2017 Summary of BENEFITS

UnitedHealthcare® MedicareComplete Choice® Plan 1 (Regional PPO)

R5342-001

Our service area includes:
New York.

This is a summary of drug coverages and health services provided by UnitedHealthcare® MedicareComplete Choice® Plan 1 (Regional PPO) January 1st, 2017 - December 31st, 2017.

For more information, please contact Customer Service at:

Toll-Free **1-800-555-5757,** TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.UHCMedicareSolutions.com

UnitedHealthcare®

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 to see the "Evidence of Coverage" or call customer service with any questions.

About this plan.

UnitedHealthcare® MedicareComplete Choice® Plan 1 (Regional PPO) is a Medicare Advantage RPPO plan with a Medicare contract.

To join UnitedHealthcare® MedicareComplete Choice® Plan 1 (Regional PPO), 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.

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® MedicareComplete Choice® Plan 1 (Regional PPO) has a network of doctors, hospitals, pharmacies, and other providers. When looking at the following charts you'll see the cost differences for in-network vs. out-of-network care and services.

You can search for a network provider and pharmacy in the online directories at 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.

UnitedHealthcare® MedicareComplete Choice® Plan 1 (Regional PPO)

Premiums and Benefits	In-Network	Out-of-Network
Monthly Plan Premium	There is no monthly premium for this plan.	
Annual Medical Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Amount (does not include prescription drugs)	$6,700 annually for services you receive from in-network providers.	$10,000 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. Please note that you will still need to pay your cost-sharing for your Part D prescription drugs.	

UnitedHealthcare® MedicareComplete Choice® Plan 1 (Regional PPO)

Benefits		In-Network	Out-of-Network
Inpatient Hospital Coverage		$395 co-pay per day: for days 1-4 $0 co-pay per day: for for days 5 and beyond	$500 co-pay per day: for days 1-20 $0 co-pay per day: for days 21 and beyond
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Doctor Visits	Primary	$10 co-pay	$50 co-pay
	Specialists	$45 co-pay	$75 co-pay
Preventive Care	Medicare-covered	$0 co-pay	$0 co-pay - 40% of the cost (depending on the service)
	Routine physical	$0 co-pay; 1 per year*	40% of the cost; 1 per year*
Emergency Care		$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.	
Urgently Needed Services		$30 - $40 co-pay	
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)	20% of the cost	40% of the cost
	Lab services	$10 co-pay	$10 co-pay
	Diagnostic tests and procedures	20% of the cost	40% of the cost
	Therapeutic Radiology	20% of the cost	40% of the cost
	Outpatient X-rays	$11 co-pay per service	$16 co-pay per service

Benefits		In-Network	Out-of-Network
Hearing Services	Exam to diagnose and treat hearing and balance issues	$10 co-pay	$75 co-pay
	Routine hearing exam	$10 co-pay; 1 per year*	$75 co-pay; 1 per year*
	Hearing aid	$330-$380 co-pay for each hi HealthInnovations™ hearing aid, up to 2 per year (Additional fees with Power Max model)*	$330-$380 co-pay for each hi HealthInnovations™ hearing aid, up to 2 per year (Additional fees with Power Max model)*
Dental Services		Additional dental benefits available with a separate premium. Please see optional benefits section below for details.	
Vision Services	Exam to diagnose and treat diseases and conditions of the eye	$20 co-pay	$45 co-pay
	Eyewear after cataract surgery	$0 co-pay	40% of the cost
	Routine eye exam	$20 co-pay Up to 1 every year*	$45 co-pay Up to 1 every year*
Mental Health Care	Inpatient visit	$395 co-pay per day: for days 1-4 $0 co-pay per day: for days 5-90	$500 co-pay per day; for days 1-20 $0 co-pay per day; for days 21-90
		Our plan covers 90 days for an inpatient hospital stay.	
	Outpatient group therapy visit	$30 co-pay	$35 co-pay
	Outpatient individual therapy visit	$40 co-pay	$45 co-pay

Benefits		In-Network	Out-of-Network
Skilled Nursing Facility (SNF)		$0 co-pay per day: for days 1-20 $160 co-pay per day: for days 21-62 $0 co-pay per day: for days 63-100	$250 co-pay per day: for days 1-40 $0 co-pay per day: for days 41-100
		Our plan covers up to 100 days in a SNF.	
Rehabilitation Services	Occupational therapy visit	$40 co-pay	$75 co-pay
	Physical therapy and speech and language therapy visit	$40 co-pay	$75 co-pay
Ambulance		$250 co-pay	$250 co-pay
Routine Transportation		Not covered	
Foot Care (podiatry services)	Foot exams and treatment	$45 co-pay	$75 co-pay
	Routine foot care	$45 co-pay; for each visit up to 6 visits every year*	$75 co-pay; for each visit up to 6 visits every year*
Medical Equipment / Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% of the cost	50% of the cost
	Prosthetics (e.g., braces, artificial limbs)	20% of the cost	40% of the cost
Wellness Programs		Optional fitness benefit available with a separate premium. Please see optional benefits section below for details.	
Medicare Part B Drugs	Chemotherapy drugs	20% of the cost	40% of the cost
	Other Part B drugs	20% of the cost	40% 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.

Stage 1: Annual Prescription Deductible	$0 per year for Tier 1 and Tier 2; $290 for Tier 3, 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	90-day supply	90-day supply	90-day supply
Tier 1: Preferred Generic Drugs	$2 co-pay	$6 co-pay	$0 co-pay	$6 co-pay
Tier 2: Generic Drugs	$12 co-pay	$36 co-pay	$0 co-pay	$36 co-pay
Tier 3: Preferred Brand Drugs	$47 co-pay	$141 co-pay	$131 co-pay	$141 co-pay
Tier 4: Non-Preferred Drugs	$100 co-pay	$300 co-pay	$290 co-pay	$300 co-pay
Tier 5: Specialty Tier Drugs	27% of the cost	27% of the cost	27% of the cost	27% of the cost
Stage 3: Coverage Gap Stage	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.			
Stage 4: Catastrophic Coverage	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: • 5% of the cost, or • $3.30 co-pay for generic (including brand drugs treated as generic) and a $8.25 co-pay for all other drugs.			

Additional Benefits		In-Network	Out-of-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation	$20 co-pay	$75 co-pay
Diabetes Management	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.	40% of the cost
	Diabetes Self-management training	$0 co-pay	40% of the cost
	Therapeutic shoes or inserts	20% of the cost	40% of the cost
Home Health Care		$0 co-pay	50% of the cost
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.	
NurseLine℠		Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Outpatient Surgery		20% of the cost	40% of the cost

Additional Benefits		In-Network	Out-of-Network
Outpatient Substance Abuse	Outpatient group therapy visit	$30 co-pay	$35 co-pay
	Outpatient individual therapy visit	$40 co-pay	$45 co-pay
Over-the-Counter Essentials		$50 credit per quarter to use on approved health products that can be ordered online or by mail.	
UnitedHealth Passport®		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 co-pay or co-insurance when you visit a participating provider for non-emergency care, including preventive care, specialist care and hospitalizations.	
Renal Dialysis		20% of the cost	20% of the cost

*Benefits are combined in and out-of-network

Optional Supplemental Benefits

Premiums and Benefits		In-Network	Out-of-Network
Dental Platinum Rider	Premium	Additional $36 per month	
	Description	The Dental Platinum Rider includes preventive and comprehensive dental benefits.	
Fitness Rider	Premium	Additional $18 per month	
	Description	The Fitness Rider includes a gym membership and fitness classes.	

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 1-866-394-7218. 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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more 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.

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 1-800-555-5757.

This information is available for free in other languages. Please call our customer service number at 1-800-555-5757, 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 1-800-555-5757, 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 1-800-555-5757. 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 1-800-555-5757. 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 1-800-555-5757。 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1-800-555-5757。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 pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-555-5757. 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 1-800-555-5757. 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 quí vị cần thông dịch viên xin gọi 1-800-555-5757 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-555-5757. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-800-555-5757번으로 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 1-800-555-5757. 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 1-800-555-7575 . 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 1-800-555-5757 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 1-800-555-5757. 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 1-800-555-5757. 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 1-800-555-5757. 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 1-800-555-5757. 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ございます。通訳をご用命になるには、1-800-555-5757 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® MedicareComplete Choice® Plan 1 (Regional PPO).

Benefit Type	Vendor Name	Contact Information
Hearing Exams	Plan network providers in your service area	1-800-711-6088, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week
Hearing Aids	hi HealthInnovations™	1-855-523-9355, TTY 711 9 a.m. - 5 p.m. Central Standard Time, Monday - Friday www.hihealthinnovations.com
Vision Care	Plan network providers in your service area	1-800-711-6088, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week
NurseLine	NurseLine℠	1-877-365-7949, TTY 711 24 hours a day, 7 days a week
Over The Counter Essentials	FirstLine Medical®	www.OTC-Essentials.com