

2018 SUMMARY OF BENEFITS



Overview of your plan

UnitedHealthcare Dual Complete® ONE (HMO SNP)
H3113-005

Look inside to learn more about the plan and the medical services and prescription drugs it covers. Call Customer Service or go online for more information about the plan.



Toll-Free 1-800-514-4911, TTY 711
8 a.m. - 8 p.m. local time, 7 days a week



www.UHCommunityPlan.com



Our service area includes these counties in:

New Jersey: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union

Summary of Benefits

January 1, 2018 – December 31, 2018

The benefit information provided is a summary of what we cover. 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.UHCCommunityPlan.com, or you can call Customer Service with questions you may have. You get a copy of the EOC when you enroll in the plan.

About this plan.

UnitedHealthcare Dual Complete® ONE (HMO SNP) is a Dual Eligible Special Needs Plan (D-SNP) with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area listed inside the cover, and be a United States citizen or lawfully present in the United States.

You can enroll in this plan if you are in one of these Medicaid categories:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance and copayment amounts.
- **Full Benefits Dual Eligible (FBDE):** Medicaid provides assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits.

Because you are eligible for Medicare benefits as well as full Medicaid benefits, as a member of the plan you will have no cost-sharing for covered services or Part D prescription drugs. You will have no premiums, deductibles, coinsurance, or copayments.

You must recertify your Medicaid eligibility every year to remain a member of this plan.

You must also live in our service area which is shown on the inside cover of this Summary of Benefits.

Use network providers and pharmacies.

This plan 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 these services or drugs.

You can go to www.UHCCommunityPlan.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 Dual Complete® ONE (HMO SNP)

Premiums and Benefits

In-Network

Monthly Plan Premium	There is no monthly premium for this plan. Medicare Part B Premiums are covered by Medicaid for enrollees of UnitedHealthcare Dual Complete® ONE (HMO SNP).
Annual Medical Deductible	This plan does not have a deductible.
Maximum Out-of-pocket Amount (does not include prescription drugs)	As a UnitedHealthcare Dual Complete® ONE (HMO SNP) member, you have no out-of-pocket expenses. You will not be responsible for any copayments or coinsurance for drugs or other covered services provided by plan providers.

UnitedHealthcare Dual Complete[®] ONE (HMO SNP)

No prior authorizations or referrals are needed for covered services from plan providers.

Benefits

In-Network

Inpatient Hospital Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, x-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.	\$0 copay Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital, including Observation	\$0 copay
Doctor Visits	Primary \$0 copay
	Specialists \$0 copay

Benefits

In-Network

<p>Preventive Care</p>		<p>\$0 copay</p> <p>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 HIV screening Lung cancer screenings Medical nutrition therapy services 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 “Welcome to Medicare” preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.</p>
	<p>Routine physical</p>	<p>\$0 copay; 1 per year</p>
<p>Emergency Care</p>		<p>\$0 copay</p> <p>\$0 copay for worldwide coverage per visit</p>
<p>Urgently Needed Services</p>		<p>\$0 copay</p> <p>\$0 copay for worldwide coverage per visit</p>

Benefits

In-Network

<p>Diagnostic Tests, Lab and Radiology Services, and X-rays</p>	<p>Diagnostic radiology services (e.g., MRI)</p>	<p>\$0 copay per service</p>
	<p>Lab services</p>	<p>\$0 copay per service</p>
	<p>Diagnostic tests and procedures</p>	<p>\$0 copay per service</p>
	<p>Therapeutic Radiology</p>	<p>\$0 copay per service</p>
	<p>Outpatient X-rays</p>	<p>\$0 copay per service</p>
<p>Hearing Services</p> <p>Routine hearing exams, exams to diagnose and treat hearing and balance issues, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration.</p> <p>Hearing aids, as well as associated accessories and supplies, are covered.</p>		<p>\$0 copay</p>
<p>Dental Services</p> <p>Includes diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, and oral and maxillofacial surgical services, including (but not limited to): routine dental exams, cleanings, dental X-rays, fillings, dentures and fixed prosthodontics. Orthodontics (with age restrictions and documentation of medical necessity) is also covered.</p>		<p>\$0 copay</p>

Benefits

In-Network

Vision Services

Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Optometric services and optical appliances are covered, including 1 pair of lenses/frames or contact lenses every 24 months for those age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Artificial eyes, low vision devices, vision training devices, and intraocular lenses are also covered.

Standard eyewear after cataract surgery is also covered.

\$0 copay

Mental Health Services

Inpatient Services

- Covered services include mental health care services that require a hospital stay. The plan covers inpatient services in a psychiatric hospital (services beyond 190 days are covered by the Medicaid portion of the plan's coverage).
- Inpatient psychiatric services in State, private, or county hospitals are covered for those under age 21, and those age 65 and older.
- All members are covered by the plan for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. Mental health services are covered by the plan for all members (services beyond 190 days are covered by the Medicaid portion of the plan's coverage).
- Services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital are covered.

\$0 copay

Our plan covers an unlimited number of days for an inpatient hospital stay.

Benefits

In-Network

Mental Health Services (cont.)

- Inpatient Medical Detox (Medically Managed Inpatient Withdrawal Management in a hospital setting) is covered.

Outpatient Services

- Outpatient psychiatric services are covered for members of all ages in Private Psychiatric Hospitals and General Hospital Outpatient settings.
- Covers mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Services provided by an Independent Practitioner Network or IPN (Psychiatrist, Psychologist or APN) are also covered.
- Partial Hospitalization/Acute Partial Hospitalization is covered for all members by the plan.

\$0 copay

Our plan covers an unlimited number of days for an inpatient hospital stay.

Skilled Nursing Facility (SNF)

Care in a Skilled Nursing Facility is covered for all members, and that coverage includes long-term (custodial) care, beyond Medicare limits.

\$0 copay

Physical Therapy

Physical Therapy and Speech-Language Pathology Services are covered.

\$0 copay

Ambulance

\$0 copay

Benefits

In-Network

Transportation Emergency: Covers medically necessary ground ambulance transportation to a hospital or skilled nursing facility for medically necessary services. May cover emergency ambulance transportation in an airplane or helicopter if ground transportation cannot provide the immediate and rapid transportation that is necessary. Non-Emergency (Routine): Non-emergency transportation is covered by Medicaid Fee-for-Service, and includes services such as mobile assistance vehicles (MAVs) and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered.		\$0 copay
Medicare Part B Drugs	Chemotherapy drugs	\$0 copay
	Other Part B drugs	\$0 copay

Prescription Drugs

Annual pharmacy deductible	Since you have no deductible, this doesn't apply.
30-day supply from retail network pharmacy	
Generic (including brand drugs treated as generic)	\$0 copay
All other drugs	\$0 copay

Other Benefits

Other Benefits		In-Network
Acupuncture		\$0 copay
Clinical Trials Covered for services rendered beyond Medicare Part B limits. Covered for Medicaid approved services.		\$0 copay
Diabetes Management	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® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Connect.
	Diabetes Self-management training	\$0 copay
	Therapeutic shoes or inserts	\$0 copay
Durable Medical Equipment	Durable Medical Equipment (e.g., wheelchairs, oxygen)	\$0 copay
	Prosthetics (e.g., braces, artificial limbs)	\$0 copay

Other Benefits

In-Network

Family Planning Services and Supplies

Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Covered for services rendered beyond Medicare Part B limits. Services furnished by out-of-network providers are covered by Medicaid Fee-for-Service.

\$0 copay

Fitness program through Optum® Fitness

Basic fitness center membership at participating fitness center locations at no cost to you.

For the complete details about the program, please visit fitnessadvantage.optum.com, and click the link in the footer entitled Terms and Conditions.

\$0 copay

Foot Care (podiatry services)

Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts.

Routine hygienic foot care, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, is only covered when medically necessary as treatment for an associated condition.

\$0 copay

Other Benefits

In-Network

Home Health Care

Covered for services rendered beyond Medicare Parts A and B limits. Includes nursing services and home health aide services.

Physical therapy, speech-language pathology, and occupational therapy are also covered as part of this benefit.

\$0 copay

Hospice

Covered in the community as well as in institutional settings. Room and board services are not covered in a member's home or in a facility (such as a nursing home) that serves as the member's normal residence. Hospice care for enrollees under 21 years of age covers both palliative and curative care.

\$0 copay

Other Benefits

In-Network

Managed Long Term Services and Supports (MLTSS)

Managed Long Term Services and Supports (MLTSS) is a program that provides Home and Community Based services for members that require the level of care typically provided in a Nursing Facility, and allows them to receive necessary care in a residential or community setting. MLTSS services include (but are not limited to): assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); vehicle modifications; social adult day care; and non-medical transportation. MLTSS is available to members who meet certain clinical and financial requirements.

For more information on MLTSS, call Customer Service (phone numbers are printed on the back cover of this booklet).

\$0 copay

Meal Benefit

Up to 3 meals per day for the first 4 weeks after an inpatient stay; up to 84 meals per year. A doctor's or provider's order is required.

\$0 copay

Medical Day Care

Provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.

\$0 copay

Other Benefits

	In-Network
NurseLineSM Speak with a registered nurse (RN) 24 hours a day, 7 days a week	\$0 copay
Nurse Midwife Services	\$0 copay
Occupational Therapy	\$0 copay
Outpatient Substance Use Disorder Treatment Services The plan covers substance use disorder screening, referrals, prescription drugs, and treatment of conditions. Services covered through the Medicaid portion of the plan's coverage include, but are not limited to, the following: <ul style="list-style-type: none">• Non-Medical Detoxification/ Non-Hospital based withdrawal management• Substance Use Disorder Short Term Residential• Ambulatory withdrawal Management with extended on-site monitoring/ Ambulatory Detoxification• Substance Use Disorder Partial Care• Substance Use Disorder Intensive Outpatient• Substance Use Disorder Outpatient• Opioid Treatment Services (Methadone Medication Assisted Treatment)• Opioid Treatment Services (Non-Methadone Medication Assisted Treatment)	\$0 copay
Outpatient Surgery	\$0 copay
Over-the-Counter Benefit	\$200 as a credit per quarter on a debit card for approved products at network retail locations
Health Products Benefit	\$225 as a credit per quarter to use on approved health products that can be ordered online or by mail.

Other Benefits

In-Network

Renal Dialysis	\$0 copay
Personal Care Assistant Covers health related tasks performed by a qualified individual in a beneficiary’s home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary’s written plan of care.	\$0 copay
Personal Emergency Response Emergency response services through an electronic monitoring system 24 hours a day, seven days a week.	\$0 copay
Private Duty Nursing When authorized, available for members up to 21 years of age. This benefit is also available to Managed Long Term Services and Supports (MLTSS) members of any age.	\$0 copay

Required Information

This information is not a complete description of benefits. Contact the plan for more information. Limitations and restrictions may apply.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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.

Benefits may change on January 1 of each year.

This plan is available to anyone who has both Medicare and full Medicaid eligibility. Premiums are covered for enrollees of UnitedHealthcare Dual Complete ONE (HMO SNP).

Plans are insured through UnitedHealthcare or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan’s contract renewal with Medicare.

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 1-888-834-3721 (TTY 711) if you are not a member, or call us at 1-800-514-4911 (TTY 711) if you are already a member.

Members must use network plan providers, pharmacies, DME (Durable Medical Equipment) suppliers, and understand and follow the rules on referrals. Members will be enrolled into Medicare Part D prescription drug coverage under the plan and will be automatically disenrolled from any other Medicare Advantage or Medicare Part D prescription drug coverage.

Vendor Information

Before contacting any of the providers below you must be fully enrolled in UnitedHealthcare Dual Complete ONE (HMO SNP).

Benefit Type	Vendor Name	Contact Information
Nurse Line	NurseLine SM	1-877-440-9407, TTY 711 24 hours a day, 7 days a week
Health Products Benefit Catalog	FirstLine Medical [®]	1-800-933-2914, TTY 711 7 a.m. – 7 p.m. Central Time, Monday – Friday; 7 a.m. – 4 p.m. Central Time, Saturday www.HealthProductsBenefit.com
Over-the-Counter Benefit	UnitedHealthcare	1-800-514-4911, TTY 711 8 a.m. – 8 p.m. local time, 7 days a week
Personal Emergency Response	Tunstall Americas	1-800-514-4911, TTY 711 8 a.m. – 8 p.m. local time, 7 days a week
Fitness Program	Optum[®] Fitness Advantage	1-800-514-4911, TTY 711 8 a.m. – 8 p.m. local time, 7 days a week fitnessadvantage.optum.com
Meals Benefit	Mom's Meals Nourishcare [®]	1-866-204-6111, TTY 711 7 a.m. – 6 p.m. Central Time, Monday – Friday http://www.momsmeals.com/care-transitions/