Benefit Highlights

UHC Dual Complete GA-D002 (HMO-POS D-SNP)

This is a short description of your 2024 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. If your eligibility for Medicaid or "Extra Help" changes, your cost sharing and premium may change.		
Monthly plan premium	$0 with "Extra Help"	$31.20 without "Extra Help"

Medical benefits				
Your plan has a deductible that applies to certain medical benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage.				
	With Medicaid Cost Share Assistance		**Without Medicaid Cost Share Assistance**	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Annual Medical Deductible	No deductible in or out-of-network		$226† combined in and out-of-network	
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	$0 In-network	$0 out-of-network	$8,850 In-network	Unlimited out-of-network

Medical benefits				
	With Medicaid Cost Share Assistance		Without Medicaid Cost Share Assistance	
	In-network	Out-of-network	In-network	Out-of-network
Doctor's office visit				
Primary care provider (PCP)	$0 copay	No coverage	20% coinsurance	No coverage
Specialist	$0 copay (no referral needed)	No coverage	20% coinsurance (no referral needed)	No coverage
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video		$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	$0 copay	Flu, pneumonia, or COVID-19 vaccines: $0 copay All other services: No coverage
Inpatient hospital care	$0 copay per stay for unlimited days	No coverage	$1,775 copay per stay for unlimited days	No coverage
Skilled nursing facility (SNF)	$0 copay per day: days 1-100	No coverage	$0 copay per day: for days 1-20 $200† copay per day: days 21-100	No coverage
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	$0 copay	No coverage	20% coinsurance	No coverage
Outpatient mental health				
Group therapy	$0 copay	$0 copay	20% coinsurance	40% coinsurance

Medical benefits				
	With Medicaid Cost Share Assistance		Without Medicaid Cost Share Assistance	
	In-network	Out-of-network	In-network	Out-of-network
Individual therapy	$0 copay	$0 copay	20% coinsurance	40% coinsurance
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video		$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	$0 copay for covered brands	No coverage
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay	No coverage	20% coinsurance	No coverage
Diagnostic tests and procedures (non-radiological)	$0 copay	No coverage	20% coinsurance	No coverage
Lab services	$0 copay	No coverage	$0 copay	No coverage
Outpatient x-rays	$0 copay	No coverage	20% coinsurance	No coverage
Ambulance	$0 copay for ground or air	$0 copay for ground or air	20% coinsurance for ground or air	20% coinsurance for ground or air
Emergency care	$0 copay (worldwide)		$100 copay ($0 copay for emergency care outside the United States) per visit	
Urgently needed services	$0 copay (worldwide)		$40 copay ($0 copay for urgently needed services outside the United States) per visit	

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 2023 Medicare-defined amounts and may change for 2024

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 $500 every year toward your purchase of frames (with standard lenses covered in full) or contact lenses (fitting and evaluation may be an additional cost) through UnitedHealthcare Vision. Home delivered eyewear available through UnitedHealthcare Vision (select products only). You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network.	
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	$3,000 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
Hearing aids	Plan pays up to $2,500 every year for 2 hearing aids through UnitedHealthcare Hearing. 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, brain health content and 1 Fitbit® device.	
Routine transportation	$0 copay for 36 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies	No coverage
Personal emergency response system	$0 copay for a personal emergency response system (PERS)	

Benefits and services beyond Original Medicare		
	In-network	**Out-of-network**
Foot care - routine	$0 copay, 4 visits per year	No coverage
Routine chiropractic care	$0 copay, 12 visits per year	No coverage
Routine acupuncture	$0 copay, 12 visits per year	No coverage
Food, over-the-counter (OTC) and utility bill credit	$185 credit every month to pay for covered healthy food, OTC products and utility bills from network utility companies	
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.	

Prescription drugs	
Annual Prescription Deductible	$0
30-day or 100-day supply from retail or mail order network pharmacy	
All covered drugs	$0 copay (Some covered drugs are limited to a 30-day supply)

Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.This information is not a complete description of benefits. Contact the plan for more information.