< Back to plans

Summary

Benefit details

Outpatient care and services

Inpatient care

Plan documents

Benefits details

UHC Preferred Dual Complete FL-D001 (HMO D-SNP)

H1045-012-000

4.5 out of 5 stars (2024 plan year)

Enroll

Summary

Monthly premium	$0.00
Medical deductible	$0
Out-of-network maximum out-of-pocket	N/A
In-network maximum out-of-pocket	$8,850
Combined maximum out-of-pocket	N/A
Drug deductible	$0
Initial coverage limit	$5,030
Catastrophic coverage limit	$8,000

Benefit details

Outpatient care and services

Plan Notes	Cost Sharing amounts assume member is protected by the State Medicaid Program from cost sharing. For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare-covered services up to the Medicaid allowed rate. You may be required to pay a Medicaid copay. Please see Summary of Benefits for details
Additional Services	**Additional Services:** Copayment for Fitness Benefit **$0.00** Copayment for Nursing Hotline **$0.00** Copayment for Bathroom Safety Devices and Modifications **$0.00** • Maximum plan benefit of **$305.00** for Bathroom Safety Devices and Modifications Copayment for In-Home Support Services **$0.00** Prior Authorization Required for Additional Services **Meal Benefit:** Copayment for Meal Benefit **$0.00** Prior Authorization Required for Meal Benefit
Ambulance Services	**In-Network:**

	Ground Ambulance: Copayment for Ground Ambulance Services **$0.00** **Air Ambulance:** Copayment for Air Ambulance Services **$0.00** Benefit Details - General 10a Note - NOTE ON AUTHORIZATION: Authorization is required for Non-emergency Medicare-covered ambulance ground and air transportation. Emergency Ambulance does not require authorization. Please see Evidence of Coverage for Prior Authorization rules
Chiropractic Services	**In-Network:** **Chiropractic Services:** Copayment for Medicare-covered Chiropractic Services **$0.00** Prior Authorization Required for Chiropractic Services
Dental Services	**In-Network:** **Preventive Dental:** Copayment for Oral Exams **$0.00** • Maximum 1 visit every six months Copayment for Prophylaxis (Cleaning) **$0.00** • Maximum 1 visit every six months Copayment for Fluoride Treatment **$0.00** • Maximum 1 visit every year Copayment for Dental X-Rays **$0.00** • Maximum 1 visit every year **Comprehensive Dental:** Copayment for Medicare-covered Benefits **$0.00** Copayment for Diagnostic Services **$0.00** • Maximum 1 visit (Please see Evidence of Coverage for details) Copayment for Restorative Services **$0.00** • Maximum 1 visit (Please see Evidence of Coverage for details) Copayment for Extractions **$0.00** • Maximum 1 visit every year Copayment for Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services **$0.00** • Maximum 1 visit (Please see Evidence of Coverage for details) Prior Authorization Required for Comprehensive Dental
Diabetes Supplies and Services	**In-Network:** **Diabetic Supplies and Services:** Copayment for Medicare-covered Diabetic Supplies **$0.00** Copayment for Medicare-covered Diabetic Therapeutic Shoes or Inserts **$0.00** Prior Authorization Required for Diabetic Supplies and Services Diabetic Supplies and Services limited to those from specified manufacturers(Please see Evidence of Coverage)
Diagnostic Tests, Lab and Radiology Services, and X-Rays	**In-Network:** **Outpatient Diag Procs/Tests/Lab Services:**

	Copayment for Medicare-covered Diagnostic Procedures/Tests **$0.00** Copayment for Medicare-covered Lab Services **$0.00** Prior Authorization Required for Outpatient Diag Procs/Tests/Lab Services **Outpatient Diag/Therapeutic Rad Services:** Copayment for Medicare-covered Diagnostic Radiological Services **$0.00** Copayment for Medicare-covered Therapeutic Radiological Services **$0.00** Copayment for Medicare-covered X-Ray Services **$0.00** Prior Authorization Required for Outpatient Diag/ Therapeutic Rad Services
Doctor Office Visits	**In-Network:** **Doctor Office Visit:** Copayment for Primary Care Office Visit **$0.00**
Doctor Specialty Visit	**In-Network:** **Doctor Specialty Visit:** Copayment for Physician Specialist Office Visit **$0.00** Prior Authorization Required for Doctor Specialty Visit
Durable Medical Equipment	**In-Network:** **Durable Medical Equipment:** Copayment for Medicare-covered Durable Medical Equipment **$0.00** Prior Authorization Required for Durable Medical Equipment This Plan has preferred Vendors/Manufacturers - Please see Evidence of Coverage
Emergency Care	**Emergency Care:** Copayment for Emergency Care **$0.00** Copayment for Medicare Covered Emergency Care waived if you are admitted to the hospital within 24 hours **Worldwide Coverage:** Copayment for Worldwide Emergency Coverage **$0.00** Copayment for Worldwide Emergency Transportation **$0.00**
Hearing Services	**In-Network:** **Hearing Exams:** Copayment for Medicare Covered Benefits **$0.00** Copayment for Routine Hearing Exams **$0.00** • Maximum 1 visit every year Prior Authorization Required for Hearing Exams **Hearing Aids:** Maximum Plan Allowance of **$2500.00** every year both ears combined Prior Authorization Required for Hearing Aids
Home Health Care	**In-Network:** **Home Health Services:**

	Copayment for Medicare-covered Home Health Services **$0.00** Prior Authorization Required for Home Health Services
Outpatient Mental Health Care	**In-Network:** **Outpatient Mental Health Services:** Copayment for Medicare-covered Individual Sessions **$0.00** Copayment for Medicare-covered Group Sessions **$0.00** Prior Authorization Required for Outpatient Mental Health Services
Outpatient Prescription Drugs	**In-Network:** **Outpatient Part B RX Drugs:** Copayment for Medicare Part B Chemotherapy Drugs **$0.00** Copayment for Other Medicare Part B Drugs **$0.00** Prior Authorization Required for Outpatient Part B RX Drugs
Outpatient Rehabilitation Services	**In-Network:** **Cardiac and Pulmonary Rehabilitation Services:** Copayment for Medicare-covered Cardiac Rehabilitation Services **$0.00** Copayment for Medicare-covered Intensive Cardiac Rehabilitation Services **$0.00** Copayment for Medicare-covered Pulmonary Rehabilitation Services **$0.00** Prior Authorization Required for Cardiac and Pulmonary Rehabilitation Services **Occupational Therapy Rehabilitation Services:** Copayment for Medicare-covered Occupational Therapy Services **$0.00** Prior Authorization Required for Occupational Therapy Rehabilitation Services **Physical Therapy and Speech-Language Pathology Services:** Copayment for Medicare-covered Physical Therapy and Speech-Language Pathology Service **$0.00** Prior Authorization Required for Physical Therapy and Speech-Language Pathology Services
Outpatient Services/Surgery	**In-Network:** **Outpatient Hospital Services:** Copayment for Medicare Covered Outpatient Hospital Services **$0.00** Prior Authorization Required for Outpatient Hospital Services **Outpatient Observation Services:** Copayment for Medicare Covered Observation Services **$0.00** Prior Authorization Required for Outpatient Observation Services **Ambulatory Surgical Center Services:** Copayment for Ambulatory Surgical Center Services **$0.00** Prior Authorization Required for Ambulatory Surgical Center Services

Outpatient Substance Abuse	**In-Network:** **Outpatient Substance Abuse Services:** Copayment for Medicare-covered Individual Sessions **$0.00** Copayment for Medicare-covered Group Sessions **$0.00** Prior Authorization Required for Outpatient Substance Abuse Services
Over-the-Counter Items	**In-Network:** **Over-The-Counter (OTC) Items:** Copayment for Over-The-Counter (OTC) Items **$0.00** Maximum Plan Benefit of **$305.00** every month Nicotine Replacement Therapy (NRT) offerred as a Part C OTC benefit
Podiatry Services	**In-Network:** **Podiatry Services:** Copayment for Medicare-Covered Podiatry Services **$0.00** Copayment for Routine Foot Care **$0.00** • Maximum 6 visits every year Prior Authorization Required for Podiatry Services
Preventive Services and Wellness/Education Programs	**In-Network:** $0.00 copay for Medicare Covered Preventive Services: Abdominal aortic aneurysm screening Alcohol misuse screenings & counseling Bone mass measurements (bone density) Cardiovascular disease screenings Cardiovascular disease (behavioral therapy) Cervical & vaginal cancer screening Colorectal cancer screenings Depression screenings Diabetes screenings Diabetes self-management training Glaucoma tests Hepatitis B (HBV) infection screening Hepatitis C screening test HIV screening Lung cancer screening Mammograms (screening) Nutrition therapy services Obesity screenings & counseling One-time Welcome to Medicare preventive visit Prostate cancer screenings(PSA) Sexually transmitted infections screening & counseling Shots: • COVID-19 shots • Flu shots • Hepatitis B shots • Pneumococcal shots Tobacco use cessation Yearly "Wellness" visit
Prosthetic Devices	**In-Network:** **Prosthetics/Medical Supplies:** Copayment for Medicare-covered Prosthetic Devices **$0.00**

	Copayment for Medicare-covered Medical Supplies **$0.00** Prior Authorization Required for Prosthetics/Medical Supplies
Renal Dialysis	**In-Network:** **Dialysis Services:** Copayment for Medicare-covered Dialysis Services **$0.00** Prior Authorization Required for Dialysis Services
Transportation	**Transportation Services:** Copayment for Transportation Services **$0.00** Plan allows for an unlimited number of one way trips to a Plan-approved location Benefit Details - General 10b Note - NOTE ON MODE OF TRANSPORTATION: Van refers to multi-load, stretcher or wheelchair van only. Car or livery service may be substituted for van transportation.
Urgently Needed Care	**Urgent Care:** Copayment for Urgent Care **$0.00** **Worldwide Coverage:** Copayment for Worldwide Urgent Coverage **$0.00**
Vision Services	**In-Network:** **Eye Exams:** Copayment for Medicare Covered Benefits **$0.00** Copayment for Routine Eye Exams **$0.00** • Maximum 1 Routine Eye Exam every year Prior Authorization Required for Eye Exams **Eyewear:** Copayment for Medicare-Covered Benefits **$0.00** Copayment for Contact Lenses **$0.00** Copayment for Eyeglasses (lenses and frames) **$0.00** Copayment for Upgrades **$0.00** Maximum Plan Benefit of **$300.00** every year for all Non-Medicare covered eyewear
Flexible Extras	All-in-one UCard, only from UnitedHealthcare, is a member ID and so much more. UCard gives access to network providers, pharmacies, and fitness locations. Plus, members with an OTC benefit or earned rewards can shop with UCard in-store or online.

Inpatient care

Inpatient Hospital Care	**In-Network:** **Acute Hospital Services:** Copayment for Acute Hospital Services per Stay **$0.00** Your plan covers an unlimited number of days for an inpatient stay. Prior Authorization Required for Acute Hospital Services

Inpatient Mental Health Care	**In-Network:** **Psychiatric Hospital Services:** Copayment for Psychiatric Hospital Services per Stay **$0.00** Prior Authorization Required for Psychiatric Hospital Services
Skilled Nursing Facility (SNF)	**In-Network:** **Skilled Nursing Facility Services:** **$0.00** per day for days 1 to 100 Prior Authorization Required for Skilled Nursing Facility Services

Plan documents

Links to plan documents	Summary of Benefits Evidence of Coverage Star Ratings Resumen de Beneficios (Español) Evidencia de Cobertura (Español) Clasificación Por Estrellas (Español)

Plan notes

Dual-Eligible Special Needs Plans	The amount paid for each drug tier depends on your low-income subsidy (LIS) level. The medication cost for a 60 or 90 day supply will be the same as a 30 day supply (excluding Specialty Tier drugs).