

# Benefit Highlights

## AARP® Medicare Advantage (HMO-POS)

This is a short description of your 2020 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	\$29
----------------------	------

### Medical Benefits

	In-Network	Out-of-Network
Annual out-of-pocket maximum (The most you may pay in a year for medical care covered by the plan)	\$4,500 In-Network	Unlimited Out-of-Network
Doctor's office visit	Primary Care Provider: \$10 copay	Primary Care Provider: No coverage
	Specialist: \$50 copay (no referral needed)	Specialist: No coverage
Preventive services	\$0 copay	Flu shots: \$0 copay All other services: No coverage
Inpatient hospital care	\$320 copay per day: for days 1-5 \$0 copay per day for unlimited days after that	No coverage
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$160 copay per day: days 21-49 \$0 copay per day: days 50-100	No coverage
Outpatient hospital, including surgery	\$0 - \$295 copay Cost sharing for additional plan covered services will apply.	No coverage
Diabetes monitoring supplies	\$0 copay for covered brands	No coverage
Home health care	\$0 copay	No coverage
Diagnostic radiology services (such as MRIs, CT scans)	\$0 - \$110 copay	No coverage
Diagnostic tests and procedures (non-radiological)	\$25 copay	No coverage
Lab services	\$10 copay	No coverage
Outpatient x-rays	\$14 copay	No coverage
Ambulance	\$275 copay for ground \$275 copay for air	\$275 copay for ground \$275 copay for air

## Medical Benefits

	In-Network	Out-of-Network
Emergency care	\$90 copay (worldwide)	
Urgently needed services	\$30 - \$40 copay (\$90 copay for worldwide coverage)	

## Benefits and Services Beyond Original Medicare

	In-Network	Out-of-Network
Routine physical	\$0 copay; 1 per year	No coverage
Vision - routine eye exams	\$0 copay; 1 every year	No coverage
Vision - eyewear	\$0 copay every 2 years; up to \$200 for lenses/frames and contacts	No coverage
Dental - preventive	\$0 copay for exams, cleanings, x-rays, and fluoride*	\$0 copay for exams, cleanings, x-rays, and fluoride*
Dental - comprehensive	\$0 copay for comprehensive dental services*	\$0 copay for comprehensive dental services*
Dental - benefit limit	\$500 limit on all covered dental services	
Hearing - routine exam	\$0 copay; 1 per year	No coverage
Hearing aids	\$375 - \$2,075 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every 2 years.	No coverage
Fitness program through Renew Active™	Standard membership to participating fitness locations with access to group fitness classes – depending on availability. Programs such as: online brain exercises, activities and an in-person fitness orientation at no cost to you. For the complete details about the program, please visit <a href="http://www.UHCRenewActive.com">www.UHCRenewActive.com</a> , and click the link in the footer entitled Terms and Conditions.	
Foot care - routine	\$50 copay; 6 visits per year	No coverage
Health & Wellness Products Catalog	\$40 credit per quarter to use on approved health products. Order online at Walmart.com, over the phone, or by mail.	
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Medical Visits	Speak to network telehealth providers using your computer or mobile device. Find participating doctors online at <a href="http://amwell.com">amwell.com</a>	No coverage

\*Benefits combined in and out-of-network

## Prescription Drugs

Your Cost		
Annual prescription deductible	\$0 for Tier 1, Tier 2 and Tier 3; \$245 for Tier 4 and Tier 5	
Initial coverage stage	Standard Retail (30-day)	Preferred Mail Order (90-day)
Tier 1: Preferred Generic Drugs	\$4 copay	\$0 copay
Tier 2: Generic Drugs	\$12 copay	\$0 copay
Tier 3: Preferred Brand Drugs	\$47 copay	\$131 copay
Tier 4: Non-Preferred Drugs	\$100 copay	\$290 copay
Tier 5: Specialty Tier Drugs	28% coinsurance	28% coinsurance
Coverage gap stage	After your total drug costs reach \$4,020, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap	
Catastrophic coverage stage	After your total out-of-pocket costs reach \$6,350, you will pay the greater of \$3.60 copay for generic (Including brand drugs treated as generic), \$8.95 copay for all other drugs, or 5% coinsurance	

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

**AARP** | Medicare Advantage  
from UnitedHealthcare

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. This information is not a complete description of benefits. Contact the plan for more information.