# Summary of Benefits 2023

**UnitedHealthcare® Assisted Living Plan 1 (PPO I-SNP)**
H2228-017-000

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

**UHC.com/Medicare**

United Healthcare

Y0066_SB_H2228_017_000_2023_M

# Summary of Benefits

## January 1st, 2023 - December 31st, 2023

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can see it online at **myUHCMedicare.com** or you can call Customer Service for help. When you enroll in the plan, you will get more information on how to view your plan details online.

## About this plan

UnitedHealthcare® Assisted Living Plan 1 (PPO I-SNP) is a Medicare Advantage PPO 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 1 (PPO I-SNP) is an Institutional Special Needs Plan designed specifically for people who require an institutional level of care.

Our service area includes these counties in:

**Oregon:** Clackamas, Linn, Multnomah, Washington, Yamhill.

## Use network providers and pharmacies

UnitedHealthcare® Assisted Living Plan 1 (PPO I-SNP) has a network of doctors, hospitals, pharmacies and other providers. With this plan, you have the freedom to see any provider nationwide that accepts Medicare. Plus, you have the flexibility to access a network of local providers. You may pay a higher copay or coinsurance when you see an out-of-network provider. When looking at the following charts you'll see the cost differences for network vs. out-of-network care and services. 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 **UHC.com/Medicare** 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 1 (PPO I-SNP)

## Premiums and Benefits

| | In-Network | Out-of-Network |
|---|---|---|
| **Monthly Plan Premium** | $33.50 | |
| **Annual Medical Deductible** | This plan does not have a deductible. | |
| **Maximum Out-of-Pocket Amount (does not include prescription drugs)** | $500 annually for Medicare-covered services you receive from in-network providers. | $5,100 annually for Medicare-covered services you receive from any provider. |
| | 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.<br><br>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 1 (PPO I-SNP)

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Inpatient Hospital Care**[2] | | $125 copay per day: days 1-2<br>$0 copay per day: days 3 and beyond | 30% coinsurance per stay |
| | | Our plan covers an unlimited number of days for an inpatient hospital stay. | |
| **Outpatient Hospital**<br><br>Cost sharing for additional plan covered services will apply. | Ambulatory Surgical Center (ASC)[2] | $0 copay for a diagnostic colonoscopy<br>$100 copay otherwise | 30% coinsurance |
| | Outpatient Hospital, including surgery[2] | $0 copay for a diagnostic colonoscopy<br>$100 copay otherwise | 30% coinsurance |
| | Outpatient Hospital Observation Services[2] | $100 copay | 30% coinsurance |
| **Doctor Visits** | Primary Care Provider | $0 copay | 30% coinsurance |
| | Specialists[2] | $0 copay | 30% coinsurance |
| | Virtual Medical Visits | $0 copay to talk with a network telehealth provider online through live audio and video | |
| **Preventive Services** | Medicare-covered | $0 copay | $0 copay - 30% coinsurance (depending on the service) |
| | | Abdominal aortic aneurysm screening<br>Alcohol misuse counseling<br>Annual wellness visit<br>Bone mass measurement<br>Breast cancer screening (mammogram)<br>Cardiovascular disease (behavioral therapy)<br>Cardiovascular screening<br>Cervical and vaginal cancer screening<br>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) | |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| | | Depression screening<br>Diabetes screenings and monitoring<br>Hepatitis C screening<br>HIV screening<br>Lung cancer with low dose computed tomography (LDCT) screening<br>Medical nutrition therapy services<br>Medicare Diabetes Prevention Program (MDPP)<br>Obesity screenings and counseling<br>Prostate cancer screenings (PSA)<br>Sexually transmitted infections screenings and counseling<br>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19<br>"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. | |
| | Routine physical | $0 copay, 1 per year* | 30% coinsurance, 1 per year* |
| **Emergency Care** | | $45 copay ($0 copay for emergency care outside the United States) per visit<br>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency Care copay. See the "Inpatient Hospital Care" section of this booklet for other costs. | |
| **Urgently Needed Services** | | $40 copay<br>($0 copay for urgently needed services outside the United States) per visit | |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays** | Diagnostic radiology services (e.g. MRI, CT scan)[2] | $0 copay | 30% coinsurance |
| | Lab services[2] | $0 copay | $0 copay |
| | Diagnostic tests and procedures[2] | $0 copay | 30% coinsurance |
| | Therapeutic radiology[2] | $0 copay per service | 30% coinsurance |
| | Outpatient X-rays[2] | $0 copay per service | 30% coinsurance |
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues[2] | $0 copay | 30% coinsurance |
| | Routine hearing exam | $0 copay, 1 per year* | 30% coinsurance, 1 per year* |
| | Hearing aids[2] | Plan pays up to $2,000 every year for 2 hearing aids through UnitedHealthcare Hearing.*<br><br>Includes hearing aids delivered directly to you with virtual follow-up care (select models). | |
| **Routine Dental Benefits** | Preventive | $0 copay for exams, cleanings, X-rays, and fluoride* | $0 copay for exams, cleanings, X-rays, and fluoride* |
| | Comprehensive[2] | $0 copay for comprehensive dental services* | $0 copay for comprehensive dental services* |
| | Benefit limit | $3,500 combined limit on all covered dental services* If you choose to see an out-of-network dentist you might be billed more, even for services listed as $0 copay | |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the eye[2] | $0 copay | 30% coinsurance |
| | Eyewear after cataract surgery | $0 copay | $0 copay |
| | Routine eye exam | $0 copay, 1 per year* | 30% coinsurance, 1 per year* |
| | Routine eyewear | $0 copay<br>Plan pays up to $300 every year for frames or contact lenses through UnitedHealthcare Vision. Standard single, bifocal, trifocal, or progressive lenses are covered in full.*<br><br>Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only). | |
| **Mental Health** | Inpatient visit[2] | $125 copay per day: days 1-2<br>$0 copay per day: days 3-90 | 30% coinsurance per stay |
| | | Our plan covers 90 days for an inpatient hospital stay. | |
| | Outpatient group therapy visit[2] | $15 copay | 30% coinsurance |
| | Outpatient individual therapy visit[2] | $25 copay | 30% coinsurance |
| | Virtual Mental Health Visits | $0 copay to talk with a network telehealth provider online through live audio and video | |
| **Skilled Nursing Facility (SNF)[2]** | | $0 copay per day: days 1-100 | 30% coinsurance per stay, up to 100 days |
| | | Our plan covers up to 100 days in a SNF. | |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Outpatient Rehabilitation Services** | Physical therapy and speech and language therapy visit[2] | $0 copay | 30% coinsurance |
| | Occupational Therapy Visit[2] | $0 copay | 30% coinsurance |
| | Virtual Visit | $0 copay | 30% coinsurance |
| **Ambulance[2]**<br><br>Your provider must obtain prior authorization for non-emergency transportation. | | $100 copay for ground<br>$100 copay for air | $100 copay for ground<br>$100 copay for air |
| **Routine Transportation** | | $0 copay for 36 one-way trips to or from approved medically related appointments and pharmacies* | 75% coinsurance* |
| **Medicare Part B Prescription Drugs**<br><br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | Chemotherapy drugs[2] | 20% coinsurance | 30% coinsurance |
| | Other Part B drugs[2] | $0 copay for allergy antigens<br>20% coinsurance for all others | $0 copay for allergy antigens<br>30% coinsurance for all others |

## 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 (Part D) 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** | **100-day supply** | **100-day supply** | **100-day supply** |
| Tier 1: Preferred Generic | $2 copay | $6 copay | $0 copay | $6 copay |
| Tier 2: Generic[3] | $12 copay | $36 copay | $0 copay | $36 copay |
| Tier 3: Preferred Brand | $47 copay | $141 copay | $131 copay | $141 copay |
| Select Insulin Drugs[4] | $35 copay | $105 copay | $95 copay | $105 copay |
| Tier 4: Non-Preferred Drug | $100 copay | $300 copay | $290 copay | $300 copay |
| Tier 5: Specialty Tier | 29% coinsurance | N/A[5] | N/A[5] | N/A[5] |
| **Stage 3: Coverage Gap Stage** | After your total drug costs reach $4,660, 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. | | | |
| **Stage 4: Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of:<br>• 5% coinsurance, or<br>• $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copay for all other drugs. | | | |

**Important Message About What You Pay for Vaccines -** Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your Part D deductible. Call Customer Service for more information.

**Important Message About What You Pay for Insulin** - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your Part D deductible.

[3] Tier includes enhanced drug coverage.

[4] For 2023, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for select insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for each 1-month supply of Part D select insulin drug through all coverage stages.

[5] Limited to a 30-day supply

## Additional Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Chiropractic Care** | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[2] | $0 copay | 30% coinsurance |
| **Diabetes Management** | Diabetes monitoring supplies[2] | $0 copay<br><br>We only cover Accu-Chek® and OneTouch® brands.<br><br>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch® Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide.<br><br>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.<br><br>Other brands are not covered by your plan. | 30% coinsurance |
| | Diabetes self-management training | $0 copay | 30% coinsurance |
| | Therapeutic shoes or inserts[2] | 20% coinsurance | 30% coinsurance |

## Additional Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Durable Medical Equipment (DME) and Related Supplies** | Durable Medical Equipment (e.g., wheelchairs, oxygen)[2] | 20% coinsurance | 30% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs)[2] | $0 copay - 20% coinsurance | 30% coinsurance |
| **Foot Care (podiatry services)** | Foot exams and treatment[2] | $0 copay | 30% coinsurance |
| | Routine foot care | $0 copay, 4 visits per year* | 30% coinsurance, 4 visits per 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. | |
| **Opioid Treatment Program Services[2]** | | $0 copay | $0 copay |
| **Outpatient Substance Abuse** | Outpatient group therapy visit[2] | $15 copay | 30% coinsurance |
| | Outpatient individual therapy visit[2] | $25 copay | 30% coinsurance |
| **Over-the-counter (OTC) credit** | | $160 credit every quarter to buy covered OTC products. Shop at network retail locations or get home delivery by ordering online, by phone or by mail through your OTC catalog. | |
| **Renal Dialysis[2]** | | 20% coinsurance | 20% coinsurance |

[2] May require your provider to get prior authorization from the plan for in-network benefits.

*Benefits are combined in and out-of-network

## Required Information

UnitedHealthcare® Assisted Living Plan 1 (PPO I-SNP) is 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.

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 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 does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.
UnitedHealthcare provides free services to help you communicate with us such as letters in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-877-370-3249 for additional information (TTY users should call 711). Hours are 24 hours a day, 7 days a week.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, cartas en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-877-370-3249, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 24 horas del día, los 7 días de la semana.

Benefits, features and/or devices vary by plan/area. Limitations and exclusions may apply.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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 100 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 five 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.