

# Benefit Highlights

## UHC Preferred Complete Care FL-0003 (HMO 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   |  |
|--|--|
| Monthly plan premium   | \$0  |
| Medical benefits   |  |
| Annual Medical Deductible  | No deductible  |
| Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)               | \$2,900  |
| <b>Doctor's office visit</b>   |  |
| Primary care provider (PCP)  | \$0 copay  |
| Specialist   | \$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  |
| <b>Inpatient hospital care</b>   | \$0 copay per stay for unlimited days  |
| <b>Skilled nursing facility (SNF)</b>  | \$0 copay per day: days 1-20<br>\$25 copay per day: days 21-100                          |
| <b>Outpatient hospital, including surgery (Cost sharing for additional plan services will apply)</b> | \$75 copay   |
| <b>Outpatient mental health</b>  |  |
| Group therapy  | \$0 copay  |
| Individual therapy   | \$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   |

## Medical benefits

|   |  |
|---|--|
| <b>Diagnostic radiology services (such as MRIs, CT scans)</b> | \$0 copay  |
| <b>Diagnostic tests and procedures (non-radiological)</b>     | \$0 copay  |
| <b>Lab services</b>   | \$0 copay  |
| <b>Outpatient x-rays</b>                                      | \$0 copay  |
| <b>Ambulance</b>  | \$150 copay for ground or air  |
| <b>Emergency care</b>   | \$135 copay (\$0 copay for emergency care outside the United States) per visit |
| <b>Urgently needed services</b>                               | \$0 copay (worldwide)  |

## 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>        | \$0 copay<br>Plan pays up to \$300 every year for lenses/frames and contacts  |
| <b>Dental - preventive</b>    | \$0 copay for exams, cleanings, X-rays, and fluoride  |
| <b>Dental - comprehensive</b> | Covered; for a complete list of services and copays, please contact the plan  |
| <b>Hearing - routine exam</b> | \$0 copay, 1 per year   |
| <b>Hearing aids</b>           | \$99 to \$1,249 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.<br><br>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 and brain health content.  |
| <b>Routine transportation</b> | \$0 copay for unlimited one-way trips to or from approved medically related appointments and pharmacies   |
| <b>Foot care - routine</b>    | \$0 copay, 6 visits per year  |

## Benefits and services beyond Original Medicare

|   |  |
|---|--|
| <b>Food and over-the-counter (OTC) credit</b> | \$50 credit every month to buy covered OTC products – and covered healthy food for qualifying members                        |
| <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.  |

## Prescription drug payment stages

**Annual Prescription Deductible**      \$0 for Part D prescription drugs

| Initial Coverage | Standard Retail (30-day supply) | Preferred Mail Order (100-day supply) |
|------------------|---------------------------------|---------------------------------------|
|------------------|---------------------------------|---------------------------------------|

|                                  |           |           |
|----------------------------------|-----------|-----------|
| <b>Tier 1: Preferred Generic</b> | \$0 copay | \$0 copay |
|----------------------------------|-----------|-----------|

|                                    |           |           |
|------------------------------------|-----------|-----------|
| <b>Tier 2: Generic<sup>1</sup></b> | \$0 copay | \$0 copay |
|------------------------------------|-----------|-----------|

|                                |           |           |
|--------------------------------|-----------|-----------|
| <b>Tier 3: Preferred Brand</b> | \$3 copay | \$9 copay |
|--------------------------------|-----------|-----------|

|                                      |           |           |
|--------------------------------------|-----------|-----------|
| <b>Tier 3: Covered Insulin Drugs</b> | \$3 copay | \$9 copay |
|--------------------------------------|-----------|-----------|

|                                   |            |             |
|-----------------------------------|------------|-------------|
| <b>Tier 4: Non-Preferred Drug</b> | \$45 copay | \$125 copay |
|-----------------------------------|------------|-------------|

|                               |                 |                  |
|-------------------------------|-----------------|------------------|
| <b>Tier 5: Specialty Tier</b> | 33% coinsurance | N/A <sup>3</sup> |
|-------------------------------|-----------------|------------------|

**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, Tier 2 and Tier 3 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.

<sup>1</sup> Tier includes enhanced drug coverage

<sup>3</sup> Limited to a 30-day supply



**Preferred  
Care Partners**

A UnitedHealthcare Company

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

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