Benefit Highlights

UnitedHealthcare Dual Complete® (PPO D-SNP)

This is a short description of your 2020 plan benefits. The values shown in-network 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. You may have small copays for your Part D prescription drugs. 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 $1, depending on your level of "Extra Help"

Medical Benefits

	With Medicaid Cost Share Assistance		Without Medicaid Cost Share Assistance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual out-of-pocket maximum (The most you may pay in a year for medical care covered by the plan)	$0 In-Network	$0 combined In and Out-of-Network	$6,700 In-Network	$10,000 combined In and Out-of-Network
Doctor's office visit	Primary Care Provider: $0 copay	Primary Care Provider: $0 copay	Primary Care Provider: $0 copay	Primary Care Provider: 30% coinsurance
	Specialist: $0 copay (no referral needed)	Specialist: $0 copay (no referral needed)	Specialist: $0 copay (no referral needed)	Specialist: 30% coinsurance (no referral needed)
Preventive services	$0 copay	$0 copay	$0 copay	$0 copay - 30% coinsurance (depending on the service)
Inpatient hospital care	$0 copay per stay for unlimited days	$0 copay per stay for unlimited days	$1,300 copay per stay for unlimited days	30% coinsurance per stay for unlimited days

Medical Benefits

	With Medicaid Cost Share Assistance		Without Medicaid Cost Share Assistance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Skilled nursing facility (SNF)	$0 copay per day: days 1-100	$0 copay per day: days 1-100	$0 copay per day: for days 1-20 $170.50† copay per day: days 21-100	30% coinsurance per stay, up to 100 days
Outpatient hospital, including surgery	$0 copay	$0 copay	$0 copay - 20% coinsurance Cost sharing for additional plan covered services will apply.	30% coinsurance Cost sharing for additional plan covered services will apply.
Diabetes monitoring supplies	$0 copay for covered brands	$0 copay	$0 copay for covered brands	30% coinsurance
Home health care	$0 copay	$0 copay	$0 copay	30% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay	$0 copay	20% coinsurance	30% coinsurance
Diagnostic tests and procedures (non-radiological)	$0 copay	$0 copay	20% coinsurance	30% coinsurance
Lab services	$0 copay	$0 copay	$0 copay	$0 copay
Outpatient x-rays	$0 copay	$0 copay	20% coinsurance	30% coinsurance
Ambulance	$0 copay for ground $0 copay for air	$0 copay for ground $0 copay for air	20% coinsurance for ground 20% coinsurance for air	20% coinsurance for ground 20% coinsurance for air
Emergency care	$0 copay (worldwide)		$90 copay ($0 copay for worldwide coverage)	
Urgently needed services	$0 copay (worldwide)		$65 copay ($0 copay for worldwide coverage)	

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.
†These are the 2019 Medicare-defined amounts and may change for 2020

Benefits and Services Beyond Original Medicare

	In-Network	Out-of-Network
Routine physical	$0 copay; 1 per year*	30% coinsurance; 1 per year*
Vision - routine eye exams	$0 copay; 1 every year*	30% coinsurance;1 every year*
Vision - eyewear	$0 copay every 2 years; up to $300 for lenses/frames and contacts*	50% coinsurance every 2 years; up to $300 for lenses/frames and contacts*
Dental - preventive	$0 copay for exams, cleanings, x-rays, and fluoride*	$0 copay for exams, cleanings, x-rays, and fluoride*
Dental - comprehensive	$0 copay for comprehensive dental services*	$0 copay for comprehensive dental services*
Dental - benefit limit	$3,500 limit on all covered dental services	
Hearing - routine exam	$0 copay; 1 per year*	30% coinsurance; 1 per year*
Hearing aids	$2,500 credit for hearing aids, up to 2 hearing aids every 2 years.*	Hearing aids available nationwide through mail order from UnitedHealthcare Hearing.*
Fitness program through Renew Active™	Standard membership access to participating fitness locations including an in-person fitness orientation, access to group fitness classes, and online brain exercises– depending on availability or enrollment into a self-directed fitness program if a network location is not convenient, all at no additional cost.	
Transportation	$0 copay; 60 one-way trips per year to or from approved locations*	75% coinsurance*
Solutions for Caregivers	$0 copay; Help from an experienced care manager who can support you in the care of a loved one, services available 24 hours a day, 7 days a week.	
Personal Emergency Response System	With the Personal Emergency Response System (PERS) help is only a button away. You can have peace of mind knowing that in any emergency situation the PERS in-home monitoring device can get you help quickly, 24 hours a day at no additional cost. The device is a lightweight button that can be worn on your wrist or as a pendant and may automatically detect falls depending on the model chosen. You must have a working landline and/or cellular phone coverage to take part in this benefit.	
Foot care - routine	$0 copay; 4 visits per year*	30% coinsurance; 4 visits per year*
Chiropractic care and Acupuncture	$0 copay; Combination of 10 chiropractic and acupuncture visits per year*	30% coinsurance; Combination of 10 chiropractic and acupuncture visits per year*
Health Products Benefit Card	$350 credit per quarter to use on approved health products	

	In-Network	Out-of-Network
Home Delivered Meals	$0 copay; Coverage for at home meal benefit. Restrictions apply. This provider must be used for the in-network and out-of-network benefit.	
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Medical Visits	Speak to network telehealth providers using your computer or mobile device. Find participating doctors online at amwell.com	No coverage
Virtual Mental Health Visits	$0 copay; Speak to network telehealth providers using your computer or mobile device.	No coverage

*Benefits combined in and out-of-network

Prescription Drugs

If you qualify for Low-Income Subsidy (LIS) you pay:

	Your Cost
Annual prescription deductible	$0 or $89, depending on the level of “Extra Help” you receive
30-day supply from retail network pharmacy	
Generic (including brand drugs treated as generic)	$0, $1.30, $3.60 copay, or 15% coinsurance
All other drugs	$0, $3.90, $8.95 copay, or 15% coinsurance

If you don’t qualify for Low-Income Subsidy (LIS), you pay:

	Your Cost	
Annual prescription deductible	$435	
Cost-Sharing for Covered Drugs	**Standard Retail (30-day)**	**Mail Order (90-day)**
Initial coverage stage	25% coinsurance	25% coinsurance
Coverage gap stage	After your total drug costs reach $4,020, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap	
Catastrophic coverage stage	After your total out-of-pocket costs reach $6,350, you will pay the greater of $3.60 copay for generic (Including brand drugs treated as generic), $8.95 copay for all other drugs, or 5% coinsurance	

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