Benefit Highlights

UHC Complete Care GS-001A (Regional PPO C-SNP)

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		
If you have full Medicaid benefits or are a Qualified Medicare Beneficiary, you will pay $0 for your Medicare-covered services. You may have small copays for your Part D prescription drugs. If your eligibility for Medicaid or "Extra Help" changes, your cost sharing and premium may change.		
Monthly plan premium	$0 with "Extra Help"	$20.70 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 combined in and out-of-network	$8,850 In-network	$8,850 combined in and 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	$0 copay	20% coinsurance	20% coinsurance
Specialist	$0 copay (no referral needed)	$0 copay (no referral needed)	20% coinsurance (no referral needed)	20% coinsurance (no referral needed)
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	$0 copay	$0 copay	$0 copay
Inpatient hospital care	$0 copay per stay for unlimited days	$0 copay per stay for unlimited days	$1,750 copay per stay for unlimited days	$1,750 copay per stay for unlimited days
Skilled nursing facility (SNF)(Stay must meet Medicare coverage criteria)	$0 copay per day: days 1-100	$0 copay per day: days 1-100	$0 copay per day: for days 1-20 $200† copay per day: days 21-100	20% coinsurance per stay, up to 100 days
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	$0 copay	$0 copay	20% coinsurance	20% coinsurance
Outpatient mental health				
Group therapy	$0 copay	$0 copay	20% coinsurance	20% coinsurance
Individual therapy	$0 copay	$0 copay	20% coinsurance	20% 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	

Medical benefits				
	With Medicaid Cost Share Assistance		Without Medicaid Cost Share Assistance	
	In-network	Out-of-network	In-network	Out-of-network
Diabetes monitoring supplies	$0 copay for covered brands	$0 copay	$0 copay for covered brands	40% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay	$0 copay	20% coinsurance	20% coinsurance
Diagnostic tests and procedures (non-radiological)	$0 copay	$0 copay	20% coinsurance	20% coinsurance
Lab services	$0 copay	$0 copay	$0 copay	$0 copay
Outpatient x-rays	$0 copay	$0 copay	20% coinsurance	20% coinsurance
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)		$80 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*	$0 copay, 1 per year*
Routine eye exams	$0 copay, 1 per year*	$0 copay, 1 per year*
Routine eyewear	$0 copay	

Benefits and services beyond Original Medicare		
	In-network	**Out-of-network**
	Plan pays up to $150 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	$2,000 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*	20% coinsurance, 1 per year*
Hearing aids	Plan pays up to $1,100 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 and brain health content.	
Routine transportation	$0 copay for 36 one-way trips to or from approved medically related appointments and pharmacies*	75% coinsurance*
Personal emergency response system	$0 copay for a personal emergency response system (PERS)	
Foot care - routine	$0 copay, 6 visits per year*	$0 copay, 6 visits per year*
Over-the-counter (OTC) credit	$245 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.	

Benefits and services beyond Original Medicare		
	In-network	**Out-of-network**
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 if you qualify for Low-Income Subsidy (LIS)	
Annual Prescription Deductible	$0
30-day or 100-day supply from retail network pharmacy	
Generic (including brand drugs treated as generic)	$0, $1.55, or $4.50 copay (Some covered drugs are limited to a 30-day supply)
All other drugs	$0, $4.60, or $11.20 copay (Some covered drugs are limited to a 30-day supply)

Prescription drug payment stages if you do not qualify for LIS		
Annual Prescription Deductible	$545 for Part D prescription drugs	
Cost-sharing for covered drugs[1]	**Standard Retail (30-day supply)**	**Mail Order (100-day supply)**
Initial Coverage	25% coinsurance	25% coinsurance (Some covered drugs are limited to a 30-day supply)
Coverage Gap (Donut hole)	After your total drug cost reaches $5,030, 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] You will pay a maximum of $35 for each 1-month supply of Part D covered insulin drugs through all drug payment stages, except the Catastrophic drug payment stage, where you pay $0.

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