Benefit Highlights

UnitedHealthcare® Medicare Advantage Walmart Flex (HMO-POS)

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

Monthly plan premium	$0

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)	$6,700 In-network	$10,000 out-of-network
Doctor's office visit		
Primary care provider (PCP)	$0 copay	No coverage
Specialist	$35 copay (no referral needed)	No coverage
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video	
Preventive services	$0 copay	Flu, pneumonia, or COVID-19 vaccines: $0 copay All other services: No coverage
Inpatient hospital care	$370 copay per day: days 1-5 $0 copay per day: days 6 and beyond	No coverage
Skilled nursing facility (SNF)	$0 copay per day: days 1-20 $196 copay per day: days 21-55 $0 copay per day: days 56-100	No coverage
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	$370 copay	No coverage
Outpatient mental health		
Group therapy	$15 copay	40% coinsurance
Individual therapy	$25 copay	40% coinsurance

Medical benefits

	In-network	Out-of-network
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video	
Diabetes monitoring supplies	$0 copay for covered brands	No coverage
Diagnostic radiology services (such as MRIs, CT scans)	$110 copay	No coverage
Diagnostic tests and procedures (non-radiological)	$20 copay	No coverage
Lab services	$0 copay	No coverage
Outpatient x-rays	$15 copay	No coverage
Ambulance	$215 copay for ground or air	$215 copay for ground or air
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

	In-network	Out-of-network
Routine physical	$0 copay, 1 per year	No coverage
Routine eye exams	$0 copay, 1 per year	No coverage
Routine eyewear	$0 copay Plan pays up to $200 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	$750 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	No coverage

	In-network	Out-of-network
Hearing aids	$175 - $1,225 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year. Includes hearing aids delivered directly to you with virtual follow-up care (select models).	
Fitness program	$0 copay for Renew Active, which includes a free gym membership, plus online fitness classes and brain health challenges.	
Foot care - routine	$35 copay, 6 visits per year	No coverage
Flex benefit	$1,000 on a prepaid Visa® card to help pay for covered dental and vision services at Walmart Health Centers, vision products at Walmart Vision Centers and over-the-counter (OTC) products at any Walmart nationwide.	
Meal benefit	$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) 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]	$14 copay	$0 copay
Tier 3: Preferred Brand	$47 copay	$131 copay
Select insulin drugs[2]	$35 copay	$95 copay
Tier 4: Non-Preferred Drug	$100 copay	$290 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 $4,660, 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 $7,400, 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	

[1] Tier includes enhanced drug coverage

[2] For 2023, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for select insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for each 1-month supply of Part D select insulin drug through all coverage stages.

[3] Limited to a 30-day supply

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