

Benefit highlights

AARP® Medicare Advantage Choice (PPO)

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

| | In-Network | Out-of-Network |
|---|--|---|
| Annual Medical Deductible | No deductible | |
| Annual out-of-pocket maximum (The most you may pay in a year for covered medical care) | \$6,700 In-Network | \$11,300 combined In and Out-of-Network |
| Doctor's office visit | Primary Care Provider: \$0 copay | Primary Care Provider: \$25 copay |
| | Specialist: \$35 copay (no referral needed) | Specialist: \$65 copay (no referral needed) |
| | Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device. | |
| Preventive services | \$0 copay | \$0 copay - 40% coinsurance (depending on the service) |
| Inpatient hospital care | \$325 copay per day: for days 1-6 \$0 copay per day for unlimited days after that | \$475 copay per day: for days 1-22 \$0 copay per day for unlimited days after that |
| Skilled nursing facility (SNF) | \$0 copay per day: days 1-20 \$188 copay per day: days 21-56 \$0 copay per day: days 57-100 | \$225 copay per day: days 1-51 \$0 copay per day: days 52-100 |
| Outpatient hospital, including surgery (Cost sharing for additional plan services will apply) | \$325 copay | 40% coinsurance |
| Mental health (outpatient and virtual) | Group therapy: \$15 copay | Group therapy: \$30 copay |
| | Individual therapy: \$25 copay | Individual therapy: \$40 copay |
| | Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device. | |
| Diabetes monitoring supplies | \$0 copay for covered brands | 50% coinsurance |

Medical Benefits

| | In-Network | Out-of-Network |
|---|---|-------------------------------|
| Diagnostic radiology services (such as MRIs, CT scans) | \$150 copay | 40% coinsurance |
| Diagnostic tests and procedures (non-radiological) | \$25 copay | 40% coinsurance |
| Lab services | \$0 copay | \$0 copay |
| Outpatient x-rays | \$15 copay | \$20 copay |
| Ambulance | \$265 copay for ground or air | \$265 copay for ground or air |
| 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

| | In-Network | Out-of-Network |
|-------------------------------|--|---|
| Routine physical | \$0 copay; 1 per year* | 40% coinsurance; 1 per year* |
| Routine eye exams | \$0 copay; 1 every year* | \$65 copay; 1 every year* |
| Routine eyewear | <p>\$0 copay; up to \$100 every 2 years 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> | |
| 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 | <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> | |
| Hearing - routine exam | \$0 copay; 1 per year* | \$65 copay; 1 per year* |
| Hearing aids | <p>\$375 - \$1,425 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every year.*</p> <p>Includes hearing aids delivered directly to you with virtual follow-up care through Right2You (select models), offered only by UnitedHealthcare Hearing.</p> | |
| Fitness program | Renew Active fitness membership, classes and online brain exercises at no cost to you. | |
| Foot care - routine | \$35 copay; 6 visits per year* | \$65 copay; 6 visits per year* |

| | In-Network | Out-of-Network |
|--|---|----------------|
| Over-the-Counter (OTC) Products Catalog | \$40 credit every quarter to use on approved over-the-counter products. | |
| 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 for Tier 1 and Tier 2; \$260 for Tier 3, Tier 4, Tier 5 | |
| Initial coverage stage | Standard Retail (30-day) | Preferred Mail Order (100-day) |
| Tier 1: Preferred Generic | \$3 copay | \$0 copay |
| Tier 2: Generic¹ | \$14 copay | \$0 copay |
| Tier 3: Preferred Brand | \$47 copay | \$131 copay |
| Select Insulin Drugs² | \$35 copay | \$95 copay |
| Tier 4: Non-Preferred Drug | \$100 copay | \$290 copay |
| Tier 5: Specialty Tier | 28% 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

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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