



# Summary of Benefits 2024

**UHC Care Advantage EX-E001 (PPO I-SNP)**

H0710-058-000

Look inside to learn more about the plan and the health and drug services it covers.  
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  
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# Summary of Benefits

**January 1, 2024 - December 31, 2024**

This is a summary of what we cover and what you pay. For a complete list of covered services, limitations and exclusions, review the Evidence of Coverage (EOC) at [myUHCMedicare.com](https://myUHCMedicare.com) or call Customer Service for help. After you enroll in the plan, you will get more information on how to view your plan details online.

## UHC Care Advantage EX-E001 (PPO I-SNP)

| Medical premium, deductible and limits                                    |  |  |
|---|--|--|
|   | In-network   | Out-of-network   |
| <b>Monthly plan premium</b>   | \$28.40  |  |
| <b>Annual medical deductible</b>  | This plan does not have a medical deductible.  |  |
| <b>Maximum out-of-pocket amount</b> (does not include prescription drugs) | \$1,600  | \$5,100  |
|   | This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers.  | This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from any provider. |
|   | If you reach this amount, you will still need to pay your monthly premiums. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount. |  |

| Medical benefits  |   |  |  |
|---|---|--|--|
|   |   | In-network   | Out-of-network   |
| <b>Inpatient hospital care<sup>2</sup></b>  |   | \$200 copay per day: days 1-7  | 30% coinsurance per stay   |
| Our plan covers an unlimited number of days for an inpatient hospital stay.                 |   | \$0 copay per day: days 8 and beyond   |  |
| <b>Outpatient hospital</b><br>Cost-sharing for additional plan covered services will apply. | Ambulatory surgical center (ASC) <sup>2</sup>         | \$0 copay for a colonoscopy<br>\$175 copay otherwise   | 30% coinsurance  |
|   | Outpatient hospital, including surgery <sup>2</sup>   | \$0 copay for a colonoscopy<br>\$175 copay otherwise   | 30% coinsurance  |
|   | Outpatient hospital observation services <sup>2</sup> | \$175 copay  | 30% coinsurance  |
| <b>Doctor visits</b>  | Primary care provider                                 | \$0 copay  | 30% coinsurance  |
|   | Specialists <sup>2</sup>                              | \$0 copay  | 30% coinsurance  |
|   | Virtual medical visits                                | \$0 copay to talk with a network telehealth provider online through live audio and video   |  |
| <b>Preventive services</b>  | Routine physical                                      | \$0 copay, 1 per year*   | 30% coinsurance, 1 per year*   |
|   | Medicare-covered                                      | \$0 copay  | \$0 copay - 30% coinsurance (depending on the service)   |
|   |   | <ul style="list-style-type: none"> <li>□ Abdominal aortic aneurysm screening</li> <li>□ Alcohol misuse counseling</li> <li>□ Annual wellness visit</li> <li>□ Bone mass measurement</li> <li>□ Breast cancer screening (mammogram)</li> <li>□ Cardiovascular disease (behavioral therapy)</li> <li>□ Cardiovascular screening</li> </ul> | <ul style="list-style-type: none"> <li>□ Cervical and vaginal cancer screening</li> <li>□ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>□ Depression screening</li> <li>□ Diabetes screenings and monitoring</li> <li>□ Hepatitis C screening</li> <li>□ HIV screening</li> </ul> |

## Medical benefits

|  | In-network   | Out-of-network   |
|--|--|--|
|  | <ul style="list-style-type: none"> <li>□ Lung cancer with low dose computed tomography (LDCT) screening</li> <li>□ Medical nutrition therapy services</li> <li>□ Medicare Diabetes Prevention Program (MDPP)</li> <li>□ Obesity screenings and counseling</li> <li>□ Prostate cancer screenings (PSA)</li> </ul> | <ul style="list-style-type: none"> <li>□ Sexually transmitted infections screenings and counseling</li> <li>□ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>□ Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</li> <li>□ “Welcome to Medicare” preventive visit (one-time)</li> </ul> |

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.

### 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


### Diagnostic tests, lab and radiology services, and X-rays

|  |                 |                 |
|--|-----------------|-----------------|
| Diagnostic radiology services (e.g. MRI, CT scan) <sup>2</sup> | 20% coinsurance | 30% coinsurance |
| Lab services <sup>2</sup>                                      | \$0 copay       | \$0 copay       |
| Diagnostic tests and procedures <sup>2</sup>                   | 20% coinsurance | 30% coinsurance |
| Therapeutic radiology <sup>2</sup>                             | 20% coinsurance | 30% coinsurance |
| Outpatient X-rays <sup>2</sup>                                 | \$0 copay       | 30% coinsurance |

## Medical benefits

|  |  | In-network   | Out-of-network               |
|--|--|--|------------------------------|
|  <b>Hearing services</b>          | Exam to diagnose and treat hearing and balance issues <sup>2</sup> | \$0 copay  | 30% coinsurance              |
|  | Routine hearing exam   | \$0 copay, 1 per year*   | 30% coinsurance, 1 per year* |
|  | Hearing aids <sup>2</sup>  | \$3,600 allowance for a broad selection of OTC and brand-name prescription hearing aids* <ul style="list-style-type: none"> <li>• Access to one of the largest national networks of hearing professionals with more than 7,000 locations</li> <li>• Broad range of popular hearing aids including Beltone™, Oticon, Phonak, ReSound, Signia, Starkey®, Unitron™ and Widex®</li> <li>• 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period</li> </ul>                           |                              |
|  <b>Routine dental benefits</b> | Preventive and comprehensive <sup>2</sup>                          | \$2,400 allowance for all covered dental services*<br>\$0 copay for covered preventive and comprehensive services like cleanings, fillings and crowns <ul style="list-style-type: none"> <li><input type="checkbox"/> No annual deductible</li> <li><input type="checkbox"/> Medicare Advantage's largest national dental network</li> <li><input type="checkbox"/> Freedom to see any dentist</li> <li><input type="checkbox"/> If you choose to see an out-of-network dentist you might be billed more, even for services listed as \$0 copay</li> </ul> |                              |

## Medical benefits

|  |  | In-network   | Out-of-network                           |
|--|--|--|--|
|  <b>Vision services</b> | Exam to diagnose and treat diseases and conditions of the eye <sup>2</sup>             | \$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  | \$200 allowance for frames or contacts* <ul style="list-style-type: none"> <li>• Access to one of Medicare Advantage’s largest national networks of vision provider and retail network</li> <li>• Free standard prescription lenses including single vision, bifocals, trifocals and Tier I (standard) progressives—all with scratch-resistant coating</li> <li>• Savings when upgrading lenses including tinting, UV/anti-reflective coating and polycarbonate lenses</li> <li>• Eyewear available from many online providers, including Warby Parker, GlassesUSA and more</li> </ul> |  |
| <b>Mental health</b>   | Inpatient visit <sup>2</sup><br>Our plan covers 90 days for an inpatient hospital stay | \$200 copay per day: days 1-7<br>\$0 copay per day: days 8-90  | 30% coinsurance per stay                 |
|  | Outpatient group therapy visit <sup>2</sup>  | \$15 copay   | 30% coinsurance                          |
|  | Outpatient individual therapy visit <sup>2</sup>                                       | \$25 copay   | 30% coinsurance                          |
|  | Virtual mental health visits   | \$0 copay to talk with a network telehealth provider online through live audio and video   |  |
| <b>Skilled nursing facility (SNF)<sup>2</sup></b><br>Our plan covers up to 100 days in a SNF.            |  | \$0 copay per day: days 1-100  | 30% coinsurance per stay, up to 100 days |

| Medical benefits   |   |   |  |
|--|---|---|--|
|  |   | In-network  | Out-of-network   |
| <b>Outpatient rehabilitation services</b>  | Physical therapy and speech and language therapy visit <sup>2</sup>                     | \$0 copay   | 30% coinsurance  |
|  | Occupational Therapy Visit <sup>2</sup>   | \$0 copay   | 30% coinsurance  |
|  | Virtual medical visits  | \$0 copay to talk with a network telehealth provider online through live audio and video          |  |
| <b>Ambulance<sup>2</sup></b>   |   | \$100 copay for ground<br>\$100 copay for air   | \$100 copay for ground<br>\$100 copay for air                    |
| Your provider must obtain prior authorization for non-emergency transportation.  |   |   |  |
| <b>Routine transportation</b>  |   | \$0 copay for 36 one-way trips to or from approved medically related appointments and pharmacies* | 75% coinsurance*   |
| <b>Medicare Part B prescription drugs</b>  | Chemotherapy drugs <sup>2</sup>   | 20% coinsurance   | 30% coinsurance  |
|  | Part B covered insulin <sup>2</sup>   | 20% coinsurance, up to \$35   | 30% coinsurance  |
|  | Other Part B drugs <sup>2</sup>   | \$0 copay for allergy antigens<br>20% coinsurance for all others                                  | \$0 copay for allergy antigens<br>30% coinsurance for all others |
|  | Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. |   |  |
| In-network cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. |   |   |  |

## Prescription drug payment stages

**Annual Prescription Deductible** This plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.

**Initial Coverage** In this stage, the plan pays its share of the cost and you pay your copay or coinsurance. You generally stay in this stage until your year-to-date total drug cost reaches \$5,030. Then you move to the Coverage Gap stage.

| Tier Drug Coverage                      | Retail                     |                  | Mail Order       |                  |
|---|----------------------------|------------------|------------------|------------------|
|   | Standard                   |                  | Preferred        | Standard         |
|   | 30-day supply <sup>^</sup> | 100-day supply   | 100-day supply   | 100-day supply   |
| <b>Tier 1:</b><br>Preferred Generic     | \$2 copay                  | \$6 copay        | \$0 copay        | \$6 copay        |
| <b>Tier 2:</b><br>Generic <sup>3</sup>  | \$12 copay                 | \$36 copay       | \$0 copay        | \$36 copay       |
| <b>Tier 3:</b><br>Preferred Brand       | \$47 copay                 | \$141 copay      | \$131 copay      | \$141 copay      |
| <b>Tier 3:</b><br>Covered Insulin Drugs | \$35 copay                 | \$105 copay      | \$95 copay       | \$105 copay      |
| <b>Tier 4:</b><br>Non-Preferred Drug    | \$100 copay                | \$300 copay      | \$290 copay      | \$300 copay      |
| <b>Tier 5:</b><br>Specialty Tier        | 33% coinsurance            | N/A <sup>5</sup> | N/A <sup>5</sup> | N/A <sup>5</sup> |

**Coverage Gap (Donut hole)** In this stage, you pay 25% of the negotiated price for covered drugs. You may pay less if your plan has additional coverage in the gap. You pay this amount until your total out-of-pocket cost reaches \$8,000.

**Catastrophic Coverage** After your total out-of-pocket drug cost reaches \$8,000, you won't pay anything for Medicare Part D covered drugs for the rest of the plan year.

**Additional covered drugs** This plan covers these additional drugs as Tier 2 medications.

These drugs are not covered by Medicare Part D and not on the plan's Drug List.

- Vitamin D (50,000)
- Sildenafil (generic Viagra)
- Cyanocobalamin (Vitamin B-12)
- Folic Acid (1 mg)




<sup>^</sup>Members living in long-term care facilities pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

<sup>3</sup> Tier includes enhanced drug coverage.

<sup>5</sup> Limited to a 30-day supply

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

| Additional benefits  |  |  |                                     |
|--|--|--|-------------------------------------|
|  |  | In-network   | Out-of-network                      |
| <b>Durable medical equipment (DME) and related supplies</b>  | DME (e.g., wheelchairs, oxygen) <sup>2</sup>   | 20% coinsurance  | 30% coinsurance                     |
|  | Prosthetics (e.g., braces, artificial limbs) <sup>2</sup>  | \$0 copay - 20% coinsurance  | 30% coinsurance                     |
| <b>Foot care</b><br>(podiatry services)  | Foot exams and treatment <sup>2</sup>  | \$0 copay  | 30% coinsurance                     |
|  | Routine foot care  | \$0 copay, 6 visits per year*  | 30% coinsurance, 6 visits per year* |
| <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>Opioid treatment program services<sup>2</sup></b>   |  | \$0 copay  | \$0 copay                           |
| <b>Outpatient substance abuse</b>  | Outpatient group therapy visit <sup>2</sup>  | \$15 copay   | 30% coinsurance                     |
|  | Outpatient individual therapy visit <sup>2</sup>   | \$25 copay   | 30% coinsurance                     |
|  <b>Over-the-Counter (OTC) Credit</b> | <p>\$195 credit every quarter for OTC products like pain relievers, cold remedies and vitamins in-store or online</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Choose from thousands of brand name and generic OTC products like vitamins, pain relievers, toothpaste and more</li> <li><input type="checkbox"/> Shop at thousands of participating stores, including Walmart, Walgreens, Kroger and CVS, or at neighborhood stores near you</li> </ul> |  |                                     |
| <b>Renal Dialysis<sup>2</sup></b>  |  | 20% coinsurance  | 20% coinsurance                     |

<sup>2</sup> May require your provider to get prior authorization from the plan for in-network benefits.

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

## Member discounts



As a UnitedHealthcare Medicare Advantage plan member, you'll have access to an exclusive collection of discounts on hundreds of products and services. Once you're a member, you can sign in to your member site for a list of discounts available to you.

## About this plan

UHC Care Advantage EX-E001 (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.

UHC Care Advantage EX-E001 (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:

**Oklahoma:** Oklahoma, Tulsa;

**Texas:** Bell, Bexar, Collin, Dallas, Denton, Harris, McLennan, Tarrant, Travis.

## Use network providers and pharmacies

UHC Care Advantage EX-E001 (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 charts above 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](https://www.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.

## Required Information

UHC Care Advantage EX-E001 (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](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.

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 documents in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-866-550-4736 for additional information (TTY users should call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-866-550-4736, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 8 a.m. a 8 p.m.: los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.

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

### Hearing aids

Other hearing exam providers are available in the UnitedHealthcare network. The plan only covers hearing aids from a UnitedHealthcare Hearing network provider. Provider network size may vary by local market. OTC hearing aid warranties, if available, will vary by device and are handled through the manufacturer. One-time professional fee may apply for prescription hearing aids.

### Routine dental benefits

If your plan offers out-of-network dental coverage and you see an out-of-network dentist, you might be billed more. Provider network may vary in local market. Dental network size based on Zelis Network360, May 2023.

### Routine eyewear

Additional charges may apply for out-of-network items and services. Provider and retail network may vary in local market. Vision network size based on Zelis Network360, March 2023. Annual routine eye exam and \$100-400 allowance for contacts or designer frames, with standard (single, bi-focal, tri-focal or standard progressive) lenses covered in full either annually or every two years. Savings based on comparison to retail. Other vision providers are available in our network.

### Over-the-Counter (OTC) Credit

OTC benefits have expiration timeframes. Call your plan or review your Evidence of Coverage (EOC) for more information.

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.

Additional authorizations may be required to access discount programs. The discounts described are neither offered

nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process. Discount offerings may vary by plan and are not available on all plans. The discount offers are made available to members through a third party. Participation in these third-party services are subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties.