# Summary of Benefits 2027

**UHC Nursing Home Plan EX-F003 (PPO I-SNP)**

H0710-026-000

Look inside to learn more about the plan and the health and drug services it covers. Contact us for more information about the plan.

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# Summary of Benefits

## January 1, 2027 - December 31, 2027

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** 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 Nursing Home Plan EX-F003 (PPO I-SNP)

| Medical premium, deductible and limits | | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **Monthly plan premium** | $18.10 | |
| **Annual medical deductible** | Your medical deductible is the Original Medicare Part B deductible amount combined in and out-of-network. The 2026 Original Medicare deductible amount is $283. The 2027 amount will be set by CMS in the fall of 2026. Our plan will provide updated rates as soon as they are released. | |
| **Maximum out-of-pocket amount** (does not include prescription drugs) | $9,850<br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers.<br><br>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. | $14,800<br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from any provider. |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Inpatient hospital care**[2]<br>Our plan covers 90 days for an inpatient hospital stay. | | $1,980 copay per stay | $1,980 copay per stay |
| **Outpatient hospital**<br>Cost-sharing for additional plan | Ambulatory surgical center (ASC)[2] | $0 copay for a colonoscopy<br>20% coinsurance otherwise | 30% coinsurance |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| covered services will apply. | Outpatient hospital, including surgery[2] | $0 copay for a colonoscopy<br>20% coinsurance otherwise | 30% coinsurance |
| | Outpatient hospital observation services[2] | 20% coinsurance | 30% coinsurance |
| **Doctor visits** | Primary care provider | 20% coinsurance | 30% coinsurance |
| | Specialists[2] | 20% coinsurance | 30% coinsurance |
| | Virtual medical visits | $0 copay | Same as a Doctor's office visit |
| **Preventive services** | Routine physical | $0 copay, 1 per year* | 30% coinsurance, 1 per year* |
| | Medicare-covered | $0 copay | $0 copay - 30% coinsurance (depending on the service) |

- 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 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.

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers. | | |
| **Emergency care** | | $115 copay 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 per visit | |
| **Diagnostic tests, lab and radiology services, and X-rays** | Diagnostic radiology services (e.g. MRI, CT scan)[2] | $0 copay for each diagnostic mammogram<br>20% coinsurance otherwise | 30% coinsurance |
| | Lab services[2] | $0 copay | $0 copay |
| | Diagnostic tests and procedures[2] | 20% coinsurance | 30% coinsurance |
| | Therapeutic radiology[2] | 20% coinsurance | 30% coinsurance |
| | Outpatient X-rays[2] | 20% coinsurance | 30% coinsurance |
| **Hearing services** | Exam to diagnose and treat hearing and balance issues[2] | 20% coinsurance | 30% coinsurance |
| | Routine hearing exam | $0 copay for a routine hearing exam to help support hearing health* | 30% coinsurance for a routine hearing exam to help support hearing health* |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | Hearing aids[2] | $2,200 allowance for 2 hearing aids every 2 years *<br>• A broad selection of high-value and brand name prescription hearing aids<br>• Access to one of the largest national networks of hearing professionals with more than 6,500 locations<br>• 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period | $0 copay* |
| **Routine dental benefits** | Preventive services | $0 copay for covered preventive services like oral exams, X-rays, routine cleanings and fluoride*<br>• No annual deductible<br>• Access to one of the largest national dental networks<br>• Freedom to see any dentist | |
| **Vision services** | Exam to diagnose and treat diseases and conditions of the eye[2] | 20% coinsurance | 30% coinsurance |
| | Eyewear after cataract surgery | $0 copay | $0 copay |
| | Routine eye exam | $0 copay for a routine eye exam each year to help protect your eyesight and health* | 30% coinsurance for a routine eye exam each year to help protect your eyesight and health* |
| | Routine eyewear | | |
| **Mental health** | Inpatient visit[2]<br>Our plan covers 90 days for an inpatient hospital stay | $1,980 copay per stay | $1,980 copay per stay |
| | Outpatient group therapy visit[2] | 20% coinsurance | 30% coinsurance |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | Outpatient individual therapy visit[2] | 20% coinsurance | 30% coinsurance |
| | Virtual mental health visits | $0 copay | Same as an Outpatient mental health office visit |
| **Skilled nursing facility (SNF)[2]** Our plan covers up to 100 days in a SNF. | | $0 copay per day: days 1-100 | 30% per stay, up to 100 days |
| **Outpatient rehabilitation services** | Physical therapy and speech and language therapy visit[2] | $0 copay | 30% coinsurance |
| | Occupational Therapy Visit[2] | $0 copay | 30% coinsurance |
| **Ambulance[2]** Your provider must obtain prior authorization for non-emergency transportation. | | 20% coinsurance for ground<br>20% coinsurance for air | 20% coinsurance for ground<br>20% coinsurance for air |
| **Routine transportation** | | $0 copayment for 36 one-way trips per year to or from approved locations* | 75% coinsurance* |
| **Medicare Part B prescription drugs** In-network cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | Chemotherapy drugs[2] | 20% coinsurance | 30% coinsurance |
| | Part B covered insulin[2] | 20% coinsurance; up to $35 | 30% coinsurance |
| | Other Part B drugs[2] Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | $0 copay for allergy antigens<br>20% coinsurance for all others | $0 copay for allergy antigens<br>30% coinsurance for all others |

## What is coinsurance?

Coinsurance is a portion or part of the total cost, typically as a percentage. For example, if your coinsurance is 25% and the total cost of your prescription is $100, you would pay $25. The plan pays the rest. You pay the full cost of your drugs until you meet the deductible, then you'll start paying the coinsurance amount.

| Prescription drug payment stages | |
|---|---|
| **Deductible** | Your plan has a $700 prescription drug deductible. You pay the full cost for your drugs until you reach the deductible amount. Then you move to the Initial Coverage stage. |

| Prescription drug payment stages | | | |
|---|---|---|---|
| **Initial Coverage** | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,400, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. | | |
| **Drug Coverage** | **Retail** | | **Mail Order** |
| | **30-day supply^** | **100-day supply** | **100-day supply** |
| **All covered drugs[3]** | 25% coinsurance | 25% coinsurance (Some covered drugs are limited to a 30-day supply) | 25% coinsurance (Some covered drugs are limited to a 30-day supply) |
| **Catastrophic Coverage** | Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year. | | |

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

[3]You pay no more than 25% of the total drug cost or a $35 copay, whichever is lower, for each 1-month supply of Part D covered insulin drugs, even if you haven't paid your deductible, until you reach the Catastrophic Coverage stage where you pay $0.

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Chiropractic services** | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[2] | 20% coinsurance | 30% coinsurance |
| **Diabetes management** | Diabetes monitoring supplies[2] | 20% coinsurance | 30% coinsurance |
| | Diabetes self-management training | $0 copay | 30% coinsurance |
| | Therapeutic shoes or inserts[2] | 20% coinsurance | 30% coinsurance |
| **Durable medical equipment (DME) and related supplies** | DME (e.g., wheelchairs, oxygen)[2] | 20% coinsurance | 30% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs)[2] | $0 copay - 20% coinsurance | 30% coinsurance |
| **Foot care** (podiatry services) | Foot exams and treatment[2] | 20% coinsurance | 30% coinsurance |

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | Routine foot care | $0 copay, 8 visits per year* | 30% coinsurance, 8 visits per year* |
| **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. | |
| **Opioid treatment program services[2]** | | $0 copay | $0 copay |
| **Outpatient substance use disorder services** | Outpatient group therapy visit[2] | 20% coinsurance | 30% coinsurance |
| | Outpatient individual therapy visit[2] | 20% coinsurance | 30% coinsurance |
| **OTC credit** | | $250 credit every quarter for over-the-counter (OTC) products<br>Choose from thousands of brand name and generic OTC products like wheelchair cushions, oral care supplies, incontinence products and more | If you use an out-of-network store, you pay 90% of the total cost |
| **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.

## Member discounts

As a UnitedHealthcare Medicare Advantage plan member, you'll have access to a 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.

## 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 the 2027 Original Medicare Part B deductible amount for covered medical services you receive from providers as described below. The 2026 Medicare deductible amount is $283. The 2027 amount will be set by CMS in the fall of 2026. Our plan will provide updated rates as soon as they are released. 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**<br>List of applicable services | **Out-of-network**<br>List of applicable services |
|---|---|
| **Outpatient hospital**<br>• Ambulatory surgical center (ASC), excluding diagnostic colonoscopy<br>• Outpatient hospital, including surgery, excluding diagnostic colonoscopy<br>• Outpatient hospital observation services | **Outpatient hospital**<br>• Ambulatory surgical center (ASC)<br>• Outpatient hospital, including surgery<br>• Outpatient hospital observation services |
| **Doctor visits**<br>• Specialists | **Doctor visits**<br>• Primary<br>• Specialists |
| **Diagnostic tests, lab and radiology services, and X-rays**<br>• Diagnostic radiology services (e.g. MRI), excluding diagnostic mammogram and in-home vascular screening<br>• Lab services<br>• Diagnostic tests and procedures<br>• Therapeutic radiology<br>• Outpatient X-rays | **Diagnostic tests, lab and radiology services, and X-rays**<br>• Diagnostic radiology services (e.g. MRI)<br>• Lab services<br>• Diagnostic tests and procedures<br>• Therapeutic radiology<br>• Outpatient X-rays |
| **Hearing services**<br>• Exam to diagnose and treat hearing and balance issues | **Hearing services**<br>• Exam to diagnose and treat hearing and balance issues |

| | |
|---|---|
| **Vision services**<br>• Exam to diagnose and treat diseases and conditions of the eye<br>• Eyewear after cataract surgery | **Vision services**<br>• Exam to diagnose and treat diseases and conditions of the eye<br>• Eyewear after cataract surgery |
| **Mental health**<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit | **Mental health**<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit |
| | **Physical therapy and speech and language therapy visit** |
| **Ambulance** | **Ambulance** |
| **Medicare Part B drugs**<br>• Chemotherapy drugs<br>• Other Part B drugs | **Medicare Part B drugs**<br>• Chemotherapy drugs<br>• Other Part B drugs |
| **Chiropractic services**<br>• Manual manipulation of the spine to correct subluxation | **Chiropractic services**<br>• Manual manipulation of the spine to correct subluxation |
| **Diabetes management**<br>• Diabetes monitoring supplies<br>• Therapeutic shoes or inserts | **Diabetes management**<br>• Diabetes monitoring supplies<br>• Diabetes self-management training<br>• Therapeutic shoes or inserts |
| **Durable medical equipment (DME) and related supplies**<br>• Durable medical equipment (e.g. wheelchairs, oxygen)<br>• Prosthetics (e.g., braces, artificial limbs) | **Durable medical equipment (DME) and related supplies**<br>• Durable medical equipment (e.g. wheelchairs, oxygen)<br>• Prosthetics (e.g., braces, artificial limbs) |
| **Foot care**<br>• Foot exams and treatment | **Foot care**<br>• Foot exams and treatment |
| | **Occupational therapy visit** |
| **Opioid treatment program services** | **Opioid treatment program services** |
| **Outpatient substance use disorder services**<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit | **Outpatient substance use disorder services**<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit |
| **Renal dialysis** | **Renal dialysis** |

**Inpatient services**

- Inpatient hospital
- Inpatient mental health

**Skilled nursing facility (SNF)**

**Home health care**

## About this plan

UHC Nursing Home Plan EX-F003 (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 Nursing Home Plan EX-F003 (PPO I-SNP) is an Institutional Special Needs Plan designed specifically for people who live in a contracted institution (like a nursing home) for 90 days or longer. You can find a list of contracted institutions at **www.uhcnursinghomeplan.com**.

Our service area includes the state of **Connecticut** and these counties in:

**Maine:** Cumberland, Franklin, Kennebec, Oxford, Penobscot, Somerset, York;

**New Hampshire:** Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, Sullivan;

**New Jersey:** Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Union.

## Use network providers and pharmacies

UHC Nursing Home Plan EX-F003 (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** 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 Nursing Home Plan EX-F003 (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.

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

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party. Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

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.

**Hearing aids -** The plan may only cover hearing aids from a UnitedHealthcare Hearing network provider. Other hearing exam providers are available in the UnitedHealthcare network.

**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 2025.

**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 $100-450 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.

**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. 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 discount offers is 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.