





Additional benefits, more comprehensive than Original Medicare	
Telehealth Service	• \$0 copayment, speak to network telehealth providers using your computer or mobile device.
Dental Services	• Visit UnitedHealthcare Dental network for \$0 copayment for Preventive & Diagnostic care. • Applicable to AARP® Medicare Advantage Choice (PPO), AARP® Medicare Advantage Plan 3 (HMO), and AARP® Medicare Advantage Plan 4 (HMO) members: Up to \$500 per year for covered preventive and comprehensive dental services.
Vision Services	• AARP® Medicare Advantage Choice (PPO) members: Visit UnitedHealthcare Vision network: Pay \$0 copayment for vision exam once per year. Eyewear: \$0 copayment for standard lenses and \$100 credit for contact lenses or eyeglasses (lenses/frames) once every 2 years. • AARP® Medicare Advantage Plan 1 (HMO), AARP® Medicare Advantage Plan 3 (HMO) and AARP® Medicare Advantage Plan 4 (HMO) members: Visit UnitedHealthcare Vision network: Pay \$0 copayment for vision exam once per year. Eyewear: \$0 copayment for standard lenses and \$200 credit for contact lenses or eyeglasses (lenses/frames) once every 2 years.
Hearing Services	• Pay \$0 copayment for hearing exam once per year. Receive up to 2 hearing aids every 2 years with a copayment of \$375 - \$2,075 for each hearing aid device with UnitedHealthcare Hearing.
Podiatry Care	• Health plan covers routine podiatry care up to 6 visits per year. Specialist visit copayment applies.
Fitness Program	• Renew Active™ offers access to a gym membership at no additional charge.*
NurseLine SM	• Speak with a registered nurse (RN) 24 hours a day**.
In-Home Physician Visits	• \$0 copayment. • Receive expert advice from health care physicians in the comfort of your home.

Ask your doctor to schedule your annual wellness visit, it is provided to you at no additional cost.	
Preventive care benefits cover:	
Pap Smears and Pelvic Exams \$0 copayment for one Pap smear every 24 months \$0 copayment for one pelvic exam every 24 months†	Routine Physical Exam \$0 copayment for one exam every year†
Pneumococcal Pneumonia Vaccine / Flu Vaccine / Hepatitis B Vaccine \$0 copayment for the vaccines†	Annual Mammogram Screening \$0 copayment for one annual screening†
	No Additional Fee Screenings Bone mass measurement, prostate cancer screening, colorectal screening†
†Additional doctor office visit services and other copayments may apply. No Primary Care Physician referral is necessary. In-network only.	



Other Providers are Available in Our Network. * 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. Equipment and classes may vary by location. Availability of the Renew Active™ program varies by plan/area. ** This 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.		
Benefits offered are valid only for the contract period from January 1, 2021 to December 31, 2021.		
Benefits listed are for AARP® Medicare Advantage products, including AARP® Medicare Advantage Choice (PPO), AARP® Medicare Advantage Plan 1 (HMO), AARP® Medicare Advantage Plan 3 (HMO), and AARP® Medicare Advantage Plan 4 (HMO).		
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. 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. AARP and its affiliates are not insurers. You do not need to be an AARP member to enroll. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.		
ATTENTION: If you speak Chinese/Korean/Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-250-5779 (TTY: 711).		
	English Chinese Korean Vietnamese	1-800-250-5779 1-800-801-1900 1-877-718-3682 1-800-382-8265
		TTY: 711 Monday - Friday 9 a.m. - 5:30 p.m.

	New Jersey: <ul style="list-style-type: none">• 1715 Rt 27 (Festival Plaza), Edison, NJ 08817• 7 Broad Avenue, Suite 301-A (Pine Plaza), Palisades Park, NJ 07650
	Manhattan: <ul style="list-style-type: none">• 161 Canal Street, New York, NY 10013• 27 E. Broadway, 2nd Floor, New York, NY 10002
	Queens: <ul style="list-style-type: none">• 136-02 Roosevelt Avenue (next to New World Mall), Flushing, NY 11354
	Brooklyn: <ul style="list-style-type: none">• 6402 8th Avenue, Suite G107, Brooklyn, NY 11220• 2343 86th Street, Brooklyn, NY 11214
Office Hours: Monday - Friday. 9 a.m. - 5:30 p.m.	
Office hours may be changed or closed based on State guidance. Please call our customer service before your visit.	
	
	



2021 AARP® Medicare Advantage from UnitedHealthcare Plans: Highlight of Benefits - New Jersey

January 1, 2021 to December 31, 2021



Y0066_200720_013342_M_NJ



New AARP® Medicare Advantage Choice (PPO) Plan now includes these benefits:

- No deductible for out-of-network coverage.
- Freedom to visit providers outside of the state (national network coverage)
- \$0 monthly premium
- \$0 copay for primary care visit

Designed to offer enhanced experience with additional benefits, services, and health resources.

Our professional team is here to serve you:

Inquiry Hotline:
1-800-250-5779
TTY: 711
Monday - Friday, 9 a.m. - 5:30 p.m.

uhcAsian.com

This document is a summary only. For more information about our benefits, please call 1-800-250-5779, TTY: 711.

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Highlights of 2021 benefits

Benefit	Original Medicare (Red/Blue Card) *	NEW AARP® Medicare Advantage Choice (PPO)	AARP® Medicare Advantage Plan 1 (HMO)	AARP® Medicare Advantage Plan 3 (HMO)	AARP® Medicare Advantage Plan 4 (HMO)
Service Area		Atlantic, Bergen, Burlington, Camden, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, Warren	❖ Atlantic, Bergen, Camden, Essex, Hudson, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, Warren ⌘ Burlington, Hunterdon, Mercer	❖ Atlantic, Bergen, Camden, Essex, Hudson, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, Warren ⌘ Burlington, Hunterdon, Mercer	❖ Atlantic, Bergen, Camden, Essex, Hudson, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, Warren ⌘ Burlington, Hunterdon, Mercer
Monthly Plan Premium	• You pay the Medicare Part B premium.	• \$0 Monthly Plan premium	• \$0 Monthly Plan premium	• \$39 Monthly Plan premium	• \$81 Monthly Plan premium
Referral Required for Specialist Visits	• No	• No	• No	• No	• No
Doctor and Hospital Choice	• You may go to any doctor, specialist, or hospital that accepts Medicare.	• In most cases, you must go to In-network doctors, specialists and hospitals.	• In most cases, you must go to In-network doctors, specialists and hospitals.	• In most cases, you must go to In-network doctors, specialists and hospitals.	• In most cases, you must go to In-network doctors, specialists and hospitals.
Doctor Office Visit	• You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾ • Each year, you pay a \$198 deductible.	• \$0 copayment for each PCP office visit. • \$40 copayment for each specialist visit.	Copayment: ❖ PCP: \$5; Specialist: \$45 ⌘ PCP: \$10; Specialist: \$50	Copayment: ❖ PCP: \$0; Specialist: \$25 ⌘ PCP: \$5; Specialist: \$25	Copayment: ❖ PCP: \$0; Specialist: \$20 ⌘ PCP: \$0; Specialist: \$25
Inpatient Hospital Care	• You pay for each benefit period: ⁽³⁾ - Days 1 to 60: an initial deductible of \$1,408. - Days 61 to 90: \$352 per day. - Days 91 to 150: \$704 each lifetime reserve day. ⁽⁴⁾	• For In-network hospital/physicians services. - \$390 inpatient facility copayment per day ⁽⁵⁾ , for days 1-5 - \$0 copayment for each additional day - You are covered for unlimited days each benefit period ⁽³⁾⁽⁵⁾	• For In-network hospital/physicians services. - ❖ \$335 inpatient facility copayment per day ⁽⁵⁾ , for days 1-6 ⌘ \$390 inpatient facility copayment per day ⁽⁵⁾ , for days 1-5 - \$0 copayment for each additional day - You are covered for unlimited days each benefit period ⁽³⁾⁽⁵⁾	• For In-network hospital/physicians services. - ❖ \$295 inpatient facility copayment per day ⁽⁵⁾ , for days 1-5 ⌘ \$295 inpatient facility copayment per day ⁽⁵⁾ , for days 1-6 - \$0 copayment for each additional day - You are covered for unlimited days each benefit period ⁽³⁾⁽⁵⁾	• For In-network hospital/physicians services. - ❖ \$225 inpatient facility copayment per day ⁽⁵⁾ , for days 1-5 ⌘ \$250 inpatient facility copayment per day ⁽⁵⁾ , for days 1-5 - \$0 copayment for each additional day - You are covered for unlimited days each benefit period ⁽³⁾⁽⁵⁾
Outpatient Hospital Care	• For Medicare-covered services - You pay 20% of doctor charges. ⁽¹⁾⁽²⁾ - You pay 20% of for outpatient facility charges. ⁽¹⁾⁽²⁾	• For In-network hospital/physicians services. - \$345 ambulatory surgery facility copayment per visit ⁽⁵⁾	• For In-network hospital/physicians services. - \$295 ambulatory surgery facility copayment per visit ⁽⁵⁾	• For In-network hospital/physicians services. - \$250 ambulatory surgery facility copayment per visit ⁽⁵⁾	• For In-network hospital/physicians services. - \$225 ambulatory surgery facility copayment per visit ⁽⁵⁾
Ambulance Services	• You pay 20% of Medicare-approved amounts or applicable fee schedule charge. ⁽¹⁾⁽²⁾	• \$250 copayment for ambulance services.	• \$250 copayment for ambulance services.	❖ \$225 copayment for ambulance services. ⌘ \$250 copayment for ambulance services.	• \$250 copayment for ambulance services.
Emergency Care	• You pay 20% of the facility charge or applicable copayment for each emergency room visit. ⁽¹⁾⁽²⁾ • You pay 20% of doctor charges. ⁽¹⁾⁽²⁾ • Not covered outside the U.S., except under limited circumstances.	• \$90 copayment for each emergency room visit. (waived if admitted to the hospital within 24 hours for the same condition). • \$0 copayment for Worldwide coverage. - When outside of the United States and its territories, the plan covers emergency transportation to a nearby medical facility within the foreign country.			
Lab and X-Rays	• In a doctor's office or independent testing facility or a hospital outpatient setting, you pay 20% of the Medicare-approved amount for covered diagnostic non-laboratory tests and X-rays.	• Lab services: \$0 copayment • X-rays: \$30 copayment	• Lab services: \$0 copayment • X-rays: \$30 copayment	• Lab services: \$0 copayment • X-rays: \$30 copayment	• Lab services: \$0 copayment • X-rays: \$30 copayment
Maximum Out-of-Pocket Amount	• There is no yearly limit.	• \$6,700 (in-network) \$10,000 (in-network and out-of-network combined)	• \$6,700.00 (in-network)	• \$6,700.00 (in-network)	• \$6,700.00 (in-network)
Prescription Drug (Medicare Part D)	• Not available through Original Medicare. You must sign up with a private plan contracted with the federal government to receive Medicare Part D.	• \$0 Deductible for Tier 1, 2 • \$240 Deductible for Tier 3, 4, 5 Before the total yearly drug costs (plan and Member contribution) reach \$4,130, you pay the following copayment for prescription drugs ⁽⁶⁾ : - Tier 1 (Preferred generic drugs): 30-day supply \$0 Preferred mail order ⁽⁷⁾ 90-day supply \$0 - Tier 2 (Non-preferred generic drugs): 30-day supply \$12 Preferred mail order ⁽⁷⁾ 90-day supply \$0 - Tier 3 (Preferred brand drugs): 30-day supply \$45 Preferred mail order ⁽⁷⁾ 90-day supply \$125 - Tier 4 (Non-preferred brand drugs): 30-day supply \$95 Preferred mail order ⁽⁷⁾ 90-day supply \$275 - Tier 5 (Specialty brand drugs): 30-day supply 28% coinsurance	• \$0 Deductible for Tier 1, 2 • \$240 Deductible for Tier 3, 4, 5 Before the total yearly drug costs (plan and Member contribution) reach \$4,130, you pay the following copayment for prescription drugs ⁽⁶⁾ : - Tier 1 (Preferred generic drugs): 30-day supply \$2 Preferred mail order ⁽⁷⁾ 90-day supply \$0 - Tier 2 (Non-preferred generic drugs): 30-day supply \$12 Preferred mail order ⁽⁷⁾ 90-day supply \$0 - Tier 3 (Preferred brand drugs): 30-day supply \$45 Preferred mail order ⁽⁷⁾ 90-day supply \$125 - Tier 4 (Non-preferred brand drugs): 30-day supply \$95 Preferred mail order ⁽⁷⁾ 90-day supply \$275 - Tier 5 (Specialty brand drugs): 30-day supply 28% coinsurance	• \$0 Deductible for Tier 1, 2 • \$200 Deductible for Tier 3, 4, 5 Before the total yearly drug costs (plan and Member contribution) reach \$4,130, you pay the following copayment for prescription drugs ⁽⁶⁾ : - Tier 1 (Preferred generic drugs): 30-day supply \$2 Preferred mail order ⁽⁷⁾ 90-day supply \$0 - Tier 2 (Non-preferred generic drugs): 30-day supply \$10 Preferred mail order ⁽⁷⁾ 90-day supply \$0 - Tier 3 (Preferred brand drugs): 30-day supply \$47 Preferred mail order ⁽⁷⁾ 90-day supply \$131 - Tier 4 (Non-preferred brand drugs): 30-day supply \$95 Preferred mail order ⁽⁷⁾ 90-day supply \$275 - Tier 5 (Specialty brand drugs): 30-day supply 29% coinsurance	• \$0 Deductible for Tier 1, 2 • \$150 Deductible for Tier 3, 4, 5 Before the total yearly drug costs (plan and Member contribution) reach \$4,130, you pay the following copayment for prescription drugs ⁽⁶⁾ : - Tier 1 (Preferred generic drugs): 30-day supply \$2 Preferred mail order ⁽⁷⁾ 90-day supply \$0 - Tier 2 (Non-preferred generic drugs): 30-day supply \$10 Preferred mail order ⁽⁷⁾ 90-day supply \$0 - Tier 3 (Preferred brand drugs): 30-day supply \$47 Preferred mail order ⁽⁷⁾ 90-day supply \$131 - Tier 4 (Non-preferred brand drugs): 30-day supply \$95 Preferred mail order ⁽⁷⁾ 90-day supply \$275 - Tier 5 (Specialty brand drugs): 30-day supply 30% coinsurance
A 90-day supply is only available at a subset of the retail pharmacy networks. Specialty drugs are limited to a 30-day supply. After the total yearly drug costs (plan and Member contribution) reach \$4,130, generally you pay no more than 25% of brand drug cost and 25% of generic drug cost. After your yearly out-of-pocket drug costs reach \$6,550, you pay the greater of: – either coinsurance of 5% of the cost of the drug – or \$3.70 for a generic drug or a drug treated like a generic; and \$9.20 for all other drugs. You must use designated retail pharmacies or mail order to get your prescription drugs.					

*These amounts in Original Medicare may change for 2021. (1) Each year, you pay a \$198 deductible. (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more. (3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each new benefit period. There is no limit to the number of benefit periods you can have. (4) Lifetime reserve days can only be used once. (5) You must get authorization from plan before you get this service. Failure to get authorization can result in significantly higher costs to you. (6) Certain prescription drugs will have maximum quantity limits. Contact plan for details. (7) Savings apply during the initial coverage period, which begins after the payment of your required deductible (if any) and ends when the total cost of your drugs (paid by UnitedHealthcare, you and others) reaches \$4,130.