

# 2018 SUMMARY OF BENEFITS



## Overview of your plan

UnitedHealthcare® MedicareComplete® Plan 3 (HMO)

H0755-033

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 **1-800-555-5757**, 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)**



Our service area includes these counties in:

**Connecticut:** Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham.

# Summary of Benefits

**January 1st, 2018 - December 31st, 2018**

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 with questions you may have. You get an EOC when you enroll in the plan.

## **About this plan.**

UnitedHealthcare® MedicareComplete® Plan 3 (HMO) 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.

## **Use network providers and pharmacies.**

UnitedHealthcare® MedicareComplete® Plan 3 (HMO) 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 formulary (drug list) to see what drugs are covered, and if there are any restrictions.

# UnitedHealthcare® MedicareComplete® Plan 3 (HMO)

Premiums and Benefits	In-Network
<b>Monthly Plan Premium</b>	There is no monthly premium for this plan.
<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>\$6,700 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.</p> <p>Please note that you will still need to pay your share of the cost for your Part D prescription drugs.</p>

# UnitedHealthcare® MedicareComplete® Plan 3 (HMO)

Benefits		In-Network
Inpatient Hospital <sup>1</sup>		\$430 copay per day: for days 1-4 \$0 copay per day: for days 5 and beyond  Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital, Including Observation <sup>1</sup>		20% coinsurance
Doctor Visits	Primary	\$20 copay
	Specialists <sup>1</sup>	\$50 copay
Preventive Care	Medicare-covered	\$0 copay
		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 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

## Benefits

## In-Network

		<p>“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
<b>Emergency Care</b>		<p>\$80 copay (worldwide) 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>		\$30 - \$40 copay
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b>	Diagnostic radiology services (e.g. MRI)	20% coinsurance
	Lab services	\$2 copay
	Diagnostic tests and procedures	20% coinsurance
	Therapeutic Radiology	20% coinsurance
	Outpatient X-rays	\$7 copay per service
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues	\$20 copay
	Routine hearing exam	\$20 copay; 1 per year
	Hearing aid	\$330-\$380 copay for each hi HealthInnovations™ hearing aid, up to 2 per year (Additional fees with Power Max model)
<b>Routine Dental Services</b>		Additional dental benefits available with a separate premium. Please see optional benefits section below for details.

<b>Benefits</b>		<b>In-Network</b>
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye	\$20 copay
	Eyewear after cataract surgery	\$0 copay
	Routine eye exam	\$20 copay Up to 1 every year
	Eyewear	\$0 copay every 2 years; up to \$70 for frames (standard lenses included) or \$105 for contacts (up to 4 boxes)
<b>Mental Health</b>	Inpatient visit	\$430 copay per day: for days 1-3 \$0 copay per day: for days 4-90
		Our plan covers 90 days for an inpatient hospital stay.
	Outpatient group therapy visit	\$15 copay
	Outpatient individual therapy visit	\$25 copay
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>		\$0 copay per day: for days 1-20 \$160 copay per day: for days 21-62 \$0 copay per day: for days 63-100
		Our plan covers up to 100 days in a SNF.
<b>Physical therapy and speech and language therapy visit<sup>1</sup></b>		\$40 copay
<b>Ambulance</b>		\$220 copay
<b>Routine Transportation</b>		Not covered
<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>	\$0 per year for Tier 1 and Tier 2; \$175 for Tier 3, 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	\$3 copay	\$9 copay	\$0 copay	\$9 copay
Tier 2: Generic Drugs	\$12 copay	\$36 copay	\$0 copay	\$36 copay
Tier 3: Preferred Brand Drugs	\$45 copay	\$135 copay	\$125 copay	\$135 copay
Tier 4: Non-Preferred Drugs	\$95 copay	\$285 copay	\$275 copay	\$285 copay
Tier 5: Specialty Tier Drugs	29% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance
<b>Stage 3: Coverage Gap Stage</b>	After your total drug costs reach \$3,750, you will pay no more than 44% coinsurance for generic drugs or 35% 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 \$5,000, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$3.35 copay for generic (including brand drugs treated as generic) and a \$8.35 copay for all other drugs.</li> </ul>			



Additional Benefits		In-Network
<b>Chiropractic Care</b>	Manual manipulation of the spine to correct subluxation	\$20 copay
<b>Diabetes Management</b>	Diabetes monitoring supplies	\$0 copay We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio® IQ, OneTouch Verio® Flex, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Guide, and ACCU-CHEK® Aviva Connect
	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)	20% coinsurance
<b>Fitness program through SilverSneakers® Fitness</b>		Basic membership in a fitness program at a network location.
<b>Foot Care (podiatry services)</b>	Foot exams and treatment	\$50 copay
	Routine foot care	\$50 copay; for each visit up to 6 visits every year
<b>Home Health Care</b> <sup>1</sup>		\$0 copay
<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>NurseLine</b> <sup>SM</sup>		Speak with a registered nurse (RN) 24 hours a day, 7 days a week

<b>Additional Benefits</b>		<b>In-Network</b>
<b>Occupational therapy visit<sup>1</sup></b>		\$40 copay
<b>Outpatient Substance Abuse</b>	Outpatient group therapy visit	\$15 copay
	Outpatient individual therapy visit	\$25 copay
<b>Outpatient Surgery<sup>1</sup></b>		20% coinsurance
<b>Over-the-Counter Essentials</b>		\$40 credit per quarter to use on approved health products that can be ordered online or by mail.
<b>UnitedHealth Passport<sup>®</sup></b>		Allows you to access all the benefits you enjoy at home while you travel within the covered service area for up to nine consecutive months. You pay your in-network copay or coinsurance when you visit a participating provider for non-emergency care, including preventive care, specialist care and hospitalizations.
<b>Renal Dialysis<sup>1</sup></b>		20% coinsurance

Services with a 1 may require a referral from your doctor.

## Optional Supplemental Benefits

<b>Premiums and Benefits</b>		<b>In-Network</b>
<b>Dental Platinum Rider</b>	Premium	Additional \$39.00 per month
	Description	The Dental Platinum Rider includes preventive and comprehensive dental benefits.

## Required Information

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.

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.

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.

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.

## Vendor Information

Before contacting any of the providers below you must be fully enrolled in UnitedHealthcare® MedicareComplete® Plan 3 (HMO).

Benefit Type	Vendor Name	Contact Information
<b>Hearing Exams</b>	Plan network providers in your service area	1-800-711-0646, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week
<b>Hearing Aids</b>	hi HealthInnovations™	1-855-523-9355, TTY 711 9 a.m. - 5 p.m. CT, Monday - Friday www.hihealthinnovations.com
<b>Vision Care</b>	UnitedHealthcare Vision®	1-800-711-0646, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week
<b>NurseLine</b>	NurseLine <sup>SM</sup>	1-877-365-7949, TTY 711 24 hours a day, 7 days a week
<b>Over The Counter Essentials</b>	FirstLine Medical®	www.OTC-Essentials.com
<b>Fitness Membership</b>	SilverSneakers® Fitness program	1-888-423-4632, TTY 711 8 a.m. - 8 p.m. ET, Monday - Friday silversneakers.com