

Benefit Highlights

AARP Medicare Advantage Patriot (PPO)

This is a short description of your 2021 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

	In-Network	Out-of-Network
Annual Medical Deductible	No deductible	
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	\$6,700 In-Network	\$10,000 combined In and Out-of-Network
Doctor's office visit	Primary Care Provider: \$10 copay	Primary Care Provider: \$40 copay
	Specialist: \$50 copay (no referral needed)	Specialist: \$75 copay (no referral needed)
	Virtual medical visits: \$0 copay	
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 \$184 copay per day: days 21-57 \$0 copay per day: days 58-100	\$225 copay per day: days 1-45 \$0 copay per day: days 46-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply.)	\$0 - \$355 copay (Type 1 facility) \$0 - \$425 copay (Type 2 facility)	40% coinsurance
Mental health (outpatient)	Group therapy: \$15 copay	Group therapy: \$30 copay
	Individual therapy: \$25 copay	Individual therapy: \$40 copay
Diabetes monitoring supplies	\$0 copay for covered brands	40% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	\$0 - \$100 copay	40% coinsurance

Medical Benefits

	In-Network	Out-of-Network
Diagnostic tests and procedures (non-radiological)	\$25 copay	40% coinsurance
Lab services	\$0 copay	\$0 copay
Outpatient x-rays	\$25 copay	\$30 copay
Ambulance	\$250 copay for ground or air	\$250 copay for ground or air
Emergency care	\$90 copay; \$0 copay worldwide	
Urgently needed services	\$30 - \$40 copay; \$0 copay worldwide	

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	\$0 copay; 1 every year*	\$75 copay; 1 every year*
Vision - eyewear	\$0 copay every 2 years; up to \$100 for frames or contact lenses. Standard single, bifocal, trifocal, or progressive lenses are covered in full.*	\$0 copay; up to \$100 for home-delivered eyewear available nationwide only through UnitedHealthcare Vision. (select products only)*
Hearing - routine exam	\$0 copay; 1 per year*	\$75 copay; 1 per year*
Hearing aids	\$375 - \$2,075 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every 2 years.*	\$375 copay for home-delivered hearing aids available nationwide through UnitedHealthcare Hearing (select products only)*
Fitness program through Renew Active™	Renew Active fitness membership, classes and online brain exercises at no cost to you.	
Foot care - routine	\$50 copay; 6 visits per year*	\$75 copay; 6 visits per year*
Routine Chiropractic care	\$10 copay; 12 chiropractic visits per year*	\$75 copay; 12 chiropractic visits per year*
Routine Acupuncture	\$10 copay; 12 acupuncture visits per year*	\$75 copay; 12 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

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



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

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