

# Benefit Highlights

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

This is a short description of your 2023 plan benefits. The values shown in-network are for those with Medicare Parts A and B cost sharing that may be covered by the state. Cost share may vary depending on your individual Medicaid eligibility. For complete information, 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.

Monthly plan premium	\$0
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### Medical benefits

	Your cost
<b>Doctor's office visit</b>	
Primary care provider (PCP)	\$0 copay
Specialist	\$0 copay (referral needed)
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
<b>Preventive services</b>	\$0 copay
<b>Inpatient hospital care</b>	\$0 copay per stay for unlimited days
<b>Skilled nursing facility (SNF)</b>	\$0 copay per day: days 1-100
<b>Outpatient hospital, including surgery</b>	\$0 copay
<b>Outpatient mental health</b>	
Group therapy	\$0 copay
Individual therapy	\$0 copay
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
<b>Diabetes monitoring supplies</b>	\$0 copay for covered brands
<b>Diagnostic radiology services (such as MRIs, CT scans)</b>	\$0 copay
<b>Diagnostic tests and procedures (non-radiological)</b>	\$0 copay
<b>Lab services</b>	\$0 copay
<b>Outpatient x-rays</b>	\$0 copay
<b>Ambulance</b>	\$0 copay for ground or air

## Medical benefits

	Your cost
<b>Emergency care</b>	\$0 copay (worldwide)
<b>Urgently needed services</b>	\$0 copay (worldwide)

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

	Your cost
<b>Routine physical</b>	\$0 copay, 1 per year
<b>Routine eye exams</b>	\$0 copay, 1 per year
<b>Routine eyewear</b>	<p>\$0 copay</p> <p>Plan pays up to \$550 every year for frames or contact lenses through UnitedHealthcare Vision. Standard single, bifocal, trifocal, or progressive lenses are covered in full.</p> <p>Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only).</p>
<b>Dental - preventive (covered in-network and out-of-network)</b>	\$0 copay for exams, cleanings, X-rays, and fluoride*
<b>Dental - comprehensive (covered in-network and out-of-network)</b>	\$0 copay for comprehensive dental services*
<b>Dental - benefit limit</b>	<p>\$4,000 combined limit on all covered dental services*</p> <p>If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay</p>
<b>Hearing - routine exam</b>	\$0 copay, 1 per year
<b>Hearing aids</b>	<p>Plan pays up to \$3,600 every year for 2 hearing aids through UnitedHealthcare Hearing.</p> <p>Includes hearing aids delivered directly to you with virtual follow-up care (select models).</p>
<b>Fitness program</b>	\$0 copay for Renew Active, which includes a free gym membership, plus online fitness classes, brain health challenges and 1 Fitbit® device.
<b>Routine transportation</b>	\$0 copay for 72 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies
<b>Personal Emergency Response System</b>	\$0 copay for a personal emergency response system (PERS)
<b>Foot care - routine</b>	\$0 copay, 12 visits per year
<b>Routine chiropractic care</b>	\$0 copay, 12 visits per year

	Your cost
<b>Routine acupuncture</b>	\$0 copay, 12 visits per year
<b>Food, over-the-counter (OTC) and utility bill credit</b>	\$280 credit every month to pay for covered groceries, OTC products and certain utility bills
<b>Meal benefit</b>	\$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay.
<b>NurseLine</b>	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.

\*Benefits combined in and out-of-network

## 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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