# Benefit Highlights

## UnitedHealthcare Dual Complete® RP (Regional PPO D-SNP)

This is a short description of your 2023 plan benefits. The values shown in-network 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.** You may have small copays for your Part D prescription drugs. If your eligibility for Medicaid or "Extra Help" changes, your cost sharing and premium may change.

| | | |
|---|---|---|
| **Monthly plan premium** | $0 with full "Extra Help" | Up to $35.90, depending on your level of "Extra Help" |

### Medical benefits

| | With Medicaid Cost Share Protection | | Without Medicaid Cost Share Protection | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Annual Medical Deductible** | No deductible | | No deductible | |
| **Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)** | $0 In-network | $0 combined in and out-of-network | $8,300 In-network | $12,450 combined in and out-of-network |
| **Doctor's office visit** | | | | |
| Primary care provider (PCP) | $0 copay | $0 copay | $0 copay | 40% coinsurance |
| Specialist | $0 copay (no referral needed) | $0 copay (no referral needed) | 20% coinsurance (no referral needed) | 40% coinsurance (no referral needed) |
| Virtual visits | $0 copay to talk with a network telehealth provider online through live audio and video | | $0 copay to talk with a network telehealth provider online through live audio and video | |
| **Preventive services** | $0 copay | $0 copay | $0 copay | $0 copay - 40% coinsurance (depending on the service) |

## Medical benefits

| | With Medicaid Cost Share Protection | | Without Medicaid Cost Share Protection | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Inpatient hospital care** | $0 copay per stay for unlimited days | $0 copay per stay for unlimited days | $750 copay per stay for unlimited days | 40% coinsurance per stay for unlimited days |
| **Skilled nursing facility (SNF)** | $0 copay per day: days 1-100 | $0 copay per day: days 1-100 | $0 copay per day: for days 1-20<br>$200.00 copay per day: days 21-100 | 40% coinsurance per stay, up to 100 days |
| **Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)** | $0 copay | $0 copay | 20% coinsurance | 40% coinsurance |
| **Outpatient mental health** | | | | |
| Group therapy | $0 copay | $0 copay | 20% coinsurance | 40% coinsurance |
| Individual therapy | $0 copay | $0 copay | 20% coinsurance | 40% coinsurance |
| Virtual visits | $0 copay to talk with a network telehealth provider online through live audio and video | | $0 copay to talk with a network telehealth provider online through live audio and video | |
| **Diabetes monitoring supplies** | $0 copay for covered brands | $0 copay | $0 copay for covered brands | 40% coinsurance |
| **Diagnostic radiology services (such as MRIs, CT scans)** | $0 copay | $0 copay | 20% coinsurance | 40% coinsurance |
| **Diagnostic tests and procedures (non-radiological)** | $0 copay | $0 copay | 20% coinsurance | 40% coinsurance |
| **Lab services** | $0 copay | $0 copay | $0 copay | $0 copay |
| **Outpatient x-rays** | $0 copay | $0 copay | 20% coinsurance | 40% coinsurance |
| **Ambulance** | $0 copay for ground or air | $0 copay for ground or air | 20% coinsurance for ground or air | 20% coinsurance for ground or air |
| **Emergency care** | $0 copay (worldwide) | | $90 copay ($0 copay for emergency care outside the United States) per visit | |

## Medical benefits

| | With Medicaid Cost Share Protection | | Without Medicaid Cost Share Protection | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Urgently needed services** | $0 copay (worldwide) | | $40 copay ($0 copay for urgently needed services outside the United States) per visit | |

Medicaid coverage of out-of-network medical benefits may vary depending on your Medicaid eligibility category. For complete information please refer to your Evidence of Coverage.

## Benefits and services beyond Original Medicare

| | In-network | Out-of-network |
|---|---|---|
| **Routine physical** | $0 copay, 1 per year* | 40% coinsurance, 1 per year* |
| **Routine eye exams** | $0 copay, 1 per year* | 40% coinsurance, 1 per year* |
| **Routine eyewear** | $0 copay<br>Plan pays up to $250 every year for frames or contact lenses through UnitedHealthcare Vision. Standard single, bifocal, trifocal, or progressive lenses are covered in full.*<br><br>Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only). | |
| **Dental - preventive** | $0 copay for exams, cleanings, X-rays, and fluoride* | $0 copay for exams, cleanings, X-rays, and fluoride* |
| **Dental - comprehensive** | $0 copay for comprehensive dental services* | $0 copay for comprehensive dental services* |
| **Dental - benefit limit** | $2,000 combined limit on all covered dental services*<br>If you choose to see an out-of-network dentist you might be billed more, even for services listed as $0 copay | |
| **Hearing - routine exam** | $0 copay, 1 per year* | 40% coinsurance, 1 per year* |
| **Hearing aids** | Plan pays up to $3,600 every year for 2 hearing aids through UnitedHealthcare Hearing.*<br><br>Includes hearing aids delivered directly to you with virtual follow-up care (select models). | |
| **Routine transportation** | $0 copay for 60 one-way trips to or from approved medically related appointments and pharmacies* | 75% coinsurance* |
| **Personal Emergency Response System** | $0 copay for a personal emergency response system (PERS) | |
| **Foot care - routine** | $0 copay, 8 visits per year* | 40% coinsurance, 8 visits per year* |

| | In-network | Out-of-network |
|---|---|---|
| **Routine chiropractic care** | $0 copay, 12 visits per year* | 40% coinsurance, 12 visits per year* |
| **Routine acupuncture** | $0 copay, 12 visits per year* | 40% coinsurance, 12 visits per year* |
| **Over-the-counter (OTC) credit** | $195 credit every quarter to buy covered OTC products | |
| **Meal benefit** | $0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay. | |
| **NurseLine** | Speak with a registered nurse (RN) 24 hours a day, 7 days a week. | |

*Benefits combined in and out-of-network

## Prescription drugs

If you don't qualify for Low-Income Subsidy (LIS), you pay the Medicare Part D cost share outlined in the Evidence of Coverage. If you do qualify for Low-Income Subsidy (LIS) you pay:

| | Your cost |
|---|---|
| **Annual prescription (Part D) deductible** | $0 or $104, depending on the level of "Extra Help" you receive |
| **30-day or 100-day supply from retail network pharmacy** | |
| **Generic (including brand drugs treated as generic)** | $0, $1.45, $4.15 copay, or 15% coinsurance<br>Some covered drugs limited to a 30-day supply |
| **All other drugs** | $0, $4.30, $10.35 copay, or 15% coinsurance<br>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.