

Benefit Highlights

UnitedHealthcare® Medicare Advantage Focus (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
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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)	\$1,900
Doctor's office visit	
Primary care provider (PCP)	\$0 copay
Specialist	\$0 copay (referral needed)
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
Preventive services	\$0 copay
Inpatient hospital care	\$0 copay per stay for unlimited days
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$125 copay per day: days 21-36 \$0 copay per day: days 37-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	\$0 copay
Outpatient mental health	
Group therapy	\$10 copay
Individual therapy	\$15 copay
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
Diabetes monitoring supplies	\$0 copay
Diagnostic radiology services (such as MRIs, CT scans)	\$50 copay
Diagnostic tests and procedures (non-radiological)	\$0 copay

Medical benefits

	Your cost
Lab services	\$0 copay
Outpatient x-rays	\$5 copay
Ambulance	\$160 copay for ground or air
Emergency care	\$90 copay (\$0 copay for emergency care outside the United States) per visit
Urgently needed services	\$10 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 per year
Routine eyewear	<p>\$0 copay</p> <p>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.</p> <p>Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only).</p>
Dental - preventive (covered in-network and out-of-network)	\$0 copay for exams, cleanings, X-rays, and fluoride*
Dental - comprehensive (covered in-network and out-of-network)	\$0 copay for comprehensive dental services*
Dental - benefit limit	<p>\$1,000 combined limit on all covered dental services*</p> <p>If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay</p>
Hearing - routine exam	\$0 copay, 1 per year
Hearing aids	<p>\$175 - \$1,225 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.</p> <p>Includes hearing aids delivered directly to you with virtual follow-up care (select models).</p>
Fitness program	\$0 copay for Renew Active, which includes a free gym membership, plus online fitness classes and brain health challenges.
Routine transportation	\$0 copay; 24 one-way trips per year to or from approved locations.
Foot care - routine	\$0 copay, 4 visits per year

	Your cost
Over-the-counter (OTC) credit	\$60 credit every quarter to buy covered OTC products
Meal benefit	\$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay.
Nurse hotline	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.

* Benefits combined in and out-of-network

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: Generic¹	\$8 copay	\$0 copay
Tier 3: Preferred Brand	\$47 copay	\$131 copay
Select insulin drugs²	\$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 and Tier 2 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 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 Coverage 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



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

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