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

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)	$4,900 In-network	$8,950 combined in and out-of-network
Doctor's office visit		
Primary care provider (PCP)	$0 copay	$45 copay
Specialist	$35 copay (no referral needed)	$70 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	$0 copay - 40% coinsurance (depending on the service)
Inpatient hospital care	$275 copay per day: days 1-4 $0 copay per day: days 5 and beyond	40% coinsurance per stay for unlimited days
Skilled nursing facility (SNF)	$0 copay per day: days 1-20 $196 copay per day: days 21-45 $0 copay per day: days 46-100	$225 copay per day: days 1-40 $0 copay per day: days 41-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	$250 copay	40% coinsurance
Outpatient mental health		
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
Diabetes monitoring supplies	$0 copay for covered brands	50% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	$110 copay	40% coinsurance
Diagnostic tests and procedures (non-radiological)	$20 copay	40% coinsurance
Lab services	$0 copay	$0 copay
Outpatient x-rays	$15 copay	$20 copay
Ambulance	$250 copay for ground or air	$250 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 per year*	$70 copay, 1 per year*
Routine eyewear	$0 copay Plan pays up to $200 every year for frames or contact lenses through UnitedHealthcare Vision. Standard single, bifocal, trifocal, or progressive lenses are covered in full.* Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only).	
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	$1,000 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*	$70 copay, 1 per year*
Hearing aids	$175 - $1,225 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.* Includes hearing aids delivered directly to you with virtual follow-up care (select models).	

	In-network	Out-of-network
Fitness program	$0 copay for Renew Active, which includes a free gym membership, plus online fitness classes and brain health challenges.	
Foot care - routine	$35 copay, 6 visits per year*	$70 copay, 6 visits per year*
Over-the-counter (OTC) credit	$45 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.	
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	$45 copay	$125 copay
Select insulin drugs[2]	$35 copay	$95 copay
Tier 4: Non-Preferred Drug	$95 copay	$275 copay
Tier 5: Specialty Tier	33% coinsurance	N/A[3]
Coverage gap stage	Tier 1 and Tier 2 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	
Catastrophic coverage stage	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	

[1] Tier includes enhanced drug coverage

[2] 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.

[3] Limited to a 30-day supply

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