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

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)	$2,600
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 1-7 $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 21-34 $0 copay per day: days 35-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	$225 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)	$125 copay
Diagnostic tests and procedures (non-radiological)	$30 copay
Lab services	$0 copay
Outpatient x-rays	$15 copay
Ambulance	$270 copay for ground or air

Medical Benefits

	Your Cost
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 every year
Routine eyewear	$0 copay; up to $200 every 2 years for frames or contact lenses through UnitedHealthcare Vision. Standard 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	$1,000 limit on all covered dental services
Hearing - routine exam	$0 copay; 1 per year
Hearing aids	$375 - $1,425 copay for each hearing aid provided through UnitedHealthcare Hearing, up to 2 hearing aids every year. Includes hearing aids delivered directly to you with virtual follow-up care through Right2You (select models), offered only by UnitedHealthcare Hearing.
Fitness program	Renew Active fitness membership, classes and online brain exercises at no cost to you.
Routine Transportation	$0 copay for 36 one-way trips to or from approved medically related appointments and pharmacies
Foot care - routine	$25 copay; 6 visits per year
Over-the-Counter (OTC) Products Catalog	$40 credit every quarter to use on approved over-the-counter products.
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

	Your Cost	
Annual prescription (Part D) deductible	$0	
Initial coverage stage	**Standard Retail (30-day)**	**Preferred Mail Order (100-day)**
Tier 1: Preferred Generic	$0 copay	$0 copay
Tier 2: Generic[1]	$8 copay	$0 copay
Tier 3: Preferred Brand	$45 copay	$125 copay
Select Insulin Drugs[2]	$35 copay	$95 copay
Tier 4: Non-Preferred Drug	$95 copay	$275 copay
Tier 5: Specialty Tier	33% coinsurance	N/A[3]
Coverage gap stage	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	
Catastrophic coverage stage	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	

[1] Tier includes enhanced drug coverage

[2] 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”).

[3] Limited to a 30-day supply