

# Benefit highlights

## UnitedHealthcare® Chronic Complete (HMO C-SNP)

This is a short description of your 2022 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
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### 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)	\$3,900
Doctor's office visit	Primary Care Provider: \$0 copay Specialist: \$25 copay (referral needed) Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device.
Preventive services	\$0 copay
Inpatient hospital care	\$225 copay per day: for days 1-6 \$0 copay per day for unlimited days after that
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$188 copay per day: days 21-41 \$0 copay per day: days 42-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	\$200 copay
Mental health (outpatient and virtual)	Group therapy: \$15 copay Individual therapy: \$25 copay Virtual visits: \$0 copay; Speak to network telehealth providers using your computer or mobile device.
Diabetes monitoring supplies	\$0 copay
Diagnostic radiology services (such as MRIs, CT scans)	\$110 copay
Diagnostic tests and procedures (non-radiological)	\$25 copay
Lab services	\$0 copay
Outpatient x-rays	\$15 copay
Ambulance	\$250 copay for ground or air

## Medical Benefits

	Your Cost
<b>Emergency care</b>	\$90 copay (\$0 copay for emergency care outside the United States) per visit
<b>Urgently needed services</b>	\$40 copay (\$0 copay for urgently needed services outside the United States) per visit

## 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>	<p>\$0 copay; up to \$200 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</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>	\$1,000 limit on all covered dental services
<b>Hearing - routine exam</b>	\$0 copay; 1 per year
<b>Hearing aids</b>	<p>\$375 - \$1,425 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every year.</p> <p>Includes hearing aids delivered directly to you with virtual follow-up care through Right2You (select models), offered only by UnitedHealthcare Hearing.</p>
<b>Fitness program</b>	Renew Active fitness membership, classes and online brain exercises at no cost to you.
<b>Routine Transportation</b>	\$0 copay for 36 one-way trips to or from approved medically related appointments and pharmacies
<b>Foot care - routine</b>	\$25 copay; 6 visits per year
<b>Over-the-Counter (OTC) Products Catalog</b>	\$80 credit every quarter to use on approved over-the-counter products.
<b>NurseLine</b>	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.

## Prescription Drugs

	Your Cost	
<b>Annual prescription (Part D) deductible</b>	\$0	
<b>Initial coverage stage</b>	<b>Standard Retail (30-day)</b>	<b>Preferred Mail Order (100-day)</b>
<b>Tier 1: Preferred Generic</b>	\$0 copay	\$0 copay
<b>Tier 2: Generic<sup>1</sup></b>	\$10 copay	\$0 copay
<b>Tier 3: Preferred Brand</b>	\$47 copay	\$131 copay
<b>Select Insulin Drugs<sup>2</sup></b>	\$35 copay	\$95 copay
<b>Tier 4: Non-Preferred Drug</b>	\$95 copay	\$275 copay
<b>Tier 5: Specialty Tier</b>	33% coinsurance	N/A <sup>3</sup>
<b>Coverage gap stage</b>	Tier 1 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach \$4,430, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap	
<b>Catastrophic coverage stage</b>	After your total out-of-pocket costs reach \$7,050, you will pay the greater of \$3.95 copay for generic (Including brand drugs treated as generic), \$9.85 copay for all other drugs, or 5% coinsurance	

<sup>1</sup> Tier includes enhanced drug coverage

<sup>2</sup> For 2022, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of \$35 for a 1-month supply of Part D select insulin drugs during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your insulin in the catastrophic stage. This cost-sharing only applies to members who do not qualify for a program that helps pay for your drugs ("Extra Help").

<sup>3</sup> Limited to a 30-day supply



This information is not a complete description of benefits. Contact the plan for more information.

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