Benefit Highlights

UnitedHealthcare® Medicare Advantage Choice Plan 1 (Regional PPO)

This is a short description of your 2020 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	$16

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
Doctor's office visit	Primary Care Provider: $0 copay	Primary Care Provider: $50 copay
	Specialist: $45 copay (no referral needed)	Specialist: $75 copay (no referral needed)
Preventive services	$0 copay	$0 copay - 40% coinsurance (depending on the service)
Inpatient hospital care	$375 copay per day: for days 1-5 $0 copay per day for unlimited days after that	$500 copay per day: for days 1-20 $0 copay per day for unlimited days after that
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	$250 copay per day: days 1-40 $0 copay per day: days 41-100
Outpatient hospital, including surgery	$0 - $325 copay 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)	$0 - $160 copay	40% coinsurance
Diagnostic tests and procedures (non-radiological)	$30 copay	40% coinsurance
Lab services	$10 copay	$10 copay
Outpatient x-rays	$50 copay	$50 copay

Medical Benefits

	In-Network	Out-of-Network
Ambulance	$250 copay for ground $250 copay for air	$250 copay for ground $250 copay for air
Emergency care	$90 copay (worldwide)	
Urgently needed services	$30 - $40 copay ($90 copay for worldwide coverage)	

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 lenses/frames and contacts*	50% coinsurance every 2 years; up to $100 for lenses/frames and contacts*
Dental - preventive	$0 copay for exams, cleanings, x-rays, and fluoride*	$0 copay for exams, cleanings, x-rays, and fluoride*
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.*	Hearing aids available nationwide through mail order from UnitedHealthcare Hearing.*
Fitness program through Renew Active™	Standard membership access to participating fitness locations including an in-person fitness orientation, access to group fitness classes, and online brain exercises– depending on availability or enrollment into a self-directed fitness program if a network location is not convenient, all at no additional cost.	
Foot care - routine	$45 copay; 6 visits per year*	$75 copay; 6 visits per year*
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Medical Visits	Speak to network telehealth providers using your computer or mobile device. Find participating doctors online at amwell.com	No coverage

*Benefits combined in and out-of-network

Prescription Drugs

	Your Cost
Annual prescription deductible	$0 for Tier 1 and Tier 2; $300 for Tier 3, Tier 4, Tier 5

Prescription Drugs

	Your Cost	
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	$47 copay	$131 copay
Tier 4: Non-Preferred Drugs	$100 copay	$290 copay
Tier 5: Specialty Tier Drugs	27% coinsurance	27% coinsurance
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	
Catastrophic coverage stage	After your total out-of-pocket costs reach $6,350, you will pay the greater of $3.60 copay for generic (Including brand drugs treated as generic), $8.95 copay for all other drugs, or 5% coinsurance	

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