



	Group Medicare (HMO-POS)	
	In-Network	Out-of-Network
Maximum Out-of-Pocket Costs	\$2,500	N/A
Doctor Visits & NurseLine		
Primary Care Provider Visit	\$5	20% coinsurance
Specialist Visit	\$10	20% coinsurance
Telehealth Visit	\$0	Available through contracted provider
24-Hour NurseLine	\$0	
Preventive Care*		
Pap Smears, Pelvic Exams, Mammograms	\$0	20% coinsurance
Prostate & Colorectal Cancer Screenings	\$0	20% coinsurance
Bone Mass Measurement	\$0	20% coinsurance
Vaccinations (COVID-19, flu, pneumonia)	\$0	\$0
Labs & Tests*		
Lab Services	\$0	20% coinsurance
Diagnostic Procedures/Tests	\$0	20% coinsurance
X-rays	\$0	20% coinsurance
Advanced Imaging (MRI, MRA, CT, CTA, PET scans, etc.)	\$0	20% coinsurance
Outpatient Surgery		
Surgery (outpatient hospital or ambulatory surgical center)	\$0	20% coinsurance
Inpatient Hospital Care per Admission		
Inpatient Deductible	\$0	Same as Medicare
Inpatient Stay per Day	\$50 days 1-10 \$0 days 11+	Same as Medicare
Worldwide Emergency Care, Urgent Care and Emergency Transportation†		
Emergency Care	\$50	\$50
Urgently Needed Care	\$10	\$10
Emergency Ambulance Services (per one-way trip, ground or air)	\$50	\$50
Emergency or Urgent Care Outside U.S.	N/A	\$50

*Office visit copay may apply.

[†]Emergency care copay waived if admitted to inpatient hospital care within 24 hours for the same condition

Home Health & Skilled Nursing Facility Care		
Home Health Care	\$0	20% coinsurance
Skilled Nursing Facility Care per Day (semiprivate room and board)	\$0 days 1-20 \$25 days 21+	\$0 days 1-20 \$25 days 21+
Outpatient Services & Supplies		
Occupational, Physical or Speech Therapy Visit	\$0	20% coinsurance
Durable Medical Equipment - DME (wheelchairs, oxygen, etc.)	5% coinsurance	20% coinsurance
Diabetes Monitoring Supplies (DME provider or retail pharmacy)	\$0	20% coinsurance
Mental Health & Substance Abuse Treatment		
Inpatient Mental Health Care (per day)	\$50 days 1-10 \$0 days 11-90	Same as Medicare
Outpatient Mental Health Visit or Substance Abuse Treatment Visit	\$10	20% coinsurance
Additional Benefits Not Covered by Medicare		
Allowance for Over-the-Counter Health & Wellness Items	\$40 per quarter	
Meals After Inpatient Hospital Stay (up to 28 meals over 14 days)	\$0	
Routine Eye Exam (one per year)	\$0	
Eyeglasses (one pair per year) or Contact Lenses	\$200 allowance	
Hearing Aids (up to two per year; includes OTC and prescription hearing aids)	\$750 allowance	
Dental - Preventive* (oral exams, cleanings and X-rays)	\$0	
Dental - Comprehensive/Restorative*	\$0	
Dental - Bridges or Dentures*	50% coinsurance	
Dental - Coverage Maximum	\$2,500	
Respite Care (12 sessions per year for members with dementia, including Alzheimer's disease)	\$0	
Fitness Benefit	\$0	
Emergency Medical Alert Device	\$0	

Part D Prescription Drug Coverage

Initial Coverage Stage	30-Day Supply	90-Day Supply
Tier 1	\$3	\$0
Tier 2	\$10	\$0
Tier 3	\$25	\$50
Tier 4	\$50	\$100
Tier 5	20% coinsurance	20% coinsurance

*Out-of-network dental services may have higher member costs.



A UnitedHealthcare Company

For more information on Medicare or our plan benefits, call toll-free:

1-866-556-8167 (TTY: 711)

Daily: 8 a.m.–8 p.m. (Oct. 1–March 31)

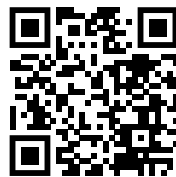
Monday–Friday: 8 a.m.–8 p.m. (April 1–Sept. 30)

Asistencia disponible en español.

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Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies. For Medicare Advantage Plans: A Medicare Advantage organization with a Medicare contract. For Dual Special Needs Plans: A Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare. Out-of-network/noncontracted providers are under no obligation to treat Peoples Health members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Contact the plan for more information.

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