Benefit Highlights

UHC Medicare Advantage CT-0002 (HMO-POS)

This is a short description of your 2024 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	$33

Medical benefits	
Annual Medical Deductible	No deductible
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	$6,000
Doctor's office visit	
Primary care provider (PCP)	$0 copay
Specialist	$40 copay (no 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	$395 copay per day: days 1-4 $0 copay per day: days 5 and beyond
Skilled nursing facility (SNF)	$0 copay per day: days 1-20 $203 copay per day: days 21-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	$395 copay
Outpatient mental health	
Group therapy	$15 copay
Individual therapy	$25 copay
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video

Medical benefits	
Diabetes monitoring supplies	$0 copay for covered brands
Diagnostic radiology services (such as MRIs, CT scans)	$160 copay
Diagnostic tests and procedures (non-radiological)	$35 copay
Lab services	$0 copay
Outpatient x-rays	$15 copay
Ambulance	$290 copay for ground or air
Emergency care	$120 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	
Routine physical	$0 copay, 1 per year
Routine eye exams	$0 copay, 1 per year
Routine eyewear	$0 copay Plan pays up to $250 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 (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)	50% coinsurance on dentures and bridges $0 copay for all other covered comprehensive services*
Dental - benefit limit	$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

Benefits and services beyond Original Medicare	
Hearing - routine exam	$0 copay, 1 per year
Hearing aids	$99 to $1,249 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 content.
Foot care - routine	$40 copay, 6 visits per year
Over-the-counter (OTC) credit	$50 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 are combined in and out-of-network

Prescription drug payment stages		
Annual Prescription Deductible	$0 for Part D prescription drugs	
Initial Coverage	**Standard Retail (30-day supply)**	**Preferred Mail Order (100-day supply)**
Tier 1: Preferred Generic	$0 copay	$0 copay
Tier 2: Generic[1]	$10 copay	$0 copay
Tier 3: Preferred Brand	$47 copay	$131 copay
Tier 3: Covered Insulin Drugs	$35 copay	$95 copay
Tier 4: Non-Preferred Drug	$100 copay	$290 copay
Tier 5: Specialty Tier	33% coinsurance	N/A[3]

Prescription drug payment stages	
Coverage Gap (Donut hole)	After your total drug cost reaches $5,030, the plan continues to pay its share of the cost of your Tier 1 drugs and you pay your copay or coinsurance. For all other tiers, you pay 25% of the negotiated price for covered drugs. You may pay less if your plan has additional coverage in the gap.
Catastrophic Coverage	After your total out-of-pocket drug cost reaches $8,000, you won't pay anything for Medicare Part D covered drugs for the rest of the plan year.

[1] Tier includes enhanced drug coverage

[3] Limited to a 30-day supply

Optional riders available – See the Summary of Benefits or Evidence of Coverage for information

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