PEOPLES HEALTH

A UnitedHealthcare Company

Peoples Health Group Medicare HMO-POS

2025

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	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.

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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.

Three Lakeway Center | 3838 N. Causeway Blvd., Suite 2500 | Metairie, LA 70002
peopleshealth.com

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