# Benefit highlights

## AARP® Medicare Advantage (HMO-POS)

This is a short description of your 2022 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

| | Your Cost |
|---|---|
| **Annual Medical Deductible** | No deductible |
| **Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)** | $3,900 In-Network |
| **Doctor's office visit** | Primary Care Provider: $0 copay |
| | Specialist: $20 copay (referral needed) |
| | Virtual visits: $0 copay; Speak to network telehealth providers using your computer or mobile device. |
| **Preventive services** | $0 copay |
| **Inpatient hospital care** | $325 copay per day: for days 1-5<br>$0 copay per day for unlimited days after that |
| **Skilled nursing facility (SNF)** | $0 copay per day: days 1-20<br>$188 copay per day: days 21-41<br>$0 copay per day: days 42-100 |
| **Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)** | $275 copay |
| **Mental health (outpatient and virtual)** | Group therapy: $15 copay |
| | Individual therapy: $25 copay |
| | Virtual visits: $0 copay; Speak to network telehealth providers using your computer or mobile device. |
| **Diabetes monitoring supplies** | $0 copay |
| **Diagnostic radiology services (such as MRIs, CT scans)** | $150 copay |
| **Diagnostic tests and procedures (non-radiological)** | $25 copay |
| **Lab services** | $0 copay |
| **Outpatient x-rays** | $0 copay |
| **Ambulance** | $265 copay for ground or air |

## Medical Benefits

| | Your Cost |
|---|---|
| **Emergency care** | $90 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

| | Your Cost |
|---|---|
| **Routine physical** | $0 copay; 1 per year |
| **Routine eye exams** | $0 copay; 1 every year |
| **Routine eyewear** | $0 copay; up to $100 every year for frames or contact lenses through UnitedHealthcare Vision. Standard single, bifocal, trifocal, or progressive lenses are covered in full.<br><br>Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only). |
| **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)** | $0 copay for comprehensive dental services* |
| **Dental - benefit limit** | $1,500 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 |
| **Hearing - routine exam** | $0 copay; 1 per year |
| **Hearing aids** | $375 - $1,425 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every year.<br><br>Includes hearing aids delivered directly to you with virtual follow-up care through Right2You (select models), offered only by UnitedHealthcare Hearing. |
| **Fitness program** | Renew Active fitness membership, classes and online brain exercises at no cost to you. |
| **Foot care - routine** | $20 copay; 6 visits per year |
| **Over-the-Counter (OTC) Products Catalog** | $45 credit every quarter to use on approved over-the-counter products. |
| **Meal Benefit** | $0 copay; Meals provided 1 time per calendar year immediately after an inpatient hospital or skilled nursing facility stay. |

| | Your Cost |
|---|---|
| **NurseLine** | 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 | |
|---|---|---|
| **Annual prescription (Part D) deductible** | $0 | |
| **Initial coverage stage** | **Standard Retail (30-day)** | **Preferred Mail Order (100-day)** |
| **Tier 1: Preferred Generic** | $0 copay | $0 copay |
| **Tier 2: Generic**[1] | $10 copay | $0 copay |
| **Tier 3: Preferred Brand** | $47 copay | $131 copay |
| **Select Insulin Drugs**[2] | $35 copay | $95 copay |
| **Tier 4: Non-Preferred Drug** | $100 copay | $290 copay |
| **Tier 5: Specialty Tier** | 33% coinsurance | N/A[3] |
| **Coverage gap stage** | Tier 1 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach $4,430, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap | |
| **Catastrophic coverage stage** | After your total out-of-pocket costs reach $7,050, you will pay the greater of $3.95 copay for generic (Including brand drugs treated as generic), $9.85 copay for all other drugs, or 5% coinsurance | |

[1] Tier includes enhanced drug coverage

[2] For 2022, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for a 1-month supply of Part D select insulin drugs during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your insulin in the catastrophic stage. This cost-sharing only applies to members who do not qualify for a program that helps pay for your drugs (“Extra Help”).

[3] Limited to a 30-day supply