

# 2019 SUMMARY OF BENEFITS



## Overview of your plan

UnitedHealthcare® Nursing Home Plan (HMO SNP)

H5253-042

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.UHC MedicareSolutions.com](http://www.UHC MedicareSolutions.com)**



Our service area includes these counties in:

**North Carolina:** Alamance, Buncombe, Cabarrus, Chatham, Cleveland, Cumberland, Davidson, Durham, Forsyth, Gaston, Guilford, Haywood, Henderson, Iredell, Johnston, Mecklenburg, Orange, Randolph, Rockingham, Rowan, Stokes, Union, Wake, Wilkes, 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](http://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® Nursing Home Plan (HMO SNP) is a Medicare Advantage HMO 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® Nursing Home Plan (HMO SNP) is an Institutional Special Needs Plan designed specifically for people who live in a contracted institution (like a nursing home) for 90 days or longer. You can find a list of contracted institutions at [www.uhc nursinghomeplan.com](http://www.uhc nursinghomeplan.com).

## Use network providers and pharmacies.

UnitedHealthcare® Nursing Home Plan (HMO SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers or pharmacies that are not in our network, the plan may not pay for those services or drugs, or you may pay more than you pay at an in-network pharmacy.

You can go to [www.UHCMedicareSolutions.com](http://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® Nursing Home Plan (HMO SNP)

Premiums and Benefits	In-Network
<b>Monthly Plan Premium</b>	\$28.90
<b>Annual Medical Deductible</b>	This plan does not have a deductible.
<b>Maximum Out-of-Pocket Amount (does not include prescription drugs)</b>	<p>\$1,800 annually for Medicare-covered services you receive from in-network providers.</p> <p>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.</p>

# UnitedHealthcare® Nursing Home Plan (HMO SNP)

Benefits		In-Network
<b>Inpatient Hospital</b>		<p>You pay the Original Medicare cost sharing amount for 2019 which will be set by CMS in the fall of 2018. These are 2018 cost sharing amounts and may change for 2019. Our plan will provide updated rates as soon as they are released.</p> <p>\$1,340 deductible for days 1 to 60;            \$335 copay each day for days 61 to 90;            \$670 copay each day for days 91 to 150 (lifetime reserve days)</p> <hr/> <p>Our plan covers 90 days for an inpatient hospital stay.</p>
<b>Outpatient Hospital</b>		<p>10% coinsurance</p> <p>Cost sharing for additional plan covered services will apply.</p>
<b>Outpatient Hospital Observation Services</b>		10% coinsurance
<b>Doctor Visits</b>	Primary	\$0 copay
	Specialists	\$0 copay in a nursing home 20% coinsurance outside of a nursing home
<b>Preventive Care</b>	Medicare-covered	\$0 copay
		<p>Abdominal aortic aneurysm screening</p> <p>Alcohol misuse counseling</p> <p>Annual “Wellness” visit</p> <p>Bone mass measurement</p> <p>Breast cancer screening (mammogram)</p> <p>Cardiovascular disease (behavioral therapy)</p> <p>Cardiovascular screening</p> <p>Cervical and vaginal cancer screening</p> <p>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</p> <p>Depression screening</p> <p>Diabetes screenings and monitoring</p> <p>Hepatitis C screening</p> <p>HIV screening</p> <p>Lung cancer with low dose computed tomography (LDCT) screening</p> <p>Medical nutrition therapy services</p>

## Benefits

## In-Network

		<p>Medicare Diabetes Prevention Program (MDPP)</p> <p>Obesity screenings and counseling</p> <p>Prostate cancer screenings (PSA)</p> <p>Sexually transmitted infections screenings and counseling</p> <p>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</p> <p>Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</p> <p>“Welcome to Medicare” preventive visit (one-time)</p>
		<p>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.</p>
<b>Emergency Care</b>		<p>\$90 copay per visit</p> <p>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.</p>
<b>Urgently Needed Services</b>		\$65 copay
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b>	Diagnostic radiology services (e.g. MRI)	\$0 copay per service in a nursing home 20% coinsurance outside of a nursing home
	Lab services	\$0 copay
	Diagnostic tests and procedures	\$0 copay in a nursing home 20% coinsurance outside of a nursing home
	Therapeutic Radiology	20% coinsurance
	Outpatient X-rays	\$0 copay per service
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues	\$0 copay in a nursing home 20% coinsurance outside of a nursing home
	Routine hearing exam	\$0 copay; 1 per year
	Hearing aid	\$2,000 allowance every 2 years

## Benefits

## In-Network

<b>Routine Dental Services</b>	Preventive	\$0 copay for covered services (exam, cleaning, x-rays)
	Comprehensive	\$0 copay for covered services
	Benefit limit	\$3,500 limit on all covered dental services
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye	\$0 copay in a nursing home 20% coinsurance outside of a nursing home
	Eyewear after cataract surgery	\$0 copay
	Routine eye exam	\$0 copay Up to 1 every 2 years
	Eyewear	\$0 copay every 2 years; up to \$300 for lenses/frames and contacts
<b>Mental Health</b>	Inpatient visit	You pay the Original Medicare cost sharing amount for 2019 which will be set by CMS in the fall of 2018. These are 2018 cost sharing amounts and may change for 2019. Our plan will provide updated rates as soon as they are released.  \$1,340 deductible for days 1 to 60; \$335 copay each day for days 61 to 90; \$670 copay each day for days 91 to 150 (lifetime reserve days)
		Our plan covers 90 days for an inpatient hospital stay.
	Outpatient group therapy visit	\$0 copay in a nursing home 20% coinsurance outside of a nursing home
	Outpatient individual therapy visit	\$0 copay in a nursing home. 20% coinsurance outside of a nursing home
<b>Skilled Nursing Facility (SNF)</b>		\$0 copay per day: for days 1-100
		Our plan covers up to 100 days in a SNF.
<b>Physical therapy and speech and language therapy visit</b>		\$0 copay

**Benefits****In-Network**

<b>Ambulance</b>		20% coinsurance for ground 20% coinsurance for air
<b>Routine Transportation</b>		\$0 copay; 18 one-way trips per year to or from approved locations
<b>Medicare Part B Drugs</b>	Chemotherapy drugs	20% coinsurance
	Other Part B drugs	20% 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.

<b>Stage 1: Annual Prescription Deductible</b>	\$415 per year for Part D prescription drugs.		
<b>Cost-sharing for covered drugs</b>	<b>Retail</b>		<b>Mail Order</b>
	<b>30-day supply</b>	<b>90-day supply</b>	<b>90-day supply</b>
<b>Stage 2: Initial Coverage (After you pay your deductible, if applicable)</b>	25% coinsurance	25% coinsurance	25% coinsurance
<b>Stage 3: Coverage Gap Stage</b>	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.		
<b>Stage 4: Catastrophic Coverage</b>	<p>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:</p> <ul style="list-style-type: none"> <li>□ 5% coinsurance, or</li> <li>□ \$3.40 copay for generic (including brand drugs treated as generic) and a \$8.50 copay for all other drugs.</li> </ul>		

## Additional Benefits

## In-Network

<b>Chiropractic Care</b>	Manual manipulation of the spine to correct subluxation	\$0 copay in a nursing home. 20% coinsurance outside of a nursing home.
<b>Diabetes Management</b>	Diabetes monitoring supplies	20% coinsurance
	Diabetes Self-management training	\$0 copay
	Therapeutic shoes or inserts	20% coinsurance
<b>Durable Medical Equipment (DME) and Related Supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs)	\$0 copay - 20% coinsurance
<b>Foot Care (podiatry services)</b>	Foot exams and treatment	\$0 copay in a nursing home. 20% coinsurance outside of a nursing home.
	Routine foot care	\$0 copay; for each visit up to 4 visits every year
<b>Hospice</b>		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.
<b>Occupational Therapy Visit</b>		\$0 copay
<b>Outpatient Substance Abuse</b>	Outpatient group therapy visit	\$0 copay in a nursing home 20% coinsurance outside of a nursing home
	Outpatient individual therapy visit	\$0 copay in a nursing home 20% coinsurance outside of a nursing home
<b>Outpatient Surgery</b>		10% coinsurance

**Additional Benefits****In-Network****Health Products Benefit**

\$365 credit per quarter to use on approved health products.

**Renal Dialysis**

\$0 copay in a nursing home

20% coinsurance outside of a nursing home

## 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.