



# 2017 Summary of BENEFITS

**UnitedHealthcare® Assisted Living Plan (HMO-POS SNP)**

H5253-043

Our service area includes the following counties in:

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

This is a summary of drug coverages and health services provided by UnitedHealthcare® Assisted Living Plan (HMO-POS SNP) January 1st, 2017 - December 31st, 2017.

For more information, please contact Customer Service at:

 Toll-Free **1-888-834-3721**, TTY **711**  
8 a.m. - 8 p.m. local time, 7 days a week

 **[www.UHCMedicareSolutions.com](http://www.UHCMedicareSolutions.com)**



# Summary of Benefits

**January 1st, 2017 - December 31st, 2017**

We're dedicated to providing clear and simple information about your plan so you always stay fully informed. The following information is a breakdown of what we cover and what you pay. This is called "cost-sharing" or "out-of-pocket" costs. Cost-sharing includes co-pays, co-insurance and deductibles. This will help you control your health care costs throughout the plan year.

Keep in mind that this isn't a full list of benefits we provide, it's just an overview. To get a complete list, visit our website at [www.UHCMedicareSolutions.com](http://www.UHCMedicareSolutions.com) to see the "Evidence of Coverage" or call customer service with any questions.

## About this plan.

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

To join UnitedHealthcare® Assisted Living Plan (HMO-POS SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed on 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. It is designed specifically for people who live in a contracted assisted living facility and require an institutional level of care.

## What's inside?

### Plan Premiums, Annual Deductibles, and Benefits

See plan costs including the monthly plan premium, deductible and maximum out-of-pocket limit.

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.

You can search for a network provider and pharmacy in the online directories at [www.UHCMedicareSolutions.com](http://www.UHCMedicareSolutions.com).

### Drug Coverage

Look to see what drugs are covered along with any restrictions in our plan formulary (list of Part D prescription drugs) found at [www.UHCMedicareSolutions.com](http://www.UHCMedicareSolutions.com).

# UnitedHealthcare® Assisted Living Plan (HMO-POS SNP)

Premiums and Benefits	In-Network	Out-of-Network
<b>Monthly Plan Premium</b>	\$16.80	
<b>Annual Medical Deductible</b>	This plan does not have a deductible.	
<b>Maximum Out-of-Pocket Amount</b> (does not include prescription drugs)	\$3,500 annually for services you receive from in-network providers.	Unlimited Out-of-Network
	<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.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>	

# UnitedHealthcare® Assisted Living Plan (HMO-POS SNP)

Benefits		In-Network	Out-of-Network
<b>Inpatient Hospital Coverage</b>		\$345 co-pay per day: for days 1-5 \$0 co-pay per day: for days 6 and beyond	30% of the cost per admit
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
<b>Doctor Visits</b>	Primary	\$0 co-pay	30% of the cost
	Specialists	\$30 co-pay	30% of the cost
<b>Preventive Care</b>	Medicare-covered	\$0 co-pay	\$0 co-pay - 30% of the cost (depending on the service)
<b>Emergency Care</b>		\$75 co-pay (worldwide) per visit  If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Emergency co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.	
<b>Urgently Needed Services</b>		\$30 - \$40 co-pay	
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b>	Diagnostic radiology services (e.g. MRI)	20% of the cost	30% of the cost
	Lab services	\$0 co-pay	\$0 co-pay
	Diagnostic tests and procedures	20% of the cost	30% of the cost
	Therapeutic Radiology	20% of the cost	30% of the cost
	Outpatient X-rays	\$0 co-pay per service	30% of the cost

<b>Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues	\$0 co-pay	30% of the cost
	Routine hearing exam	\$0 co-pay; 1 per year	Not covered
	Hearing aid	\$1,600 allowance every 2 years	Not covered
<b>Dental Services</b>	Preventive	\$0 co-pay for covered services (exam, cleaning, x-rays)	Not covered
	Comprehensive	\$0 co-pay for covered services	Not covered
	Benefit limit	\$500 limit on all covered dental services	
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye	\$20 co-pay	30% of the cost
	Eyewear after cataract surgery	\$0 co-pay	\$0 co-pay
	Routine eye exam	\$0 co-pay Up to 1 every year*	30% of the cost Up to 1 every year*
	Eyewear	\$0 co-pay every year; up to \$200 for lenses/frames and contacts*	Not covered

Benefits		In-Network	Out-of-Network
<b>Mental Health Care</b>	Inpatient visit	\$345 co-pay per day: for days 1-4 \$0 co-pay per day: for days 5-90	30% of the cost per admit
	Our plan covers 90 days for an inpatient hospital stay.		
	Outpatient group therapy visit	\$30 co-pay	30% of the cost
	Outpatient individual therapy visit	\$40 co-pay	30% of the cost
<b>Skilled Nursing Facility (SNF)</b>		\$0 co-pay per day: for days 1-100	30% of the cost per admit, up to 100 days
Our plan covers up to 100 days in a SNF.			
<b>Rehabilitation Services</b>	Occupational therapy visit	\$0 co-pay	30% of the cost
	Physical therapy and speech and language therapy visit	\$0 co-pay	30% of the cost
<b>Ambulance</b>		\$100 co-pay	\$100 co-pay
<b>Routine Transportation</b>		\$0 co-pay; 36 one-way trips per year to or from approved locations	Not covered
<b>Foot Care</b> (podiatry services)	Foot exams and treatment	\$0 co-pay	30% of the cost
	Routine foot care	\$0 co-pay; for each visit up to 4 visits every year*	30% of the cost; for each visit up to 4 visits every year*

<b>Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Medical Equipment / Supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% of the cost	30% of the cost
	Prosthetics (e.g., braces, artificial limbs)	\$0 co-pay - 20% of the cost.	30% of the cost
<b>Wellness Programs</b>		Not covered	
<b>Medicare Part B Drugs</b>	Chemotherapy drugs	20% of the cost	30% of the cost
	Other Part B drugs	20% of the cost	30% of the cost

## 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>	\$0 per year for Tier 1, Tier 2 and Tier 3; \$100 for Tier 4 and Tier 5 Part D prescription drugs.			
<b>Stage 2: Initial Coverage</b> (After you pay your deductible, if applicable)	<b>Retail</b>		<b>Mail Order</b>	
	<b>Standard</b>		<b>Preferred</b>	<b>Standard</b>
	30-day supply	90-day supply	90-day supply	90-day supply
<b>Tier 1:</b> Preferred Generic Drugs	\$2 co-pay	\$6 co-pay	\$0 co-pay	\$6 co-pay
<b>Tier 2:</b> Generic Drugs	\$12 co-pay	\$36 co-pay	\$0 co-pay	\$36 co-pay
<b>Tier 3:</b> Preferred Brand Drugs	\$47 co-pay	\$141 co-pay	\$131 co-pay	\$141 co-pay
<b>Tier 4:</b> Non-Preferred Drugs	\$100 co-pay	\$300 co-pay	\$290 co-pay	\$300 co-pay
<b>Tier 5:</b> Specialty Tier Drugs	31% of the cost	31% of the cost	31% of the cost	31% of the cost
<b>Stage 3: Coverage Gap Stage</b>	After your total drug costs reach \$3,700, you will pay no more than 51% of the total cost for generic drugs or 40% of the total cost 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 \$4,950, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% of the cost, or</li> <li>• \$3.30 co-pay for generic (including brand drugs treated as generic) and a \$8.25 co-pay for all other drugs.</li> </ul>			

Additional Benefits		In-Network	Out-of-Network
<b>Chiropractic Care</b>	Manual manipulation of the spine to correct subluxation	\$20 co-pay	30% of the cost
<b>Diabetes Management</b>	Diabetes monitoring supplies	\$0 co-pay  We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2 System, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio® Sync, OneTouch Verio® IQ, OneTouch Verio® Flex System Kit, ACCU-CHEK® Nano SmartView, and ACCU-CHEK® Aviva Plus.	30% of the cost
	Diabetes Self-management training	\$0 co-pay	30% of the cost
	Therapeutic shoes or inserts	20% of the cost	30% of the cost
<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>Outpatient Surgery</b>		\$250 co-pay	30% of the cost
<b>Outpatient Substance Abuse</b>	Outpatient group therapy visit	\$30 co-pay	30% of the cost
	Outpatient individual therapy visit	\$40 co-pay	30% of the cost
<b>Renal Dialysis</b>		20% of the cost	20% of the cost

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

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

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

Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

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 1-877-889-6358, TTY 711. OptumRx is an affiliate of UnitedHealthcare Insurance Company. \$0 co-pay is applicable for tier 1 and tier 2 medications during the initial coverage phase and may not apply during the coverage gap; it does not apply during the catastrophic stage.

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 contract renewal with Medicare. This plan is available to anyone who lives in a contracted assisted living facility and requires an institutional level of care.

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 <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.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-888-834-3721.

This information is available for free in other languages. Please call our customer service number at 1-888-834-3721, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-888-834-3721, TTY 711, 8 a.m. a 8 p.m. hora local, los 7 días de la semana.

## Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-834-3721. Someone who speaks English/ Language can help you. This is a free service

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-834-3721. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-834-3721。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-888-834-3721。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa 1-888-834-3721. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-834-3721. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-888-834-3721 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-834-3721. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-834-3721번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-834-3721. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-834-3721. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-834-3721 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-834-3721. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-834-3721. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-834-3721. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-834-3721. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-888-834-3721 にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

## Vendor Information

Before contacting any of the providers below you must be fully enrolled in UnitedHealthcare® Assisted Living Plan (HMO-POS SNP).

<b>Benefit Type</b>	<b>Vendor Name</b>	<b>Contact Information</b>
<b>Hearing Exams</b>	EPIC Hearing Health Care	1-866-956-5400, TTY 711 6 a.m. - 6 p.m. Pacific Standard Time, Monday - Friday <a href="http://www.epichearing.com">www.epichearing.com</a>
<b>Hearing Aids</b>	EPIC Hearing Health Care	1-866-956-5400, TTY 711 6 a.m. - 6 p.m. Pacific Standard Time, Monday - Friday <a href="http://www.epichearing.com">www.epichearing.com</a>
<b>Vision Care</b>	UnitedHealthcare Vision®	1-800-393-0993, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week
<b>Dental Services</b>	UnitedHealthcare Dental	1-800-393-0993, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week
<b>Routine Transportation (Limited to ground transportation only)</b>	LogistiCare®	1-866-418-9812, TTY 1-866-288-3133 8 a.m. - 5 p.m. local time, Monday - Friday <a href="http://www.logisticare.com">www.logisticare.com</a>