# Summary of Benefits 2027

**AARP® Medicare Advantage from UHC MA-0006 (PPO)**

H8768-055-002

Look inside to learn more about the plan and the health and drug services it covers. Contact us for more information about the plan.

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

AARP® | Medicare Advantage from UnitedHealthcare®

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# Summary of Benefits

## January 1, 2027 - December 31, 2027

This is a summary of what we cover and what you pay. For a complete list of covered services, limitations and exclusions, review the Evidence of Coverage (EOC) at **myAARPMedicare.com** or call Customer Service for help. After you enroll in the plan, you will get more information on how to view your plan details online.

## AARP® Medicare Advantage from UHC MA-0006 (PPO)

| **Medical premium, deductible and limits** | | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **Monthly plan premium** | $75 | |
| **Annual medical deductible** | No deductible | Your medical deductible is $1,000 for covered medical services you receive from providers as described in the Plan Deductible chart later in this document. Until you have paid the deductible amount, you must pay the full cost of your covered medical services. |
| **Maximum out-of-pocket amount** (does not include prescription drugs) | $7,150<br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers. | $10,750<br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from any provider. |
| | If you reach this amount, you will still need to pay your monthly premiums. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount. | |

| **Medical benefits** | | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **Inpatient hospital care**[2]<br>Our plan covers an unlimited number of days for an inpatient hospital stay. | $685 copay per day: days 1-4<br>$0 copay per day: days 5 and beyond | 50% coinsurance per stay |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Outpatient hospital** Cost-sharing for additional plan covered services will apply. | Ambulatory surgical center (ASC)[2] | $0 copay for a colonoscopy<br>$635 copay otherwise | 50% coinsurance |
| | Outpatient hospital, including surgery[2] | $0 copay for a colonoscopy<br>$685 copay otherwise | 50% coinsurance |
| | Outpatient hospital observation services[2] | $685 copay | 50% coinsurance |
| **Doctor visits** | Primary care provider | $0 copay | $20 copay |
| | Specialists[2] | $70 copay | $100 copay |
| | Virtual medical visits | $0 copay | Same as a Doctor's office visit |
| **Preventive services** | Routine physical | $0 copay, 1 per year* | 50% coinsurance, 1 per year* |
| | Medicare-covered | $0 copay | $0 copay - 50% coinsurance (depending on the service) |

- 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
- 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 those for the flu, Hepatitis B, pneumonia, or COVID-19
- "Welcome to Medicare" preventive visit (one-time)

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | Any additional preventive services approved by Medicare during the contract year will be covered.<br>This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers. | | |
| **Emergency care** | | $130 copay per visit. If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency Care copay. See the "Inpatient Hospital Care" section of this booklet for other costs. | |
| **Urgently needed services** | | $50 copay per visit | |
| **Diagnostic tests, lab and radiology services, and X-rays** | Diagnostic radiology services (e.g. MRI, CT scan)[2] | $0 copay for each diagnostic mammogram<br>$320 copay otherwise | 50% coinsurance |
| | Lab services[2] | $0 copay | $0 copay |
| | Diagnostic tests and procedures[2] | $25 copay | 50% coinsurance |
| | Therapeutic radiology[2] | 20% coinsurance | 50% coinsurance |
| | Outpatient X-rays[2] | $30 copay | $50 copay |
| **Hearing services** | Exam to diagnose and treat hearing and balance issues[2] | $0 copay | $100 copay |
| | Routine hearing exam | $0 copay for a routine hearing exam to help support hearing health* | $100 copay for a routine hearing exam to help support hearing health* |
| | Hearing aids[2] | $700 allowance for 2 hearing aids every year*<br>• A broad selection of high-value and brand name prescription hearing aids<br>• Access to one of the largest national networks of hearing professionals with more than 6,500 locations<br>• 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period | If you use an out-of-network provider, you are responsible for 90% of the allowance amount.* |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Routine dental benefits** | Optional Dental Rider | For an extra $66 per month, you'll get access to dental coverage that includes:<br>• $1,500 per year for covered dental services through the Platinum Dental Rider*<br>• $0 copay for covered network preventative services such as exams, routine cleanings, X-rays and fluoride<br>• 50% coinsurance for all covered network comprehensive services such as fillings, crowns, root canals, dentures, bridges and extractions | |
| **Vision services** | Exam to diagnose and treat diseases and conditions of the eye[2] | $0 copay | $100 copay |
| | Eyewear after cataract surgery | $0 copay | $100 copay |
| | Routine eye exam | $0 copay for a routine eye exam each year to help protect your eyesight and health* | $100 copay for a routine eye exam each year to help protect your eyesight and health* |
| | Routine eyewear | $200 allowance every 2 years for 1 pair of eyeglasses (lenses and frames) or contacts*<br>• Access to one of Medicare Advantage's largest national networks of vision providers and retail providers<br>• Eyewear available from many online providers, including Warby Parker and GlassesUSA | If you use an out-of-network provider, you are responsible for 90% of the allowance amount* |
| **Mental health** | Inpatient visit[2]<br>Our plan covers 90 days for an inpatient hospital stay | $685 copay per day: days 1-3<br>$0 copay per day: days 4-90 | 50% coinsurance per stay |
| | Outpatient group therapy visit[2] | $15 copay | $30 copay |
| | Outpatient individual therapy visit[2] | $25 copay | $40 copay |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | Virtual mental health visits | $0 copay | Same as an Outpatient mental health office visit |
| **Skilled nursing facility (SNF)[2]**<br>Our plan covers up to 100 days in a SNF. | | $0 copay per day: days 1-20<br>$221 copay per day: days 21-100 | $250 copay per day: days 1-100 |
| **Outpatient rehabilitation services** | Physical therapy and speech and language therapy visit[2] | $70 copay | $100 copay |
| | Occupational Therapy Visit[2] | $50 copay | $100 copay |
| **Ambulance[2]**<br>Your provider must obtain prior authorization for non-emergency transportation. | | $275 copay for ground<br>$275 copay for air | $275 copay for ground<br>$275 copay for air |
| **Medicare Part B prescription drugs**<br>In-network cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | Chemotherapy drugs[2] | 20% coinsurance | 50% coinsurance |
| | Part B covered insulin[2] | 20% coinsurance; up to $35 | 50% coinsurance |
| | Other Part B drugs[2]<br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | $0 copay for allergy antigens<br>20% coinsurance for all others | $0 copay for allergy antigens<br>50% coinsurance for all others |

## What is coinsurance?

Coinsurance is a portion or part of the total cost, typically as a percentage. With this plan, you pay part of the cost of Tier 3, Tier 4 and Tier 5 drugs. For example, if your coinsurance is 25% and the total cost of your prescription is $100, you would pay $25. The plan pays the rest. You pay the full cost of your drugs until you meet the deductible, then you'll start paying the coinsurance amount.

| Prescription drug payment stages | |
|---|---|
| **Deductible** | There is no deductible for drugs in Tier 1 and 2. Your coverage for these drugs starts in the Initial Coverage stage.<br>There is a $685 deductible for drugs in Tier 3, 4 and 5. You pay the full cost for your drugs in these tiers until you reach the deductible amount. Then you move to the Initial Coverage stage. |
| **Initial Coverage** | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of |

| Prescription drug payment stages | | | | |
|---|---|---|---|---|
| | $2,400, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. | | | |
| **Tier drug coverage** | **Retail** | | **Mail Order** | |
| | **Standard** | | **Preferred** | **Standard** |
| | **30-day supply^** | **100-day supply** | **100-day supply** | **100-day supply** |
| **Tier 1:** Preferred Generic | $0 copay | $0 copay | $0 copay | $0 copay |
| **Tier 2:** Generic[3] | $8 copay | $24 copay | $0 copay | $24 copay |
| **Tier 3:** Preferred Brand | 19% coinsurance | 19% coinsurance | 19% coinsurance | 19% coinsurance |
| Covered Insulin Drugs[4] | 19% coinsurance, up to $35 copay | 19% coinsurance, up to $105 copay | 19% coinsurance, up to $105 copay | 19% coinsurance, up to $105 copay |
| **Tier 4:** Non-Preferred Drug[5] | 28% coinsurance | N/A | N/A | N/A |
| **Tier 5:** Specialty Tier[5] | 26% coinsurance | N/A | N/A | N/A |
| **Catastrophic Coverage** | Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year. | | | |
| **Additional covered drugs** These drugs are not covered by Medicare Part D and not on the plan's Drug List. | This plan covers these additional drugs as Tier 2 medications.<br>• Vitamin D (50,000)<br>• Sildenafil (generic Viagra)<br>• Cyanocobalamin (Vitamin B-12)<br>• Folic Acid (1 mg) | | | |

^Members living in long-term care facilities pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

[3]Tier includes enhanced drug coverage.

[4]You pay no more than 19% of the total drug cost or a $35 copay, whichever is lower, for each 1-month supply of Part D covered insulin drugs, even if you haven't paid your deductible, until you reach the Catastrophic Coverage stage where you pay $0.

[5]Limited to a 30-day supply

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Chiropractic services** | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[2] | $15 copay | $100 copay |

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Diabetes management** | Diabetes monitoring supplies[2] | $0 copay<br>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.<br>Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.<br>Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Check Aviva Plus. | 50% coinsurance |
| | Diabetes self-management training | $0 copay | 50% coinsurance |
| | Therapeutic shoes or inserts[2] | 30% coinsurance | 50% coinsurance |
| **Durable medical equipment (DME) and related supplies** | DME (e.g., wheelchairs, oxygen)[2] | 30% coinsurance | 50% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs)[2] | 30% coinsurance | 50% coinsurance |
| **Foot care** (podiatry services) | Foot exams and treatment[2] | $45 copay | $100 copay |
| | Routine foot care | $45 copay, 6 visits per year* | $100 copay, 6 visits per year* |
| **Home health care[2]** | | $0 copay | 50% coinsurance |
| **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. | |
| **Opioid treatment program services[2]** | | $0 copay | $0 copay |

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Outpatient substance use disorder services** | Outpatient group therapy visit[2] | $15 copay | $30 copay |
| | Outpatient individual therapy visit[2] | $25 copay | $40 copay |
| **Renal dialysis[2]** | | 20% coinsurance | 20% coinsurance |

[2] May require your provider to get prior authorization from the plan for in-network benefits.

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

| Optional supplemental benefits | |
|---|---|
| **Platinum Dental Rider premium** | Additional $66 per month<br><br>The Platinum Dental Rider includes preventive and comprehensive dental benefits. It can be purchased to replace any dental benefits that may already be offered within your Medicare Advantage Plan. |

## Member discounts



As a UnitedHealthcare Medicare Advantage plan member, you'll have access to a collection of discounts on hundreds of products and services. Once you're a member, you can sign in to your member site for a list of discounts available to you.

## Plan deductible

Your plan has a deductible for certain services. 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.

The deductible applies to the following Medicare-covered benefit categories, unless otherwise specified.

## Annual medical deductible

Your deductible is $1,000 per year for covered medical services you receive from providers as described below. Until you have paid the deductible amount, you must pay the full cost of your covered medical services.

**Here's how it works:**

1. You pay your plan's deductible in full; then,
2. You pay your copay or coinsurance; finally,
3. Your plan pays the rest.

The deductible applies out-of-network to the following Medicare-covered benefit categories, unless otherwise specified:

**Out-of-network**
List of applicable services

**Inpatient services**

- Inpatient hospital
- Inpatient mental health

**Outpatient hospital**

- Ambulatory surgical center (ASC)
- Outpatient hospital, including surgery
- Outpatient hospital observation services

**Diagnostic tests, lab and radiology services, and X-rays**

- Diagnostic radiology services (e.g. MRI)
- Lab services
- Diagnostic tests and procedures
- Therapeutic radiology
- Outpatient X-rays

**Doctor visits**

- Primary
- Specialists

**Hearing services**

- Exam to diagnose and treat hearing and balance issues

**Vision services**

- Exam to diagnose and treat diseases and conditions of the eye
- Eyewear after cataract surgery

**Mental health**

- Outpatient group therapy visit
- Outpatient individual therapy visit

**Skilled nursing facility (SNF)**

**Physical therapy and speech and language therapy visit**

**Ambulance**

**Medicare Part B drugs**

- Chemotherapy drugs
- Other Part B drugs

**Chiropractic services**

- Manual manipulation of the spine to correct subluxation

**Diabetes management**

- Diabetes monitoring supplies
- Diabetes self-management training
- Therapeutic shoes or inserts

**Durable medical equipment (DME) and related supplies**

- Durable medical equipment (e.g. wheelchairs, oxygen)
- Prosthetics (e.g., braces, artificial limbs)

**Foot care (podiatry services)**

- Foot exams and treatment

**Home health care**

**Occupational therapy visit**

**Opioid treatment program services**

**Outpatient substance use disorder services**

- Outpatient group therapy visit
- Outpatient individual therapy visit

**Renal dialysis**

## About this plan

AARP® Medicare Advantage from UHC MA-0006 (PPO) is a Medicare Advantage PPO 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:

**Massachusetts:** Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk.

## Use network providers and pharmacies

AARP® Medicare Advantage from UHC MA-0006 (PPO) has a network of doctors, hospitals, pharmacies and other providers. With this plan, you have the freedom to enjoy access to care at in-network costs when you visit any provider participating in the UnitedHealthcare® Medicare National Network (exclusions may apply). Plus, you have the flexibility to visit any provider nationwide who accepts Medicare. You may pay a higher copay or coinsurance when you see an out-of-network provider. When looking at the charts above you'll see the cost differences for network vs. out-of-network care and services. 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 **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.

# Required Information

AARP® Medicare Advantage from UHC MA-0006 (PPO) is 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. 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.

Benefits, features, and/or devices vary by plan/area. Limitations, exclusions and/or network restrictions may apply.

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party. Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

**Hearing aids -** The plan may only cover hearing aids from a UnitedHealthcare Hearing network provider. Other hearing exam providers are available in the UnitedHealthcare network.

**Routine dental benefits -** If your plan offers out-of-network dental coverage and you see an out-of-network dentist, you might be billed more. Provider network may vary in local market. Dental network size based on Zelis Network360, May 2025.

**Routine eyewear -** Additional charges may apply for out-of-network items and services. Provider and retail network may vary in local market. Vision network size based on Zelis Network360, March 2023. Annual routine eye exam and $100-450 allowance for contacts or designer frames, with standard (single, bi-focal, tri-focal or standard progressive) lenses covered in full either annually or every two years. Savings based on comparison to retail. Other vision providers are available in our network.

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. There may be other pharmacies in our network. Optum Home Delivery Pharmacy and Optum Rx affiliates may not be available in Arkansas.

**Member discounts -** As a UnitedHealthcare Medicare Advantage plan member, you'll have access to an exclusive collection of discounts on hundreds of products and services. Once you're a member, you can sign in to your member site for a list of discounts available to you. The discounts described are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process. Discount offerings may vary by plan and are not available on all plans. The discount offers are made available to members through a third party. Participation in these third-party discount offers is subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties.

**Rewards Program -** Medicare Advantage reward offerings may vary by plan and are not available in all plans. By participating in the program or accessing rewards funds, you agree to the **Rewards Program Terms of Service**. Members must participate January through December to earn all available rewards. Rewards must be earned and reported within time frames specified by the plan.