# Benefit Highlights

## AARP® Medicare Advantage from UHC IA-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** | $39 |

| **Medical benefits** | |
|---|---|
| **Annual Medical Deductible** | No deductible |
| **Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)** | $3,400 |
| **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** | $325 copay per day: days 1-5<br>$0 copay per day: days 6 and beyond |
| **Skilled nursing facility (SNF)** | $0 copay per day: days 1-20<br>$203 copay per day: days 21-100 |
| **Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)** | $325 copay |
| **Outpatient mental health** | |
| Group therapy | $0 copay |
| Individual therapy | $0 copay |
| Virtual visits | $0 copay to talk with a network telehealth provider online through live audio and video |

| Medical benefits | |
|---|---|
| **Diabetes monitoring supplies** | $0 copay for covered brands |
| **Diagnostic radiology services (such as MRIs, CT scans)** | $140 copay |
| **Diagnostic tests and procedures (non-radiological)** | $50 copay |
| **Lab services** | $0 copay |
| **Outpatient x-rays** | $15 copay |
| **Ambulance** | $290 copay for ground or air |
| **Emergency care** | $135 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** | $0 copay<br>Plan pays up to $300 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.<br><br>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. |
| **Dental - preventive (covered in-network and out-of-network)** | $0 copay for exams, cleanings, X-rays, and fluoride* |
| **Dental - comprehensive (covered in-network and out-of-network)** | 50% coinsurance on dentures and bridges<br>$0 copay for all other covered comprehensive services* |

| Benefits and services beyond Original Medicare | |
|---|---|
| **Dental - benefit limit** | $1,000 combined limit on all covered dental services*<br>If you choose to see an out-of-network dentist you might be billed more, even for services listed as $0 copay |
| **Hearing - routine exam** | $0 copay, 1 per year |
| **Hearing aids** | $99 to $1,249 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.<br><br>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. |
| **Personal emergency response system** | $0 copay for a personal emergency response system (PERS) |
| **Foot care - routine** | $35 copay, 6 visits per year |
| **Over-the-counter (OTC) credit** | $40 credit every quarter to buy covered OTC products |
| **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 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: Generic[1]** | $10 copay | $0 copay |
| **Tier 3: Preferred Brand** | $47 copay | $131 copay |

| Prescription drug payment stages | | |
|---|---|---|
| **Tier 3: Covered Insulin Drugs** | $35 copay | $95 copay |
| **Tier 4: Non-Preferred Drug** | $100 copay | $290 copay |
| **Tier 5: Specialty Tier** | 33% 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. | |
| **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

AARP | Medicare Advantage
from UnitedHealthcare

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