

# Benefit highlights

## UnitedHealthcare Dual Complete® (HMO D-SNP)

This is a short description of your 2022 plan benefits. The values shown represent a range based upon the amount of the Medicare Parts A and B cost sharing covered by the state. For complete information and for costs for those without Medicare Parts A and B cost sharing covered by the state, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions and restrictions may apply.

### Plan Costs

**If you have full Medicaid benefits or are a Qualified Medicare Beneficiary, you will pay \$0 for your Medicare-covered services.** If your eligibility for Medicaid or “Extra Help” changes, your cost sharing and premium may change.

<b>Monthly plan premium</b>	\$0 with full “Extra Help”	Up to \$25.10, depending on your level of “Extra Help”
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### Medical Benefits

Your plan has a deductible that applies to certain medical benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage.

	With Medicaid Cost Share Assistance	Without Medicaid Cost Share Assistance
<b>Annual Medical Deductible</b>	No deductible	\$203
<b>Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)</b>	\$0	\$7,550
<b>Doctor’s office visit</b>	Primary Care Provider: \$0 copay	Primary Care Provider: \$0 copay
	Specialist: \$0 copay (referral needed)	Specialist: 20% coinsurance (referral needed)
	Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device.	Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device.
<b>Preventive services</b>	\$0 copay	\$0 copay
<b>Inpatient hospital care</b>	\$0 copay per stay for unlimited days	\$1,480 copay per stay for unlimited days
<b>Skilled nursing facility (SNF)</b>	\$0 copay per day: days 1-100	\$0 copay per day: for days 1-20 \$185.50 <sup>†</sup> copay per day: days 21-100

## Medical Benefits

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	With Medicaid Cost Share Assistance	Without Medicaid Cost Share Assistance
<b>Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)</b>	\$0 copay	20% coinsurance
<b>Mental health (outpatient and virtual)</b>	Group therapy: \$0 copay	Group therapy: 20% coinsurance
	Individual therapy: \$0 copay	Individual therapy: 20% coinsurance
	Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device.	Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device.
<b>Diabetes monitoring supplies</b>	\$0 copay	\$0 copay
<b>Diagnostic radiology services (such as MRIs, CT scans)</b>	\$0 copay	20% coinsurance
<b>Diagnostic tests and procedures (non-radiological)</b>	\$0 copay	20% coinsurance
<b>Lab services</b>	\$0 copay	\$0 copay
<b>Outpatient x-rays</b>	\$0 copay	20% coinsurance
<b>Ambulance</b>	\$0 copay for ground or air	20% coinsurance for ground or air
<b>Emergency care</b>	\$0 copay (worldwide)	\$90 copay (\$0 copay for emergency care outside the United States) per visit
<b>Urgently needed services</b>	\$0 copay (worldwide)	\$65 copay (\$0 copay for urgently needed services outside the United States) per visit

†These are the 2021 Medicare-defined amounts and may change for 2022

## Benefits and Services Beyond Original Medicare

	Your Cost
<b>Routine physical</b>	\$0 copay; 1 per year
<b>Routine eye exams</b>	\$0 copay; 1 every year
<b>Routine eyewear</b>	\$0 copay; up to \$400 every year for frames or contact lenses through UnitedHealthcare Vision. Standard

	<b>Your Cost</b>
	single, bifocal, trifocal, or progressive lenses are covered in full.  Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only).
<b>Dental - preventive</b>	\$0 copay for exams, cleanings, x-rays, and fluoride
<b>Dental - comprehensive</b>	\$0 copay for comprehensive dental services
<b>Dental - benefit limit</b>	\$2,500 limit on all covered dental services
<b>Hearing - routine exam</b>	\$0 copay; 1 per year
<b>Hearing aids</b>	\$3,600 allowance for hearing aids, up to 2 hearing aids every year through UnitedHealthcare Hearing.  Includes hearing aids delivered directly to you with virtual follow-up care through Right2You (select models), through UnitedHealthcare Hearing.
<b>Fitness program</b>	Renew Active fitness membership, classes and online brain exercises at no cost to you.  With your fitness benefit you also get a Fitbit device at no cost to you.
<b>Routine Transportation</b>	\$0 copay; 60 one-way trips per year to or from approved locations
<b>Personal Emergency Response System</b>	Emergency monitoring device at no cost.
<b>Foot care - routine</b>	\$0 copay; 4 visits per year
<b>Over-the-Counter (OTC) + Healthy Food Card</b>	\$105 credit on a prepaid card every month to purchase approved over-the-counter products or healthy groceries.
<b>Meal Benefit</b>	\$0 copay; Meals provided up to 2 times per calendar year immediately after an inpatient hospital or skilled nursing facility stay.
<b>NurseLine</b>	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.

## Prescription Drugs

<b>Annual prescription (Part D) deductible</b>	\$0
<b>30-day or 100-day supply from retail network pharmacy</b>	
<b>All covered drugs</b>	\$0 copay Some covered drugs limited to a 30-day supply



Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details. This information is not a complete description of benefits. Contact the plan for more information.

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