

# Summary of Benefits 2020



## Overview of your plan

**AARP® Medicare Advantage Value (HMO-POS)**

H5253-072-000

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](http://www.AARPMedicarePlans.com)**

**AARP®** | Medicare Advantage  
from UnitedHealthcare

# Summary of Benefits

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## 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](http://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 Value (HMO-POS) is a Medicare Advantage HMOPOS 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:

**Wisconsin:** Lincoln, Marathon, Oneida, Portage, Wood.

### Use network providers and pharmacies.

AARP® Medicare Advantage Value (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to [www.AARPMedicarePlans.com](http://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 Value (HMO-POS)

Premiums and Benefits	In-Network	Out-of-Network
<b>Monthly Plan Premium</b>	There is no monthly premium for this plan.	
<b>Annual Medical Deductible</b>	This plan does not have a deductible.	
<b>Maximum Out-of-Pocket Amount (does not include prescription drugs)</b>	\$6,400 annually for Medicare-covered services you receive from in-network providers.	Unlimited Out-of-Network
	<p>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.</p> <p>Please note that you will still need to pay your share of the cost for your Part D prescription drugs.</p>	

# AARP® Medicare Advantage Value (HMO-POS)

Benefits		In-Network	Out-of-Network
<b>Inpatient Hospital<sup>2</sup></b>		\$295 copay per day: for days 1-6 \$0 copay per day: for days 7 and beyond Our plan covers an unlimited number of days for an inpatient hospital stay.	Not covered
<b>Outpatient Hospital</b>  Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC) <sup>2</sup>	\$0 copay for a diagnostic colonoscopy \$275 copay otherwise	Not covered
	Outpatient Hospital, including surgery <sup>2</sup>	\$0 copay for a diagnostic colonoscopy \$275 copay otherwise	Not covered
	Outpatient Hospital Observation Services <sup>2</sup>	\$275 copay	Not covered
<b>Doctor Visits</b>	Primary	\$15 copay	Not covered
	Specialists <sup>2</sup>	\$50 copay	Not covered
	Virtual Medical Visits	Speak to network telehealth providers using your computer or mobile device. Find participating doctors online at <a href="http://www.amwell.com">www.amwell.com</a>	Not covered
<b>Preventive Care</b>	Medicare-covered	\$0 copay	Flu shots: \$0 copay All other services: Not covered
		Abdominal aortic aneurysm screening Alcohol misuse counseling Annual "Wellness" visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screening	

<b>Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
		<p>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            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)</p> <hr/> <p>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.</p>	
	Routine physical	\$0 copay; 1 per year	Not covered
<b>Emergency Care</b>		\$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.	
<b>Urgently Needed Services</b>		\$30 - \$40 copay	

<b>Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b>	Diagnostic radiology services (e.g. MRI) <sup>2</sup>	\$0 copay for each diagnostic mammogram \$160 copay per service otherwise	Not covered
	Lab services <sup>2</sup>	\$10 copay	Not covered
	Diagnostic tests and procedures <sup>2</sup>	\$25 copay	Not covered
	Therapeutic Radiology <sup>2</sup>	\$60 copay per service	Not covered
	Outpatient X-rays <sup>2</sup>	\$14 copay per service	Not covered
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues <sup>2</sup>	\$0 copay	Not covered
	Routine hearing exam	\$0 copay; 1 per year	Not covered
	Hearing aid <sup>2</sup>	\$375 - \$2,075 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every 2 years.	Not covered
<b>Routine Dental Services</b>	Optional Dental Rider	Additional dental benefits available with a separate premium. Please see optional benefits section below for details.	
	Preventive	\$0 copay for exams, cleanings, x-rays, and fluoride*	\$0 copay for exams, cleanings, x-rays, and fluoride*
	Comprehensive <sup>2</sup>	\$0 copay for comprehensive dental services*	\$0 copay for comprehensive dental services*
	Benefit limit	\$500 limit on all covered dental services	

<b>Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye <sup>2</sup>	\$0 copay	Not covered
	Eyewear after cataract surgery	\$0 copay	Not covered
	Routine eye exam	\$0 copay; 1 every year	Not covered
	Eyewear	\$0 copay every 2 years; up to \$100 for lenses/frames and contacts	Not covered
<b>Mental Health</b>	Inpatient visit <sup>2</sup>	\$295 copay per day: for days 1-5 \$0 copay per day: for days 6-90 Our plan covers 90 days for an inpatient hospital stay.	Not covered
	Outpatient group therapy visit <sup>2</sup>	\$15 copay	Not covered
	Outpatient individual therapy visit <sup>2</sup>	\$20 copay	Not covered
<b>Skilled Nursing Facility (SNF)<sup>2</sup></b>		\$0 copay per day: for days 1-20 \$160 copay per day: for days 21-60 \$0 copay per day: for days 61-100  Our plan covers up to 100 days in a SNF.	Not covered
<b>Physical therapy and speech and language therapy visit<sup>2</sup></b>		\$40 copay	Not covered
<b>Ambulance<sup>2</sup></b>  Your provider must obtain prior authorization for non-emergency transportation.		\$275 copay for ground \$275 copay for air	\$275 copay for ground \$275 copay for air

Benefits		In-Network	Out-of-Network
Routine Transportation		Not covered	
<b>Medicare Part B Drugs</b>	Chemotherapy drugs <sup>2</sup>	20% coinsurance	Not covered
Part B Drugs may be subject to Step Therapy. See Evidence of Coverage for details.	Other Part B drugs <sup>2</sup>	20% coinsurance	Not covered



## 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.

<b>Stage 1: Annual Prescription Deductible</b>	\$0 per year for Tier 1 and Tier 2; \$355 for Tier 3, Tier 4 and Tier 5 Part D prescription drugs.			
<b>Stage 2: Initial Coverage (After you pay your deductible, if applicable)</b>	<b>Retail</b>		<b>Mail Order</b>	
	<b>Standard</b>		<b>Preferred</b>	<b>Standard</b>
	<b>30-day supply</b>	<b>90-day supply</b>	<b>90-day supply</b>	<b>90-day supply</b>
Tier 1: Preferred Generic Drugs	\$4 copay	\$12 copay	\$0 copay	\$12 copay
Tier 2: Generic Drugs	\$14 copay	\$42 copay	\$0 copay	\$42 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
<b>Stage 3: Coverage Gap Stage</b>	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.			
<b>Stage 4: Catastrophic Coverage</b>	<p>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:</p> <ul style="list-style-type: none"> <li>□ 5% coinsurance, or</li> <li>□ \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copay for all other drugs.</li> </ul>			

<b>Additional Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Chiropractic Care</b>	Manual manipulation of the spine to correct subluxation <sup>2</sup>	\$20 copay	Not covered
<b>Diabetes Management</b>	Diabetes monitoring supplies <sup>2</sup>	\$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio® Flex, Accu-Chek® Guide Me, Accu-Chek® Guide, and Accu-Chek® Aviva Plus. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, Accu-Chek® SmartView, and Accu-Chek® Compact Plus. Other brands are not covered by your plan.	Not covered
	Diabetes Self-management training	\$0 copay	Not covered
	Therapeutic shoes or inserts <sup>2</sup>	20% coinsurance	Not covered
<b>Durable Medical Equipment (DME) and Related Supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>2</sup>	20% coinsurance	Not covered
	Prosthetics (e.g., braces, artificial limbs) <sup>2</sup>	20% coinsurance	Not covered

Additional Benefits		In-Network	Out-of-Network
<b>Fitness program through Renew Active™</b>		Standard membership to participating fitness locations with access to group fitness classes – depending on availability. Programs such as: online brain exercises, activities and an in-person fitness orientation at no cost to you. For the complete details about the program, please visit <a href="http://www.UHCRenewActive.com">www.UHCRenewActive.com</a> , and click the link in the footer entitled Terms and Conditions.	
<b>Foot Care (podiatry services)</b>	Foot exams and treatment <sup>2</sup>	\$50 copay	Not covered
	Routine foot care	\$50 copay; for each visit up to 6 visits every year	Not covered
<b>Home Health Care<sup>2</sup></b>		\$0 copay	Not covered
<b>Hospice</b>		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.	
<b>NurseLine</b>		Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
<b>Occupational Therapy Visit<sup>2</sup></b>		\$40 copay	Not covered
<b>Opioid Treatment Services</b>		\$0 copay	Not covered
<b>Outpatient Substance Abuse</b>	Outpatient group therapy visit <sup>2</sup>	\$15 copay	Not covered
	Outpatient individual therapy visit <sup>2</sup>	\$20 copay	Not covered
<b>UnitedHealth Passport®</b>		Allows you to access all the benefits you enjoy at home while you travel within the covered service area for up to nine consecutive months. You pay your in-network copay or coinsurance when you visit a participating provider for non-emergency care, including preventive care, specialist care and hospitalizations.	
<b>Renal Dialysis<sup>2</sup></b>		20% coinsurance	Not covered out-of-network (except in emergency situations).

Services with a 2 may require your provider to obtain prior authorization from the plan for in-network benefits.

\*Benefits are combined in and out-of-network

## Optional Supplemental Benefits

Premiums and Benefits		In-Network
Platinum Dental Rider	Premium	Additional \$36.00 per month
	Description	The Platinum Dental Rider includes preventive and comprehensive dental benefits.

## 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，您可以免費獲得語言援助服務。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.

Participation in the Renew Active™ program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership. Equipment, classes, personalized fitness plans, and events may vary by location.

Certain services, classes and events are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in AARP® Staying Sharp and the Fitbit® Community for Renew Active is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. The Renew Active program varies by plan/area.

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

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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. 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.
- ✓ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.