

Benefit highlights

UnitedHealthcare Dual Complete® LP1 (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.

Monthly plan premium	\$0 with full “Extra Help”	Up to \$33.50, 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
Annual Medical Deductible	No deductible	\$203
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	\$0	\$7,550
Doctor’s office visit	Primary Care Provider: \$0 copay	Primary Care Provider: 20% coinsurance
	Specialist: \$0 copay (no referral needed)	Specialist: 20% coinsurance (no 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.
Preventive services	\$0 copay	\$0 copay
Inpatient hospital care	\$0 copay per stay for unlimited days	\$1,480 copay per stay for unlimited days
Skilled nursing facility (SNF)	\$0 copay per day: days 1-100	\$0 copay per day: for days 1-20 \$185.50 [†] copay per day: days 21-100

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
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	\$0 copay	20% coinsurance
Mental health (outpatient and virtual)	Group therapy: \$0 copay	Group therapy: \$0 copay
	Individual therapy: \$0 copay	Individual therapy: \$0 copay
	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.
Diabetes monitoring supplies	\$0 copay for covered brands	\$0 copay for covered brands
Diagnostic radiology services (such as MRIs, CT scans)	\$0 copay	20% coinsurance
Diagnostic tests and procedures (non-radiological)	\$0 copay	20% coinsurance
Lab services	\$0 copay	\$0 copay
Outpatient x-rays	\$0 copay	20% coinsurance
Ambulance	\$0 copay 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
Urgently needed services	\$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
Routine physical	\$0 copay; 1 per year
Routine eye exams	\$0 copay; 1 every year
Routine eyewear	\$0 copay; up to \$400 every year for frames or contact lenses through UnitedHealthcare Vision. Standard

	Your Cost
	single, bifocal, trifocal, or progressive lenses are covered in full. Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only).
Dental - preventive	\$0 copay for exams, cleanings, x-rays, and fluoride
Dental - comprehensive	\$0 copay for comprehensive dental services
Dental - benefit limit	\$3,000 limit on all covered dental services
Hearing - routine exam	\$0 copay; 1 per year
Hearing aids	\$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.
Fitness program	Renew Active fitness membership, classes and online brain exercises at no cost to you.
Routine Transportation	\$0 copay for 60 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies
Personal Emergency Response System	Emergency monitoring device at no cost.
Foot care - routine	\$0 copay; 8 visits per year
Routine Chiropractic care	\$0 copay; 12 chiropractic visits per year
Over-the-Counter (OTC) + Healthy Food Card	\$125 credit on a prepaid card every month to purchase approved over-the-counter products or healthy groceries.
Meal Benefit	\$0 copay; Meals provided 1 time per calendar year immediately after an inpatient hospital or skilled nursing facility stay.
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.

Prescription Drugs

Annual prescription (Part D) deductible	\$0
30-day or 90-day supply from retail network pharmacy	
All covered drugs	\$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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