

# Benefit Highlights

## AARP® Medicare Advantage from UHC VA-0011 (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)	\$5,900
--	---------

### Doctor's office visit

Primary care provider (PCP)	\$0 copay
-----------------------------	-----------

Specialist	\$35 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	\$295 copay per day: days 1-6 \$0 copay per day: days 7 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)	\$295 copay
---	-------------

### Outpatient mental health

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>	\$160 copay
<b>Diagnostic tests and procedures (non-radiological)</b>	\$50 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>	\$120 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 2 years 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>	\$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
<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>Foot care - routine</b>	\$35 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>
<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

## Prescription drug payment stages

### Tier 4: Non-Preferred Drug

\$100 copay

\$290 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