

# Benefit Highlights

## AARP® Medicare Advantage Choice (PPO)

This is a short description of your 2023 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

### Plan costs

<b>Monthly plan premium</b>	\$0
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### Medical benefits

	In-network	Out-of-network
<b>Annual Medical Deductible</b>	No deductible	
<b>Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)</b>	\$7,550 In-network	\$10,000 combined in and out-of-network
<b>Doctor's office visit</b>		
Primary care provider (PCP)	\$0 copay	\$0 copay
Specialist	\$35 copay (no referral needed)	\$40 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	\$0 copay - 40% coinsurance (depending on the service)
<b>Inpatient hospital care</b>	\$390 copay per day: days 1-5 \$0 copay per day: days 6 and beyond	\$390 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 \$196 copay per day: days 21-59 \$0 copay per day: days 60-100	\$225 copay per day: days 1-45
<b>Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)</b>	\$345 copay	40% coinsurance
<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	

## Medical benefits

	In-network	Out-of-network
<b>Diabetes monitoring supplies</b>	\$0 copay for covered brands	50% coinsurance
<b>Diagnostic radiology services (such as MRIs, CT scans)</b>	\$150 copay	40% coinsurance
<b>Diagnostic tests and procedures (non-radiological)</b>	\$40 copay	40% coinsurance
<b>Lab services</b>	\$0 copay	\$0 copay
<b>Outpatient x-rays</b>	\$30 copay	\$30 copay
<b>Ambulance</b>	\$235 copay for ground or air	\$235 copay for ground or air
<b>Emergency care</b>	\$90 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*	\$40 copay, 1 per year*
<b>Routine eyewear</b>	<p>\$0 copay Plan pays up to \$100 every year for frames or contact lenses through UnitedHealthcare Vision. Standard single, bifocal, trifocal, or progressive lenses are covered in full.*</p> <p>Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only).</p>	
<b>Dental - preventive</b>	\$0 copay for exams, cleanings, X-rays, and fluoride*	\$0 copay for exams, cleanings, X-rays, and fluoride*
<b>Dental - comprehensive</b>	\$0 copay for comprehensive dental services*	\$0 copay for comprehensive dental services*
<b>Dental - benefit limit</b>	<p>\$500 combined limit on all covered dental services*</p> <p>If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay</p>	
<b>Hearing - routine exam</b>	\$0 copay, 1 per year*	\$40 copay, 1 per year*
<b>Hearing aids</b>	<p>\$175 - \$1,225 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.*</p> <p>Includes hearing aids delivered directly to you with virtual follow-up care (select models).</p>	

	In-network	Out-of-network
<b>Fitness program</b>	\$0 copay for Renew Active, which includes a free gym membership, plus online fitness classes and brain health challenges.	
<b>Foot care - routine</b>	\$35 copay, 6 visits per year*	\$40 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>NurseLine</b>	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.	

\*Benefits combined in and out-of-network

## Prescription drugs

	Your cost	
<b>Annual prescription (Part D) deductible</b>	\$0	
<b>Initial coverage stage</b>	<b>Standard Retail (30-day)</b>	<b>Preferred Mail Order (100-day)</b>
<b>Tier 1: Preferred Generic</b>	\$0 copay	\$0 copay
<b>Tier 2: Generic<sup>1</sup></b>	\$12 copay	\$0 copay
<b>Tier 3: Preferred Brand</b>	\$45 copay	\$125 copay
<b>Select insulin drugs<sup>2</sup></b>	\$35 copay	\$95 copay
<b>Tier 4: Non-Preferred Drug</b>	\$95 copay	\$275 copay
<b>Tier 5: Specialty Tier</b>	33% coinsurance	N/A <sup>3</sup>
<b>Coverage gap stage</b>	Tier 1 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach \$4,660, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap	
<b>Catastrophic coverage stage</b>	After your total out-of-pocket costs reach \$7,400, you will pay the greater of \$4.15 copay for generic (Including brand drugs treated as generic), \$10.35 copay for all other drugs, or 5% coinsurance	

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

<sup>2</sup> For 2023, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for select insulin through the different Part D benefit coverage stages. You will pay a maximum of \$35 for each 1-month supply of Part D select insulin drug through all coverage stages.

<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.

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