Summary of Benefits 2023

UnitedHealthcare® Medicare Advantage Choice Plan 3 (Regional PPO)

R3444-023-000

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 **1-844-723-6473**, TTY **711**
8 a.m.-8 p.m. local time, 7 days a week

UHC.com/Medicare

United Healthcare
Medicare Advantage

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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® Medicare Advantage Choice Plan 3 (Regional PPO) is a Medicare Advantage RPPO 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.

Our service area includes **Arkansas, and Missouri.**

Use network providers and pharmacies

UnitedHealthcare® Medicare Advantage Choice Plan 3 (Regional PPO) has a network of doctors, hospitals, pharmacies, and other providers. With this plan, you have the freedom to enjoy nationwide access to care at in-network costs when you visit any provider participating in the UnitedHealthcare® Medicare National Network (exclusions may apply). Plus, you have the flexibility to visit any provider nationwide who accepts Medicare. 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® Medicare Advantage Choice Plan 3 (Regional PPO)

Premiums and Benefits

	In-Network	Out-of-Network
Monthly Plan Premium	$21	
Annual Medical Deductible	Your deductible is $1,000 per year for covered medical services you receive from providers as described in the Plan Deductible chart later in this document. Until you have paid the deductible amount, you must pay the full cost of your covered medical services.	
Maximum Out-of-Pocket Amount (does not include prescription drugs)	$6,700 annually for Medicare-covered 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 monthly premiums and share of the cost for your Part D prescription drugs.	

UnitedHealthcare® Medicare Advantage Choice Plan 3 (Regional PPO)

Benefits

		In-Network	Out-of-Network
Inpatient Hospital Care[2]		$325 copay per day: days 1-5 $0 copay per day: days 6 and beyond	$325 copay per day: for days 1-5 $0 copay per day: for days 6 and beyond
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC)[2]	$0 copay for a diagnostic colonoscopy $325 copay otherwise	$0 copay for a diagnostic colonoscopy $325 copay otherwise
	Outpatient Hospital, including surgery[2]	$0 copay for a diagnostic colonoscopy $325 copay otherwise	$0 copay for a diagnostic colonoscopy $325 copay otherwise
	Outpatient Hospital Observation Services[2]	$325 copay	$325 copay
Doctor Visits	Primary Care Provider	$0 copay	$25 copay
	Specialists[2]	$40 copay	$40 copay
	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
		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
		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 those for the flu, Hepatitis B, pneumonia, or COVID-19 "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*	$0 copay, 1 per year*
Emergency Care		$90 copay ($0 copay for emergency care outside the United States) per visit 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 ($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 for each diagnostic mammogram $100 copay otherwise	$0 copay for each diagnostic mammogram $100 copay otherwise
	Lab services[2]	$0 copay	$0 copay
	Diagnostic tests and procedures[2]	$20 copay	$20 copay
	Therapeutic Radiology[2]	$50 copay per service	$50 copay per service
	Outpatient X-rays[2]	$15 copay per service	$15 copay per service
Hearing Services	Exam to diagnose and treat hearing and balance issues[2]	$0 copay	$40 copay
	Routine hearing exam	$0 copay, 1 per year*	$40 copay, 1 per year*
	Hearing aids[2]	$175 - $1,225 copay for each hearing aid through UnitedHealthcare Hearing, up to 2 hearing aids every year.* Includes hearing aids delivered directly to you with virtual follow-up care (select models).	
Routine Dental Benefits	Optional Dental Rider	Additional dental benefits available with a separate premium. Please see optional benefits section below for details.	
	Preventive	$0 copay for exams, cleanings, X-rays, and fluoride*	$0 copay for exams, cleanings, X-rays, and fluoride* 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	$20 copay
	Eyewear after cataract surgery	$0 copay	$0 copay
	Routine eye exam	$0 copay, 1 per year*	$20 copay, 1 per year*
	Routine eyewear	$0 copay Plan pays up to $150 every year for frames or contact lenses through UnitedHealthcare Vision. Standard single, bifocal, trifocal, or progressive lenses are covered in full.* Home delivered eyewear available nationwide through UnitedHealthcare Vision (select products only).	
Mental Health	Inpatient visit[2]	$325 copay per day: days 1-5 $0 copay per day: days 6-90	$325 copay per day: days 1-5 $0 copay per day: days 6-90
		Our plan covers 90 days for an inpatient hospital stay.	
	Outpatient group therapy visit[2]	$15 copay	$15 copay
	Outpatient individual therapy visit[2]	$25 copay	$25 copay
	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 1-20 $196 copay per day: days 21-55 $0 copay per day: days 56-100	$225 copay per day: days 1-45 $0 copay per day: days 46-100
		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]	$40 copay	$40 copay
	Occupational Therapy Visit[2]	$40 copay	$40 copay
	Virtual Visit	$0 copay	$0 copay
Ambulance[2] Your provider must obtain prior authorization for non-emergency transportation.		$250 copay for ground $250 copay for air	$250 copay for ground $250 copay for air
Routine Transportation		Not covered	
Medicare Part B Prescription Drugs Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	Chemotherapy drugs[2]	20% coinsurance	20% coinsurance
	Other Part B drugs[2]	$0 copay for allergy antigens 20% coinsurance for all others	$0 copay for allergy antigens 20% 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 and Tier 2; $245 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	**100-day supply**	**100-day supply**	**100-day supply**
Tier 1: Preferred Generic	$4 copay	$10 copay	$0 copay	$12 copay
Tier 2: Generic[3]	$15 copay	$37.50 copay	$0 copay	$45 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	Tier 1 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach $4,660, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs 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: □ 5% coinsurance, or □ $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copay for all other drugs.			

[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 covered insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for a 1-month supply of Part D select insulin drugs during the deductible, Initial Coverage and Coverage Gap or "Donut Hole" stages of your benefit. You will pay 5% of the cost of your insulin in the Catastrophic Coverage stage. This cost sharing only applies to members who do not qualify for a program that helps pay for your drugs (“Extra Help”).

[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]	$20 copay	$20 copay
Diabetes Management	Diabetes monitoring supplies[2]	$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch®Ultra 2, 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.	50% coinsurance
	Diabetes self-management training	$0 copay	$0 copay
	Therapeutic shoes or inserts[2]	20% coinsurance	50% 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	50% coinsurance
	Prosthetics (e.g., braces, artificial limbs)[2]	20% coinsurance	50% coinsurance
Foot Care (podiatry services)	Foot exams and treatment[2]	$40 copay	$40 copay
	Routine foot care	$40 copay, 6 visits per year*	$40 copay, 6 visits per year*
Meal Benefit[2]		$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay.	
Home Health Care[2]		$0 copay	50% coinsurance
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.	
Opioid Treatment Program Services[2]		$0 copay	$0 copay
Outpatient Substance Abuse	Outpatient group therapy visit[2]	$15 copay	$15 copay
	Outpatient individual therapy visit[2]	$25 copay	$25 copay
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

Optional Supplemental Benefits

Premiums and Benefits

Platinum Dental Rider	Premium	Additional $52.00 per month
	Description	The Platinum Dental Rider includes preventive and comprehensive dental benefits.

Plan Deductible

Your plan has a deductible for certain services. 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.

The deductible applies to the following Medicare-covered benefit categories, unless otherwise specified.

Annual Medical Deductible

Your deductible is $1,000 per year for covered medical services you receive from providers as described below. Until you have paid the deductible amount, you must pay the full cost of your covered medical services.

Here's how it works:

1. You pay your plan's deductible in full; then,
2. You pay your copay or coinsurance; finally,
3. Your plan pays the rest.

The deductible applies in and out-of–network to the following Medicare-covered benefit categories, unless otherwise specified:

In-Network List of applicable services	Out-of-Network List of applicable services
Inpatient Services ☐ Inpatient hospital ☐ Inpatient mental health	**Inpatient Services** ☐ Inpatient hospital ☐ Inpatient mental health
Outpatient Hospital ☐ Ambulatory Surgical Center (ASC), excluding diagnostic colonoscopy ☐ Outpatient Hospital, including surgery, excluding diagnostic colonoscopy ☐ Outpatient Hospital Observation Services	**Outpatient Hospital** ☐ Ambulatory Surgical Center (ASC) ☐ Outpatient Hospital, including surgery ☐ Outpatient Hospital Observation Services
	Diagnostic Tests, Lab and Radiology Services, and X-Rays ☐ Diagnostic radiology services (e.g. MRI) ☐ Lab services ☐ Diagnostic tests and procedures ☐ Therapeutic radiology ☐ Outpatient X-rays
	Doctor Visits

☐ Primary ☐ Specialists
Hearing Services ☐ Exam to diagnose and treat hearing and balance issues
Vision Services ☐ Exam to diagnose and treat diseases and conditions of the eye ☐ Eyewear after cataract surgery
Mental Health ☐ Outpatient group therapy visit ☐ Outpatient individual therapy visit
Skilled Nursing Facility (SNF)
Physical Therapy and Speech and Language Therapy Visit
Ambulance
Medicare Part B Drugs ☐ Chemotherapy drugs ☐ Other Part B drugs
Chiropractic Care ☐ Manual manipulation of the spine to correct subluxation
Diabetes Management ☐ Diabetes monitoring supplies ☐ Therapeutic shoes or inserts
Durable Medical Equipment (DME) and Related Supplies ☐ Durable Medical Equipment (e.g. wheelchairs, oxygen) ☐ Prosthetics (e.g., braces, artificial limbs)
Foot Care ☐ Foot exams and treatment
Home Health Care
Occupational Therapy Visit
Opioid Treatment Program Services

Outpatient Substance Abuse

- ☐ Outpatient group therapy visit
- ☐ Outpatient individual therapy visit

Renal Dialysis

Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans 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 1-877-370-3207 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 1-877-370-3207, 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.

The Nurseline service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.