

# Benefit Highlights

## UHC Dual Complete NC-D001 (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.

<b>Monthly plan premium</b>	\$0 with “Extra Help”	\$46.90 without “Extra Help”
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### 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
<b>Annual Medical Deductible</b>	No deductible	\$226 <sup>†</sup>
<b>Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)</b>	\$0	\$8,850
<b>Doctor’s office visit</b>		
Primary care provider (PCP)	\$0 copay	20% coinsurance
Specialist	\$0 copay (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
<b>Preventive services</b>	\$0 copay	\$0 copay

<b>Medical benefits</b>		
	<b>With Medicaid Cost Share Assistance</b>	<b>Without Medicaid Cost Share Assistance</b>
<b>Inpatient hospital care</b>	\$0 copay per stay for unlimited days	\$1,730 copay per stay for unlimited days
<b>Skilled nursing facility (SNF)</b>	\$0 copay per day: days 1-100	\$0 copay per day: for days 1-20 \$200 <sup>†</sup> copay per day: days 21-100
<b>Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)</b>	\$0 copay	20% coinsurance
<b>Outpatient mental health</b>		
Group therapy	\$0 copay	20% coinsurance
Individual therapy	\$0 copay	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
<b>Diabetes monitoring supplies</b>	\$0 copay for covered brands	\$0 copay for covered brands
<b>Diagnostic radiology services (such as MRIs, CT scans)</b>	\$0 copay	20% coinsurance
<b>Diagnostic tests and procedures (non-radiological)</b>	\$0 copay	20% coinsurance
<b>Lab services</b>	\$0 copay	\$0 copay
<b>Outpatient x-rays</b>	\$0 copay	20% coinsurance
<b>Ambulance</b>	\$0 copay for ground or air	20% coinsurance for ground or air
<b>Emergency care</b>	\$0 copay (worldwide)	\$100 copay (\$0 copay for emergency care outside the United States) per visit

Medical benefits		
	With Medicaid Cost Share Assistance	Without Medicaid Cost Share Assistance
<b>Urgently needed services</b>	\$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	
<b>Routine physical</b>	\$0 copay, 1 per year
<b>Routine eye exams</b>	\$0 copay, 1 per year
<b>Routine eyewear</b>	<p>\$0 copay Plan pays up to \$400 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.</p> <p>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.</p>
<b>Dental - preventive (covered in-network and out-of-network)</b>	\$0 copay for exams, cleanings, X-rays, and fluoride*
<b>Dental - comprehensive (covered in-network and out-of-network)</b>	\$0 copay for comprehensive dental services*
<b>Dental - benefit limit</b>	<p>\$4,000 combined limit on all covered dental services*</p> <p>If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay</p>
<b>Hearing - routine exam</b>	\$0 copay, 1 per year
<b>Hearing aids</b>	<p>Plan pays up to \$2,500 every year for 2 hearing aids through UnitedHealthcare Hearing.</p> <p>Includes hearing aids delivered directly to you with virtual follow-up care (select models).</p>

## Benefits and services beyond Original Medicare

<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
<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
<b>Routine chiropractic care</b>	\$0 copay, 20 visits per year
<b>Food, over-the-counter (OTC) and utility bill credit</b>	\$326 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.