

# Summary of Benefits 2021

Medicare Advantage Plan  
with Prescription Drugs

**UnitedHealthcare® Assisted Living Plan (HMO-POS I-SNP)**  
H5253-043-000

Look inside to take advantage of 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 Medicare Solutions.com](http://www.UHC Medicare Solutions.com)**



# Summary of Benefits

## January 1st, 2021 - December 31st, 2021

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® Assisted Living Plan (HMO-POS I-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 below, and be a United States citizen or lawfully present in the United States.

UnitedHealthcare® Assisted Living Plan (HMO-POS I-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](http://www.uhcassistedlivingplan.com).

Our service area includes these counties in:

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

### Use network providers and pharmacies.

UnitedHealthcare® Assisted Living Plan (HMO-POS I-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 a 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® Assisted Living Plan (HMO-POS I-SNP)

## Premiums and Benefits

	In-Network	Out-of-Network
<b>Monthly Plan Premium</b>	\$25	
<b>Annual Medical Deductible</b>	This plan does not have a deductible.	
<b>Maximum Out-of-Pocket Amount (does not include prescription drugs)</b>	\$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 I-SNP)

## Benefits

		In-Network	Out-of-Network
<b>Inpatient Hospital<sup>2</sup></b>		\$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.	
<b>Outpatient Hospital</b>  Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC) <sup>2</sup>	\$0 copay for a diagnostic colonoscopy \$175 copay otherwise	30% coinsurance
	Outpatient Hospital, including surgery <sup>2</sup>	\$0 copay for a diagnostic colonoscopy \$175 copay otherwise	30% coinsurance
	Outpatient Hospital Observation Services <sup>2</sup>	\$175 copay	30% coinsurance
<b>Doctor Visits</b>	Primary Care Provider	\$0 copay	30% coinsurance
	Virtual Medical Visits	\$0 copay; Speak to network telehealth providers using your computer or mobile device.	
	Specialists <sup>2</sup>	\$15 copay	30% coinsurance
<b>Preventive Care</b>	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)	

## Benefits

		In-Network	Out-of-Network
		<p>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            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)</p> <hr/> <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>	
	Routine physical	\$0 copay; 1 per year*	30% coinsurance; 1 per year*
<b>Emergency Care</b>		<p>\$30 copay (\$0 copay for worldwide coverage) 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” section of this booklet for other costs.</p>	
<b>Urgently Needed Services</b>		<p>\$25 - \$40 copay            (\$0 copay for worldwide coverage)</p>	

## Benefits

		In-Network	Out-of-Network
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b>	Diagnostic radiology services (e.g. MRI) <sup>2</sup>	20% coinsurance	30% coinsurance
	Lab services <sup>2</sup>	\$0 copay	\$0 copay
	Diagnostic tests and procedures <sup>2</sup>	20% coinsurance	30% coinsurance
	Therapeutic Radiology <sup>2</sup>	20% coinsurance	30% coinsurance
	Outpatient X-rays <sup>2</sup>	\$0 copay per service	30% coinsurance
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues <sup>2</sup>	\$0 copay	30% coinsurance
	Routine hearing exam	\$0 copay; 1 per year*	30% coinsurance; 1 per year*
	Hearing aid <sup>2</sup>	\$2,000 allowance for hearing aids, up to 2 hearing aids every 2 years.	Not covered
<b>Routine Dental Benefits</b>	Preventive	\$0 copay for exams, cleanings, x-rays, and fluoride*	\$0 copay for exams, cleanings, x-rays, and fluoride*
	Comprehensive <sup>2</sup>	\$0 copay for comprehensive dental services*	\$0 copay for comprehensive dental services*
	Benefit limit	\$2,400 limit on all covered dental services*	

## Benefits

		In-Network	Out-of-Network
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye <sup>2</sup>	\$0 copay	30% coinsurance
	Eyewear after cataract surgery	\$0 copay	\$0 copay
	Routine eye exam	\$0 copay; 1 every year*	30% coinsurance; 1 every year*
	Eyewear	\$0 copay every year; up to \$200 for frames or contact lenses. Standard single, bifocal, trifocal, or progressive lenses are covered in full.*	\$0 copay; up to \$200 for home-delivered eyewear available nationwide only through UnitedHealthcare Vision. (select products only)*
<b>Mental Health</b>	Inpatient visit <sup>2</sup>	\$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 <sup>2</sup>	\$15 copay	30% coinsurance
	Outpatient individual therapy visit <sup>2</sup>	\$25 copay	30% coinsurance
	Virtual Mental Health Visits	\$0 copay; Speak to network telehealth providers using your computer or mobile device.	
<b>Skilled Nursing Facility (SNF)<sup>2</sup></b>		\$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.	
<b>Physical therapy and speech and language therapy visit<sup>2</sup></b>		\$0 copay	30% coinsurance
<b>Ambulance<sup>2</sup></b>		\$100 copay for ground \$100 copay for air	\$100 copay for ground \$100 copay for air
Your provider must obtain prior authorization for non-emergency transportation.			

## Benefits

		In-Network	Out-of-Network
<b>Routine Transportation</b>		\$0 copay; 36 one-way trips per year to or from approved locations	Not covered
<b>Medicare Part B Drugs</b>	Chemotherapy drugs <sup>2</sup>	20% coinsurance	30% coinsurance
	Other Part B drugs <sup>2</sup>	20% coinsurance	30% coinsurance
Part B Drugs may be subject to Step Therapy. See Evidence of Coverage for details.			



## 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 (Part D) Deductible</b>	\$0 per year for Tier 1, Tier 2 and Tier 3; \$200 for Tier 4 and Tier 5 Part D prescription drugs.			
<b>Stage 2: Initial Coverage (After you pay your deductible, if applicable)</b>	<b>Retail</b>		<b>Mail Order</b>	
	<b>Standard</b>		<b>Preferred</b>	<b>Standard</b>
	<b>30-day supply</b>	<b>90-day supply</b>	<b>90-day supply</b>	<b>90-day supply</b>
Tier 1: Preferred Generic Drugs	\$2 copay	\$6 copay	\$0 copay	\$6 copay
Tier 2: Generic Drugs <sup>3</sup>	\$12 copay	\$36 copay	\$0 copay	\$36 copay
Tier 3: Preferred Brand Drugs	\$47 copay	\$141 copay	\$131 copay	\$141 copay
Select Insulin Drugs <sup>4</sup>	\$35 copay	\$105 copay	\$95 copay	\$105 copay
Tier 4: Non-Preferred Drugs	\$100 copay	\$300 copay	\$290 copay	\$300 copay
Tier 5: Specialty Tier Drugs	29% coinsurance	N/A <sup>5</sup>	N/A <sup>5</sup>	N/A <sup>5</sup>
<b>Stage 3: Coverage Gap Stage</b>	After your total drug costs reach \$4,130, you will pay no more than 25% 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 \$6,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$3.70 copay for generic (including brand drugs treated as generic) and a \$9.20 copay for all other drugs.</li> </ul>			

<sup>3</sup> Tier includes enhanced drug coverage.

<sup>4</sup> For 2021, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of \$35 for a 1-month supply of covered insulin during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your covered insulin in the catastrophic stage. Your cost maybe less if you receive Extra Help from Medicare.

<sup>5</sup> Limited to a 30-day supply

## Additional Benefits

		In-Network	Out-of-Network
<b>Acupuncture</b>	Medicare-covered acupuncture <sup>2</sup>	\$0 copay for services provided by a primary care physician \$15 copay for services provided by a specialist	30% coinsurance for services provided by a primary care physician 30% coinsurance for services provided by a specialist
<b>Chiropractic Care</b>	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>2</sup>	\$15 copay	30% coinsurance
<b>Diabetes Management</b>	Diabetes monitoring supplies <sup>2</sup>	\$0 copay  We only cover Accu-Chek® and OneTouch® brands.  Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.  Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.  Other brands are not covered by your plan.	30% coinsurance
	Diabetes Self-management training	\$0 copay	30% coinsurance
	Therapeutic shoes or inserts <sup>2</sup>	20% coinsurance	30% coinsurance

## Additional Benefits

		In-Network	Out-of-Network
<b>Durable Medical Equipment (DME) and Related Supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>2</sup>	20% coinsurance	30% coinsurance
	Prosthetics (e.g., braces, artificial limbs) <sup>2</sup>	\$0 copay - 20% coinsurance	30% coinsurance
<b>Fitness through Fitbit®</b>		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.	
<b>Foot Care (podiatry services)</b>	Foot exams and treatment <sup>2</sup>	\$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*
<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<sup>2</sup></b>		\$0 copay	30% coinsurance
<b>Opioid Treatment Program Services<sup>2</sup></b>		\$0 copay	\$0 copay
<b>Outpatient Substance Abuse</b>	Outpatient group therapy visit <sup>2</sup>	\$15 copay	30% coinsurance
	Outpatient individual therapy visit <sup>2</sup>	\$25 copay	30% coinsurance
<b>Over-the-Counter (OTC) Products Catalog</b>		\$140 credit per quarter to use on approved OTC products. Order online, over the phone, or by mail through your FirstLine Essentials+ Catalog.	
<b>Renal Dialysis<sup>2</sup></b>		20% coinsurance	20% coinsurance

Services with a 2 may require your provider to obtain prior authorization from the plan for in-network benefits.

\* Benefits are combined in and out-of-network

# Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the Benefits

- ✓ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Call us or go online to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✓ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✓ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

## Understanding Important Rules

- ✓ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ✓ Benefits, premiums and/or copays/coinsurance may change on January 1 of each year.
- ✓ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.
- ✓ This plan is an Institutional Special Needs Plan (I-SNP). Your ability to enroll will be based on verification that your condition makes it likely that either the length of stay or the need for an institutional level of care would be at least 90 days.

## 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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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 [www.medicare.gov](http://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.

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. ©2017 Fitbit, Inc. All rights reserved.