2019 SUMMARY OF BENEFITS

Overview of your plan

UnitedHealthcare® Assisted Living Plan (HMO-POS SNP)

H5253-043

Look inside to learn more about the health services and drug coverages the plan provides. Call Customer Service or go online for more information about the plan.

Toll-free **1-855-544-4342**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.UHCMedicareSolutions.com

UnitedHealthcare®

Y0066_SB_H5253_043_2019_M

Our service area includes these counties in:

North Carolina: Alamance, Buncombe, Cabarrus, Chatham, Cumberland, Davidson, Durham, Forsyth, Gaston, Guilford, Henderson, Iredell, Mecklenburg, Orange, Randolph, Rockingham, Rowan, Stokes, Wake, Yadkin.

Summary of Benefits

January 1st, 2019 - December 31st, 2019

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.UHCMedicareSolutions.com or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

About this plan.

UnitedHealthcare® Assisted Living Plan (HMO-POS SNP) is a Medicare Advantage HMOPOS plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed inside the cover, and be a United States citizen or lawfully present in the United States.

UnitedHealthcare® Assisted Living Plan (HMO-POS SNP) is an Institutional Special Needs Plan designed specifically for people who live in a contracted assisted living facility and require an institutional level of care. You can find a list of contracted assisted living facilities at www.uhcassistedlivingplan.com.

Use network providers and pharmacies.

UnitedHealthcare® Assisted Living Plan (HMO-POS SNP) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network. Out-of-network services are limited to the plan's service area as described on the cover. If you have any questions, please contact customer service. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at an in-network pharmacy.

You can go to www.UHCMedicareSolutions.com to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

UnitedHealthcare® Assisted Living Plan (HMO-POS SNP)

Premiums and Benefits	In-Network	Out-of-Network
Monthly Plan Premium	$28.90	
Annual Medical Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Amount (does not include prescription drugs)	$1,800 annually for Medicare-covered services you receive from in-network providers.	Unlimited Out-of-Network
	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and share of the cost for your Part D prescription drugs.	

UnitedHealthcare® Assisted Living Plan (HMO-POS SNP)

Benefits		In-Network	Out-of-Network
Inpatient Hospital		$200 copay per day: for days 1-7 $0 copay per day: for days 8 and beyond	30% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital		$175 copay Cost sharing for additional plan covered services will apply.	30% coinsurance Cost sharing for additional plan covered services will apply.
Outpatient Hospital Observation Services		$175 copay	30% coinsurance
Doctor Visits	Primary	$0 copay	30% coinsurance
	Specialists	$25 copay	30% coinsurance
Preventive Care	Medicare-covered	$0 copay	$0 copay - 30% coinsurance (depending on the service)
		Abdominal aortic aneurysm screening Alcohol misuse counseling Annual “Wellness” visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screening Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screening Diabetes screenings and monitoring Hepatitis C screening HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy services Medicare Diabetes Prevention Program (MDPP) Obesity screenings and counseling	

Benefits		In-Network	Out-of-Network
		Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including flu shots, hepatitis B shots, pneumococcal shots “Welcome to Medicare” preventive visit (one-time)	
		Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.	
Emergency Care		$90 copay (worldwide) per visit If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See the “Inpatient Hospital Care” section of this booklet for other costs.	
Urgently Needed Services		$25 - $40 copay	
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)	20% coinsurance	30% coinsurance
	Lab services	$0 copay	$0 copay
	Diagnostic tests and procedures	20% coinsurance	30% coinsurance
	Therapeutic Radiology	20% coinsurance	30% coinsurance
	Outpatient X-rays	$0 copay per service	30% coinsurance
Hearing Services	Exam to diagnose and treat hearing and balance issues	$0 copay	30% coinsurance
	Routine hearing exam	$0 copay; 1 per year	Not covered
	Hearing aid	$1,600 allowance every 2 years	Not covered

Benefits		In-Network	Out-of-Network
Routine Dental Services	Preventive	$0 copay for covered services (exam, cleaning, x-rays)	Not covered
	Comprehensive	$0 copay for covered services	Not covered
	Benefit limit	$2,400 limit on all covered dental services	Not covered
Vision Services	Exam to diagnose and treat diseases and conditions of the eye	$20 copay	30% coinsurance
	Eyewear after cataract surgery	$0 copay	$0 copay
	Routine eye exam	$0 copay Up to 1 every year*	30% coinsurance Up to 1 every year*
	Eyewear	$0 copay every year; up to $200 for lenses/ frames and contacts	Not covered
Mental Health	Inpatient visit	$200 copay per day: for days 1-7 $0 copay per day: for days 8-90	30% coinsurance per stay
		Our plan covers 90 days for an inpatient hospital stay.	
	Outpatient group therapy visit	$30 copay	30% coinsurance
	Outpatient individual therapy visit	$40 copay	30% coinsurance
Skilled Nursing Facility (SNF)		$0 copay per day: for days 1-100	30% coinsurance per stay, up to 100 days
		Our plan covers up to 100 days in a SNF.	
Physical therapy and speech and language therapy visit		$0 copay	30% coinsurance
Ambulance		$100 copay for ground $100 copay for air	$100 copay for ground $100 copay for air

Benefits		In-Network	Out-of-Network
Routine Transportation		$0 copay; 36 one-way trips per year to or from approved locations	Not covered
Medicare Part B Drugs	Chemotherapy drugs	20% coinsurance	30% coinsurance
	Other Part B drugs	20% coinsurance	30% coinsurance

Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

Stage 1: Annual Prescription Deductible	$0 per year for Tier 1, Tier 2 and Tier 3; $200 for Tier 4 and Tier 5 Part D prescription drugs.			
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail**		**Mail Order**	
	Standard		**Preferred**	**Standard**
	30-day supply	**90-day supply**	**90-day supply**	**90-day supply**
Tier 1: Preferred Generic Drugs	$2 copay	$6 copay	$0 copay	$6 copay
Tier 2: Generic Drugs	$12 copay	$36 copay	$0 copay	$36 copay
Tier 3: Preferred Brand Drugs	$47 copay	$141 copay	$131 copay	$141 copay
Tier 4: Non-Preferred Drugs	$100 copay	$300 copay	$290 copay	$300 copay
Tier 5: Specialty Tier Drugs	29% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance
Stage 3: Coverage Gap Stage	After your total drug costs reach $3,820, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.			
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: □ 5% coinsurance, or □ $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copay for all other drugs.			

Additional Benefits		In-Network	Out-of-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation	$20 copay	30% coinsurance
Diabetes Management	Diabetes monitoring supplies	$0 copay We only cover ACCU-CHEK® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio®, OneTouch Verio® IQ, OneTouch Verio® Flex, ACCU-CHEK® Guide, ACCU-CHEK® Aviva, and ACCU-CHEK® Nano SmartView. Test strips: OneTouch Verio®, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® SmartView, and OneTouch Ultra®. Other brands are not covered by your plan.	30% coinsurance
	Diabetes Self-management training	$0 copay	30% coinsurance
	Therapeutic shoes or inserts	20% coinsurance	30% coinsurance
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% coinsurance	30% coinsurance
	Prosthetics (e.g., braces, artificial limbs)	$0 copay - 20% coinsurance	30% coinsurance
Fitness through Fitbit®		Get a Fitbit® activity tracker at no additional cost to you. This device may help you improve or maintain good health by tracking your physical activity and exercise.	

Additional Benefits		In-Network	Out-of-Network
Foot Care (podiatry services)	Foot exams and treatment	$0 copay	30% coinsurance
	Routine foot care	$0 copay; for each visit up to 6 visits every year*	30% coinsurance; for each visit up to 6 visits every year*
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.	
Occupational Therapy Visit		$0 copay	30% coinsurance
Outpatient Substance Abuse	Outpatient group therapy visit	$30 copay	30% coinsurance
	Outpatient individual therapy visit	$40 copay	30% coinsurance
Outpatient Surgery		$175 copay	30% coinsurance
Health Products Benefit		$140 credit per quarter to use on approved health products.	
Renal Dialysis		20% coinsurance	20% coinsurance

*Benefits are combined in and out-of-network

Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is available to anyone living in a contracted nursing home.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服 務。請致電 1-855-814-6894（TTY：711).

This information is available for free in other languages. Please call our customer service number located on the first page of this book.

Esta información esta disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la cobertura de este libro.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

Benefits, premium and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

Every year, Medicare evaluates plans based on a 5-star rating system.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-877-266-4832, TTY 711.

Use of any Fitbit device is voluntary. Consult a health care professional before beginning any exercise program. Availability of the Fitbit benefit varies by plan/market. Refer to your Evidence of Coverage for more details. Fitbit is a registered trademark of Fitbit, Inc.

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