Benefit Highlights

AARP® MedicareComplete Choice® Plan 1 (PPO)

This is a short description of your 2019 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage.

Plan Costs

	Your Cost
Monthly plan premium	$0

Medical Benefits

	In-Network	Out-of-Network
Doctor's office visit	Primary Care Provider: $15 copay	Primary Care Provider: $40 copay
	Specialist: $50 copay (no referral needed)	Specialist: $70 copay (no referral needed)
Preventive services	$0 copay	$0 copay - 40% coinsurance (depending on the service)
Inpatient hospital care	$450 copay per day: for days 1-4 $0 copay per day for unlimited days after that	40% coinsurance per stay for unlimited days
Skilled nursing facility (SNF)	$0 copay per day: days 1-20 $160 copay per day: days 21-62 $0 copay per day: days 63-100	$195 copay per day: days 1-52 $0 copay per day: days 53-100
Outpatient surgery	20% coinsurance Cost sharing for additional plan covered services will apply.	40% coinsurance Cost sharing for additional plan covered services will apply.
Diabetes monitoring supplies	$0 copay for covered brands	40% coinsurance
Home health care	$0 copay	50% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	20% coinsurance	40% coinsurance
Diagnostic tests and procedures (non-radiological)	20% coinsurance	40% coinsurance
Lab services	$22 copay	$22 copay
Outpatient x-rays	$25 copay	$30 copay
Ambulance	$225 copay for ground $225 copay for air	$225 copay for ground $225 copay for air
Emergency care	$90 copay (worldwide)	
Urgently needed services	$30 - $40 copay ($90 copay for worldwide coverage)	

Medical Benefits

	In-Network	Out-of-Network
Annual out-of-pocket maximum (The most you may pay in a year for medical care covered by the plan)	$6,700 In-Network	$10,000 combined In and Out-of-Network

Benefits and Services Beyond Original Medicare

	In-Network	Out-of-Network
Routine physical	$0 copay; 1 per year*	40% coinsurance; 1 per year*
Vision - routine eye exams	$20 copay; 1 every year*	$70 copay; 1 every year*
Vision - eyewear	$0 copay every 2 years; up to $70 for lenses/frames and contacts*	$0 copay every 2 years; up to $70 for lenses/frames and contacts*
Hearing - routine exam	$15 copay; 1 per year*	$70 copay; 1 per year*
Hearing aids	$330 - $380 copay for each hearing aid provided through hi HealthInnovations®; up to 2 hearing aids per year.*	$330 - $380 copay for each hearing aid provided through hi HealthInnovations®; up to 2 hearing aids per year.*
Fitness program through SilverSneakers®	Membership in a fitness program at a network location or enrollment into a self-directed fitness program if a network location is not convenient.	
Solutions for Caregivers	$0 copay; Help from an experienced care manager who can support you in the care of a loved one, services available 24 hours a day, 7 days a week.	
Foot care - routine	$50 copay; 6 visits per year*	$70 copay; 6 visits per year*
Chiropractic care and Acupuncture	$10 copay; Combination of 18 chiropractic and acupuncture visits per year*	$70 copay; Combination of 18 chiropractic and acupuncture visits per year*
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 deductible	$0 for Tier 1 and Tier 2; $315 for Tier 3, Tier 4, Tier 5	
Initial coverage stage	Standard Retail (30-day)	Preferred Mail Order (90-day)
Tier 1: Preferred Generic Drugs	$3 copay	$0 copay
Tier 2: Generic Drugs	$12 copay	$0 copay
Tier 3: Preferred Brand Drugs	$45 copay	$125 copay
Tier 4: Non-Preferred Drugs	$95 copay	$275 copay

Prescription Drugs

	Your Cost	
Tier 5: Specialty Tier Drugs	26% coinsurance	26% coinsurance
Coverage gap stage	After your total drug costs reach $3,820, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap	
Catastrophic coverage stage	After your total out-of-pocket costs reach $5,100, you will pay the greater of $3.40 copay for generic (Including brand drugs treated as generic), $8.50 copay for all other drugs, or 5% coinsurance	

Optional riders available – See the Summary of Benefits or Evidence of Coverage for information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. This information is not a complete description of benefits. Contact the plan for more information. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.