over-the-counter (OTC) credit</b>	\$40 credit every quarter to buy covered OTC products	
<b>Meal benefit</b>	\$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay.	
<b>Nurse Hotline</b>	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

<b>Annual Prescription Deductible</b>	\$0 for Part D prescription drugs	
<b>Initial Coverage</b>	<b>Standard Retail (30-day supply)</b>	<b>Preferred Mail Order (100-day supply)</b>

## Prescription drug payment stages

<b>Tier 1: Preferred Generic</b>	\$0 copay	\$0 copay
<b>Tier 2: Generic<sup>1</sup></b>	\$14 copay	\$0 copay
<b>Tier 3: Preferred Brand</b>	\$47 copay	\$131 copay
<b>Tier 3: Covered Insulin Drugs</b>	\$35 copay	\$95 copay
<b>Tier 4: Non-Preferred Drug</b>	\$100 copay	\$290 copay
<b>Tier 5: Specialty Tier</b>	33% coinsurance	N/A <sup>3</sup>
<b>Coverage Gap (Donut hole)</b>	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.	
<b>Catastrophic Coverage</b>	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.	

<sup>1</sup> Tier includes enhanced drug coverage

<sup>3</sup> 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.

Y0066\_MABH\_2024\_M H2577027000

AAVA24LP0131332\_000