Summary of Benefits 2020

Overview of your plan

AARP® Medicare Advantage SecureHorizons® Plan 1 (HMO)

H0543-070-000

Look inside to take advantage of the health services and drug coverages the plan provides. Call Customer Service or go online for more information about the plan.

Toll-free **1-844-723-6473**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.AARPMedicarePlans.com

AARP® | Medicare Advantage from UnitedHealthcare

Y0066_SB_H0543_070_000_2020_M

Summary of Benefits

January 1st, 2020 - December 31st, 2020

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.AARPMedicarePlans.com or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

About this plan.

AARP® Medicare Advantage SecureHorizons® Plan 1 (HMO) is a Medicare Advantage HMO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed below, and be a United States citizen or lawfully present in the United States.

Our service area includes these counties in:

California: Alameda, Contra Costa.

Use network providers and pharmacies.

AARP® Medicare Advantage SecureHorizons® Plan 1 (HMO) has a network of doctors, hospitals, pharmacies, and other providers. This health plan requires you to select a primary care provider (PCP) from the network. Your PCP can handle most routine health care needs and will be responsible to coordinate your care. If you need to see a network specialist or other network provider, you may need to get a referral from your PCP. We encourage you to find out which specialists and hospitals your primary care provider would recommend for you and would refer you to for care, prior to selecting them as your plan's PCP. If you use providers or pharmacies that are not in our network, the plan may not pay for those services or drugs, or you may pay more than you pay at a network pharmacy.

You can go to www.AARPMedicarePlans.com to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

AARP® Medicare Advantage SecureHorizons® Plan 1 (HMO)

Premiums and Benefits	In-Network
Monthly Plan Premium	$107
Annual Medical Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Amount (does not include prescription drugs)	$6,700 annually for Medicare-covered services you receive from in-network providers.
	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and share of the cost for your Part D prescription drugs.

AARP® Medicare Advantage SecureHorizons® Plan 1 (HMO)

Benefits		In-Network
Inpatient Hospital[1,2]		$390 copay per day: for days 1-5 $0 copay per day: for days 6 and beyond
		Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC)[1,2]	$0 copay for a diagnostic colonoscopy $370 copay otherwise
	Outpatient Hospital, including surgery[1,2]	$0 copay for a diagnostic colonoscopy $370 copay otherwise
	Outpatient Hospital Observation Services[1,2]	$370 copay
Doctor Visits	Primary	$10 copay
	Specialists[1,2]	$15 copay
	Virtual Medical Visits	Speak to network telehealth providers using your computer or mobile device. Find participating doctors online at www.amwell.com
Preventive Care	Medicare-covered	$0 copay
		Abdominal aortic aneurysm screening Alcohol misuse counseling Annual “Wellness” visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screening Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screening Diabetes screenings and monitoring Hepatitis C screening HIV screening

Benefits		In-Network
		Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy services Medicare Diabetes Prevention Program (MDPP) Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including flu shots, hepatitis B shots, pneumococcal shots "Welcome to Medicare" preventive visit (one-time)
		Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.
	Routine physical	$0 copay; 1 per year
Emergency Care		$90 copay (worldwide) per visit If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services		$40 copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)[1,2]	$0 copay for each diagnostic mammogram $105 copay per service otherwise
	Lab services[1,2]	$0 copay
	Diagnostic tests and procedures[1,2]	$0 copay
	Therapeutic Radiology[1,2]	$60 copay per service
	Outpatient X-rays[1,2]	$15 copay per service

Benefits		In-Network
Hearing Services	Exam to diagnose and treat hearing and balance issues[1,2]	$0 copay
	Routine hearing exam	$0 copay; 1 per year
	Hearing aid[2]	$375 - $2,075 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every 2 years.
Routine Dental Services		Additional dental benefits available with a separate premium. Please see optional benefits section below for details.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye[1,2]	$0 copay
	Eyewear after cataract surgery[1]	$0 copay
	Routine eye exam	$0 copay; 1 every year
	Eyewear	$0 copay every 2 years; up to $100 for frames and contact lenses. Standard (single, bifocal, trifocal, or progressive) lenses are covered in full.
Mental Health	Inpatient visit[1,2]	$390 copay per day: for days 1-4 $0 copay per day: for days 5-90
		Our plan covers 90 days for an inpatient hospital stay.
	Outpatient group therapy visit[1,2]	$30 copay
	Outpatient individual therapy visit[1,2]	$40 copay
Skilled Nursing Facility (SNF)[1,2]		$0 copay per day: for days 1-20 $160 copay per day: for days 21-62 $0 copay per day: for days 63-100
		Our plan covers up to 100 days in a SNF.
Physical therapy and speech and language therapy visit[1,2]		$15 copay

Benefits		In-Network
Ambulance[1,2] Your provider must obtain prior authorization for non-emergency transportation. Referral is required for non-emergency transportation.		$250 copay for ground $250 copay for air
Routine Transportation		Not covered
Medicare Part B Drugs	Chemotherapy drugs[2]	20% coinsurance
	Other Part B drugs[2]	20% coinsurance

Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

Stage 1: Annual Prescription Deductible	$0 per year for Tier 1 and Tier 2; $350 for Tier 3, Tier 4 and Tier 5 Part D prescription drugs.			
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail**		**Mail Order**	
	Standard		**Preferred**	**Standard**
	30-day supply	**90-day supply**	**90-day supply**	**90-day supply**
Tier 1: Preferred Generic Drugs	$3 copay	$9 copay	$0 copay	$9 copay
Tier 2: Generic Drugs	$12 copay	$36 copay	$12 copay	$36 copay
Tier 3: Preferred Brand Drugs	$47 copay	$141 copay	$131 copay	$141 copay
Tier 4: Non-Preferred Drugs	$100 copay	$300 copay	$290 copay	$300 copay
Tier 5: Specialty Tier Drugs	26% coinsurance	26% coinsurance	26% coinsurance	26% coinsurance
Stage 3: Coverage Gap Stage	After your total drug costs reach $4,020, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.			
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of: • 5% coinsurance, or • $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copay for all other drugs.			

Additional Benefits		In-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation[1,2]	$15 copay
Diabetes Management	Diabetes monitoring supplies[2]	$0 copay
	Diabetes Self-management training	$0 copay
	Therapeutic shoes or inserts[2]	20% coinsurance
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[2]	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs)[2]	20% coinsurance
Foot Care (podiatry services)	Foot exams and treatment[1,2]	$15 copay
	Routine foot care	$15 copay; for each visit up to 6 visits every year
Home Health Care[1,2]		$0 copay
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
NurseLine		Speak with a registered nurse (RN) 24 hours a day, 7 days a week
Occupational Therapy Visit[1,2]		$15 copay
Opioid Treatment Services		$0 copay

Additional Benefits		In-Network
Outpatient Substance Abuse	Outpatient group therapy visit[1,2]	$30 copay
	Outpatient individual therapy visit[1,2]	$40 copay
Renal Dialysis[1,2]		20% coinsurance

Services with a 1 may require a referral from your doctor.

Services with a 2 may require your provider to obtain prior authorization from the plan.

Optional Supplemental Benefits

Premiums and Benefits		In-Network
Platinum Dental Rider	Premium	Additional $43.00 per month
	Description	The Platinum Dental Rider includes preventive and comprehensive dental benefits.
Optional Dental Rider	Premium	Additional $2.50 per month
	Description	The Optional Dental Rider includes diagnostic and preventive services, including basic and major dental services at fixed copays.
High Option Dental Rider	Premium	Additional $12.50 per month
	Description	The High Option Dental Rider includes diagnostic and preventive services, including basic and major dental services at fixed copays.

Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies. A Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. You do not need to be an AARP member to enroll in a Medicare Advantage or Prescription Drug Plan. AARP and its affiliates are not insurers. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語　援助服 務。請致電 1-855-814-6894（TTY：711).

This information is available for free in other languages. Please call our customer service number located on the first page of this book.

Esta información esta disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la cobertura de este libro.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-877-266-4832, TTY 711.

The Nurseline service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Call us or go online to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copays/coinsurance may change on January 1 of each year.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).