

# Benefit Highlights

## AARP® Medicare Advantage from UHC TC-0002 (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
Medical benefits	
Annual Medical Deductible	No deductible
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	\$3,500
<b>Doctor's office visit</b>	
Primary care provider (PCP)	\$0 copay
Specialist	\$30 copay (no referral needed)
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
<b>Preventive services</b>	\$0 copay
<b>Inpatient hospital care</b>	\$250 copay per day: days 1-5 \$0 copay per day: days 6 and beyond
<b>Skilled nursing facility (SNF)</b>	\$0 copay per day: days 1-20 \$203 copay per day: days 21-100
<b>Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)</b>	\$250 copay
<b>Outpatient mental health</b>	
Group therapy	\$15 copay
Individual therapy	\$25 copay
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video

## Medical benefits

<b>Diabetes monitoring supplies</b>	\$0 copay for covered brands
<b>Diagnostic radiology services (such as MRIs, CT scans)</b>	\$110 copay
<b>Diagnostic tests and procedures (non-radiological)</b>	\$45 copay
<b>Lab services</b>	\$0 copay
<b>Outpatient x-rays</b>	\$15 copay
<b>Ambulance</b>	\$290 copay for ground or air
<b>Emergency care</b>	\$135 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

<b>Routine physical</b>	\$0 copay, 1 per year
<b>Routine eye exams</b>	\$0 copay, 1 per year
<b>Routine eyewear</b>	<p>\$0 copay Plan pays up to \$250 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>
<b>Dental - preventive (covered in-network and out-of-network)</b>	\$0 copay for exams, cleanings, X-rays, and fluoride*
<b>Dental - comprehensive (covered in-network and out-of-network)</b>	50% coinsurance on dentures and bridges \$0 copay for all other covered comprehensive services*

## Benefits and services beyond Original Medicare

<b>Dental - benefit limit</b>	\$2,500 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
<b>Hearing - routine exam</b>	\$0 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>Personal emergency response system</b>	\$0 copay for a personal emergency response system (PERS)
<b>Foot care - routine</b>	\$30 copay, 6 visits per year
<b>Over-the-counter (OTC) credit</b>	\$100 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>
<b>Tier 1: Preferred Generic</b>	\$0 copay	\$0 copay
<b>Tier 2: Generic<sup>1</sup></b>	\$8 copay	\$0 copay
<b>Tier 3: Preferred Brand</b>	\$45 copay	\$125 copay

## Prescription drug payment stages

### Tier 3: Covered Insulin Drugs

\$35 copay

\$95 copay

### Tier 4: Non-Preferred Drug

\$95 copay

\$275 copay

### Tier 5: Specialty Tier

33% coinsurance

N/A<sup>3</sup>

### 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.

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

<sup>3</sup> Limited to a 30-day supply