Benefit Highlights

UnitedHealthcare® Nursing Home Plan (PPO I-SNP)

This is a short description of your 2023 plan benefits. 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. You may have small copays for your Part D prescription drugs.

Monthly plan premium	$35.30

Medical benefits

	In-network	Out-of-network
Annual Medical Deductible	No deductible	
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	$1,800 In-network	$5,100 combined in and out-of-network
Doctor's office visit		
Primary care provider (PCP)	$0 copay	30% coinsurance
Specialist	$0 copay - 20% coinsurance (no referral needed)	30% coinsurance (no referral needed)
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video	
Preventive services	$0 copay	$0 copay - 30% coinsurance (depending on the service)
Inpatient hospital care	$1,556 copay per stay	$1,556 copay per stay
Skilled nursing facility (SNF)	$0 copay per day: days 1-100	30% coinsurance per stay, up to 100 days
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	20% coinsurance	30% coinsurance
Outpatient mental health		
Group therapy	$0 copay - 20% coinsurance	30% coinsurance
Individual therapy	$0 copay - 20% coinsurance	30% coinsurance
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video	

Medical benefits

	In-network	Out-of-network
Diabetes monitoring supplies	20% coinsurance	30% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	20% coinsurance	30% coinsurance
Diagnostic tests and procedures (non-radiological)	$0 copay - 20% coinsurance	30% coinsurance
Lab services	$0 copay	$0 copay
Outpatient x-rays	$0 copay	30% coinsurance
Ambulance	20% coinsurance for ground or air	20% coinsurance for ground or air
Emergency care	$90 copay	
Urgently needed services	$40 copay	

Benefits and services beyond Original Medicare

	In-network	Out-of-network
Routine physical	$0 copay, 1 per year*	30% coinsurance, 1 per year*
Routine eye exams	$0 copay, 1 per year*	30% coinsurance, 1 per year*
Routine eyewear	$0 copay Plan pays up to $300 every year 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*	$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 combined limit on all covered dental services* If you choose to see an out-of-network dentist you might be billed more, even for services listed as $0 copay	
Hearing - routine exam	$0 copay, 1 per year*	30% coinsurance, 1 per year*
Hearing aids	Plan pays up to $2,000 every year for 2 hearing aids through UnitedHealthcare Hearing.* Includes hearing aids delivered directly to you with virtual follow-up care (select models).	

	In-network	Out-of-network
Routine transportation	$0 copay; 36 one-way trips per year to or from approved locations; additional unlimited trips for dialysis.*	75% coinsurance*
Foot care - routine	$0 copay, 8 visits per year*	30% coinsurance, 8 visits per year*
Over-the-counter (OTC) credit	$275 credit every quarter to buy covered OTC products	

*Benefits combined in and out-of-network

Prescription drugs

	Your cost	
Annual prescription (Part D) deductible	$505	
Cost-Sharing for Covered Drugs	**Standard Retail (30-day)**	**Mail Order (100-day)**
Initial coverage stage	25% coinsurance	25% coinsurance Some covered drugs limited to a 30-day supply
Coverage gap stage	After your total drug costs reach $4,660, 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 $7,400, you will pay the greater of $4.15 copay for generic (Including brand drugs treated as generic), $10.35 copay for all other drugs, or 5% coinsurance	

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