Premiums	Original Medicare
Monthly Plan Premium	Medicare Part A & B premium if not otherwise paid for under Medicaid or by another third party.
Medical Deductible	Part B Deductible: $183
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	There is no limit to how much you will pay for covered services.

Benefits		Original Medicare
Inpatient Hospital Coverage		• $1,316 deductible for days 1 through 60 • $329 co-pay per day for days 61 through 90 • $658 co-pay each day for days 91 to 150 (lifetime reserve days) Covers 90 days for an inpatient hospital stay.
Doctor Visits	Primary	20% of the cost per visit
	Specialists	20% of the cost per visit
Preventive Care		$0 co-pay
Emergency Care		20% of the cost If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for certain services. If you are treated in a hospital emergency room and then admitted as a hospital inpatient during the same visit, you do not need to pay cost sharing on the hospital bill for the ER visit. But you are responsible for cost sharing on the physician services during both the ER and the inpatient stay. (And also responsible for the inpatient deductible.)
Urgently Needed Services		20% of the cost per visit

Benefits		Original Medicare
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for these services may be different if received in an outpatient surgery setting)	Diagnostic radiology services (e.g. MRI)	20% of the cost
	Lab services	$0 co-pay
	Diagnostic tests and procedures	20% of the cost
	Therapeutic Radiology	20% of the cost
	Outpatient x-rays	20% of the cost
Hearing Services	Exam to diagnose and treat hearing and balance issues	20% of the cost
Dental Services		Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): 20% of the cost
Vision Care	Exam to diagnose and treat diseases and conditions of the eye	20% of the cost
	Eyewear after cataract surgery	20% of the cost
Mental Health Care	Inpatient visit	• $1,316 deductible for days 1 through 60 • $329 co-pay per day for days 61 through 90 • $658 co-pay each day for days 91 to 150 (lifetime reserve days) Covers 90 days for an inpatient hospital stay.
	Outpatient group therapy visit	20% of the cost
	Outpatient individual therapy visit	20% of the cost

Benefits		Original Medicare
Skilled Nursing Facility (SNF) (Stay must meet Medicare coverage criteria)		• You pay nothing for days 1 through 20 • $164.50 co-pay per day for days 21 through 100 Covers up to 100 days in a SNF as long as you previously stayed in a hospital for 3 days.
Rehabilitation Services	Occupational therapy visit	20% of the cost
	Physical therapy and speech and language therapy visit	20% of the cost
Ambulance		20% of the cost
Routine Transportation		Not Covered
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	20% of the cost
Medical Equipment/ Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% of the cost
	Prosthetics (e.g., braces, artificial limbs)	20% of the cost
Wellness Programs		Not Covered
Medicare Part B Drugs	Most Part B drugs	20% of the cost
Outpatient Surgery	Ambulatory surgical center	20% of the cost
	Outpatient hospital	20% of the cost

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY: 711).

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