

# Benefit Highlights

## UHC Dual Complete NC-S001 (PPO D-SNP)

This is a short description of your 2024 plan benefits. The values shown in-network are for those with Medicare Parts A and B cost sharing that may be covered by the state. Cost share may vary depending on your individual Medicaid eligibility. 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.** If your eligibility for Medicaid or “Extra Help” changes, your cost sharing and premium may change.

<b>Monthly plan premium</b>	\$0
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### Medical benefits

	In-network	Out-of-network
<b>Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)</b>	\$0 In-network	\$0 combined in and out-of-network
<b>Doctor’s office visit</b>		
Primary care provider (PCP)	\$0 copay	\$0 copay
Specialist	\$0 copay (no referral needed)	\$0 copay (no referral needed)
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video	
<b>Preventive services</b>	\$0 copay	\$0 copay
<b>Inpatient hospital care</b>	\$0 copay per stay for unlimited days	\$0 copay per stay for unlimited days
<b>Skilled nursing facility (SNF)</b>	\$0 copay per day: days 1-100	\$0 copay per day: days 1-100
<b>Outpatient hospital, including surgery</b>	\$0 copay	\$0 copay
<b>Outpatient mental health</b>		

<b>Medical benefits</b>		
	<b>In-network</b>	<b>Out-of-network</b>
Group therapy	\$0 copay	\$0 copay
Individual therapy	\$0 copay	\$0 copay
Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video	
<b>Diabetes monitoring supplies</b>	\$0 copay for covered brands	\$0 copay
<b>Diagnostic radiology services (such as MRIs, CT scans)</b>	\$0 copay	\$0 copay
<b>Diagnostic tests and procedures (non-radiological)</b>	\$0 copay	\$0 copay
<b>Lab services</b>	\$0 copay	\$0 copay
<b>Outpatient x-rays</b>	\$0 copay	\$0 copay
<b>Ambulance</b>	\$0 copay for ground or air	\$0 copay for ground or air
<b>Emergency care</b>	\$0 copay (worldwide)	
<b>Urgently needed services</b>	\$0 copay (worldwide)	

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.

<b>Benefits and services beyond Original Medicare</b>		
	<b>In-network</b>	<b>Out-of-network</b>
<b>Routine physical</b>	\$0 copay, 1 per year*	40% coinsurance, 1 per year*
<b>Routine eye exams</b>	\$0 copay, 1 per year*	40% coinsurance, 1 per year*
<b>Routine eyewear</b>	\$0 copay Plan pays up to \$400 every year for lenses/frames and contacts*	\$0 copay Plan pays up to \$400 every year for lenses/frames and contacts*
<b>Dental - preventive</b>	\$0 copay for exams, cleanings, X-rays, and fluoride*	\$0 copay for exams, cleanings, X-rays, and fluoride*

## Benefits and services beyond Original Medicare

	In-network	Out-of-network
<b>Dental - comprehensive</b>	\$0 copay for comprehensive dental services*	\$0 copay for comprehensive dental services*
<b>Dental - benefit limit</b>	\$3,500 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	
<b>Hearing - routine exam</b>	\$0 copay, 1 per year*	40% coinsurance, 1 per year*
<b>Hearing aids</b>	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).	
<b>Fitness program</b>	\$0 copay for Renew Active®, which includes a free gym membership, plus online fitness classes, brain health content and 1 Fitbit® device.	
<b>Routine transportation</b>	\$0 copay for 48 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies*	75% coinsurance*
<b>Personal emergency response system</b>	\$0 copay for a personal emergency response system (PERS)	
<b>Foot care - routine</b>	\$0 copay, 4 visits per year*	40% coinsurance, 4 visits per year*
<b>Routine chiropractic care</b>	\$0 copay, 20 visits per year*	40% coinsurance, 20 visits per year*
<b>Food, over-the-counter (OTC) and utility bill credit</b>	\$301 credit every month to pay for covered healthy food, OTC products and utility bills from network utility companies	
<b>Meal benefit</b>	\$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay.	
<b>Nurse Hotline</b>	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.	

\*Benefits are combined in and out-of-network

**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.