# Benefit Highlights

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

This is a short description of your 2023 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 with full “Extra Help” | Up to $38.40, depending on your level of “Extra Help” |

### Medical benefits

| | **Your cost** |
|---|---|
| **Annual Medical Deductible** | No deductible |
| **Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)** | $3,600 |
| **Doctor’s office visit** | |
| Primary care provider (PCP) | $0 copay |
| Specialist | $10 copay (no referral needed) |
| Virtual visits | $0 copay to talk with a network telehealth provider online through live audio and video |
| **Preventive services** | $0 copay |
| **Inpatient hospital care** | $295 copay per day: days 1-5<br>$0 copay per day: days 6 and beyond |
| **Skilled nursing facility (SNF)** | $0 copay per day: days 1-20<br>$196 copay per day: days 21-39<br>$0 copay per day: days 40-100 |
| **Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)** | $295 copay |
| **Outpatient mental health** | |
| Group therapy | $15 copay |
| Individual therapy | $25 copay |
| Virtual visits | $0 copay to talk with a network telehealth provider online through live audio and video |
| **Diabetes monitoring supplies** | $0 copay for covered brands |
| **Diagnostic radiology services (such as MRIs, CT scans)** | $110 copay |

## Medical benefits

| | Your cost |
|---|---|
| **Diagnostic tests and procedures (non-radiological)** | $20 copay |
| **Lab services** | $0 copay |
| **Outpatient x-rays** | $15 copay |
| **Ambulance** | $250 copay for ground or air |
| **Emergency care** | $90 copay ($0 copay for emergency care outside the United States) per visit |
| **Urgently needed services** | $40 copay ($0 copay for urgently needed services outside the United States) per visit |

## Benefits and services beyond Original Medicare

| | Your cost |
|---|---|
| **Routine physical** | $0 copay, 1 per year |
| **Routine eye exams** | $0 copay, 1 per year |
| **Routine eyewear** | $0 copay<br>Plan pays up to $350 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 (covered in-network and out-of-network)** | $0 copay for exams, cleanings, X-rays, and fluoride* |
| **Dental - comprehensive (covered in-network and out-of-network)** | $0 copay for comprehensive dental services* |
| **Dental - benefit limit** | $1,000 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 |
| **Hearing aids** | Plan pays up to $1,100 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). |
| **Fitness program** | $0 copay for Renew Active, which includes a free gym membership, plus online fitness classes and brain health challenges. |

| | Your cost |
|---|---|
| **Routine transportation** | $0 copay for 24 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies |
| **Personal Emergency Response System** | $0 copay for a personal emergency response system (PERS) |
| **Foot care - routine** | $10 copay, 6 visits per year |
| **Food, over-the-counter (OTC) and utility bill credit** | $55 credit every month to pay for covered groceries, OTC products and certain utility bills |
| **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

| | Your cost |
|---|---|
| **Annual prescription (Part D) deductible** | $0 |
| **30-day or 100-day supply from retail network pharmacy** | |
| **All covered drugs** | $0 copay<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.