

Benefit Highlights

UHC Dual Complete VA-Y001 (HMO-POS 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.

Monthly plan premium	\$0
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Medical benefits

Doctor’s office visit

Primary care provider (PCP)	\$0 copay
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Specialist	\$0 copay (no referral needed)
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Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
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Preventive services	\$0 copay
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Inpatient hospital care	\$0 copay per stay for unlimited days
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Skilled nursing facility (SNF)	\$0 copay per day: days 1-100
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Outpatient hospital, including surgery	\$0 copay
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Outpatient mental health

Group therapy	\$0 copay
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Individual therapy	\$0 copay
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Virtual visits	\$0 copay to talk with a network telehealth provider online through live audio and video
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Diabetes monitoring supplies	\$0 copay for covered brands
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Diagnostic radiology services (such as MRIs, CT scans)	\$0 copay
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Medical benefits

Diagnostic tests and procedures (non-radiological)	\$0 copay
Lab services	\$0 copay
Outpatient x-rays	\$0 copay
Ambulance	\$0 copay for ground or air
Emergency care	\$0 copay (worldwide)
Urgently needed services	\$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.

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 \$400 every year for lenses/frames and contacts
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)	\$0 copay for comprehensive dental services*
Dental - benefit limit	\$3,000 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
Hearing aids	Plan pays up to \$3,600 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, brain health content and 1 Fitbit® device.

Benefits and services beyond Original Medicare

Routine transportation	\$0 copay for unlimited one-way trips to or from approved locations, such as medically related appointments, gyms, adult day cares and pharmacies
Personal emergency response system	\$0 copay for a personal emergency response system (PERS)
Adult day care	\$0 copay for 16 hours per week of adult day care through a network of contracted providers.
Foot care - routine	\$0 copay, 4 visits per year
Routine chiropractic care	\$0 copay, 12 visits per year
Routine acupuncture	\$0 copay, 12 visits per year
Food, over-the-counter (OTC) and utility bill credit	\$359 credit every month to pay for covered healthy food, OTC products and utility bills from network utility companies
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.
Respite care	Members with disabilities or other qualified medical conditions may be eligible for up to 40 hours per month of respite care.
Home support services	\$450 credit per quarter for pest control

*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.

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