Benefit Highlights

UHC Medicare Advantage GS-0001 (Regional PPO)

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	$62

Medical benefits		
	In-network	**Out-of-network**
Annual Medical Deductible	No deductible in or out-of-network	
Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)	$6,300 In-network	$6,300 combined in and out-of-network
Doctor's office visit		
Primary care provider (PCP)	$0 copay	$25 copay
Specialist	$45 copay (no referral needed)	$45 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	$0 copay
Inpatient hospital care	$395 copay per day: days 1-4 $0 copay per day: days 5 and beyond	$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	$225 copay per day: days 1-28 $0 copay per day: days 29-100
Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)	$395 copay	$395 copay

Medical benefits		
	In-network	**Out-of-network**
Outpatient mental health		
Group therapy	$15 copay	$15 copay
Individual therapy	$25 copay	$25 copay
Virtual visits	$0 copay to talk with a network telehealth provider online through live audio and video	
Diabetes monitoring supplies	$0 copay for covered brands	50% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	$220 copay	$220 copay
Diagnostic tests and procedures (non-radiological)	$40 copay	$40 copay
Lab services	$0 copay	$0 copay
Outpatient x-rays	$15 copay	$15 copay
Ambulance	$275 copay for ground or air	$275 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		
	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*
Hearing - routine exam	$0 copay, 1 per year*	$45 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).	

Benefits and services beyond Original Medicare		
	In-network	**Out-of-network**
Personal emergency response system	$0 copay for a personal emergency response system (PERS)	
Foot care - routine	$45 copay, 6 visits per year*	$45 copay, 6 visits per year*
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 Tier 1 and Tier 2 Part D prescription drugs; $345 for Tier 3, Tier 4, Tier 5 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]	$14 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	28% coinsurance	N/A[3]
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.

Y0066_MABH_2024_M R2604001000 UHEX24RP0131679_000