

# Benefit Highlights

## AARP® Medicare Advantage Flex (HMO-POS)

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
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### 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)	\$6,700
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	\$195 copay per day: days 1-5 \$0 copay per day: days 6 and beyond
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$196 copay per day: days 21-55 \$0 copay per day: days 56-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	\$195 copay
Outpatient mental health	
Group therapy	\$15 copay
Individual therapy	\$25 copay
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
Diabetes monitoring supplies	\$0 copay for covered brands
Diagnostic radiology services (such as MRIs, CT scans)	\$135 copay

## Medical benefits

	Your cost
<b>Diagnostic tests and procedures (non-radiological)</b>	\$30 copay
<b>Lab services</b>	\$0 copay
<b>Outpatient x-rays</b>	\$15 copay
<b>Ambulance</b>	\$250 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

	Your cost
<b>Routine physical</b>	\$0 copay, 1 per year
<b>Routine eye exams</b>	\$0 copay, 1 per year
<b>Routine eyewear</b>	<p>\$0 copay</p> <p>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 (covered in-network and out-of-network)</b>	\$0 copay for exams, cleanings, X-rays, and fluoride*
<b>Dental - comprehensive (covered in-network and out-of-network)</b>	\$0 copay for comprehensive dental services*
<b>Dental - benefit limit</b>	<p>\$1,000 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
<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>
<b>Fitness program</b>	\$0 copay for Renew Active, which includes a free gym membership, plus online fitness classes and brain health challenges.

	Your cost
<b>Routine transportation</b>	\$0 copay for 24 one-way trips to or from approved medically related appointments and pharmacies
<b>Foot care - routine</b>	\$35 copay, 6 visits per year
<b>Over-the-counter (OTC) credit</b>	\$50 credit every quarter to buy covered OTC products
<b>Flex benefit</b>	\$200 on a prepaid Visa® card to help pay for covered dental, vision and hearing services
<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>	\$10 copay	\$0 copay
<b>Tier 3: Preferred Brand</b>	\$47 copay	\$131 copay
<b>Select insulin drugs<sup>2</sup></b>	\$35 copay	\$95 copay
<b>Tier 4: Non-Preferred Drug</b>	\$100 copay	\$290 copay
<b>Tier 5: Specialty Tier</b>	33% coinsurance	N/A <sup>3</sup>
<b>Coverage gap stage</b>	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	
<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



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