Summary of Benefits 2027

UHC Nursing Home Plan WA-F001 (PPO I-SNP)

H0710-031-000

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 WA-F001 (PPO I-SNP)

Medical premium, deductible and limits		
	In-network	**Out-of-network**
Monthly plan premium	$0 You need to continue to pay your Medicare Part B premium	
Annual medical deductible	Your medical deductible is $75 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)	$9,850 This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount.	$14,800 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] Our plan covers 90 days for an inpatient hospital stay.		$2,200 copay per stay	$2,200 copay per stay
Outpatient hospital Cost-sharing for additional plan covered services will apply.	Ambulatory surgical center (ASC)[2]	$0 copay for a colonoscopy 20% coinsurance otherwise	30% coinsurance
	Outpatient hospital, including surgery[2]	$0 copay for a colonoscopy	30% coinsurance

Medical benefits			
		In-network	**Out-of-network**
		20% coinsurance otherwise	
	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.
This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.

Medical benefits			
		In-network	**Out-of-network**
Emergency care		$110 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 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*
	Hearing aids[2]	$2,200 allowance for 2 hearing aids every 2 years * • A broad selection of high-value and brand name prescription hearing aids • Access to one of the largest national networks of hearing professionals with more than 6,500 locations • 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period	$0 copay*

Medical benefits			
		In-network	**Out-of-network**
Routine dental benefits	Preventive and comprehensive services	$2,000 allowance for all covered dental services* $0 copay for covered preventive and comprehensive services like cleanings, fillings, crowns, bridges and dentures • No annual deductible • Access to one of the largest national dental networks • 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] Our plan covers 90 days for an inpatient hospital stay	$2,091 copay per stay	$2,091 copay per stay
	Outpatient group therapy visit[2]	20% coinsurance	30% coinsurance
	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 20% coinsurance for air	20% coinsurance for ground 20% coinsurance for air

Medical benefits			
		In-network	**Out-of-network**
Routine transportation		$0 copayment for 60 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 20% coinsurance for all others	$0 copay for allergy antigens 30% coinsurance for all others

What is coinsurance?

Coinsurance is a portion or part of the total cost, typically as a percentage. With this plan, you pay part of the cost of Tier 3, Tier 4 and Tier 5 drugs. 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	There is no deductible for drugs in Tier 1 and 2. Your coverage for these drugs starts in the Initial Coverage stage. There is a $700 deductible for drugs in Tier 3, 4 and 5. You pay the full cost for your drugs in these tiers until you reach the deductible amount. Then you move to the Initial Coverage stage.		
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.		
Tier drug coverage	**Retail**		**Mail Order**
	30-day supply^	**100-day supply**	**100-day supply**
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$3 copay	$9 copay	$9 copay
Tier 3: Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Covered Insulin Drugs[4]	25% coinsurance, up to $35 copay	25% coinsurance, up to $105 copay	25% coinsurance, up to $105 copay
Tier 4:	25% coinsurance	N/A	N/A

Prescription drug payment stages			
Non-Preferred Drug[5]			
Tier 5: Specialty Tier[5]	25% coinsurance	N/A	N/A
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.

[4]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.

[5]Limited to a 30-day supply

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
	Routine foot care	$0 copay, 6 visits per year*	30% coinsurance, 6 visits per year*
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the	

Additional plan benefits			
		In-network	**Out-of-network**
		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**		$110 credit every quarter for over-the-counter (OTC) products 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 $75 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
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
Doctor visits • Specialists	**Doctor visits** • Primary • Specialists
Diagnostic tests, lab and radiology services, and X-rays • Diagnostic radiology services (e.g. MRI), excluding diagnostic mammogram and in-home vascular screening • Lab services • Diagnostic tests and procedures • Therapeutic radiology • Outpatient X-rays	**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
Hearing services • Exam to diagnose and treat hearing and balance issues	**Hearing services** • Exam to diagnose and treat hearing and balance issues
Vision services	**Vision services**

• Exam to diagnose and treat diseases and conditions of the eye • Eyewear after cataract surgery	• 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	**Mental health** • Outpatient group therapy visit • Outpatient individual therapy visit
	Physical therapy and speech and language therapy visit
Ambulance	**Ambulance**
Medicare Part B drugs • Chemotherapy drugs • Other Part B drugs	**Medicare Part B drugs** • Chemotherapy drugs • Other Part B drugs
Chiropractic services • Manual manipulation of the spine to correct subluxation	**Chiropractic services** • Manual manipulation of the spine to correct subluxation
Diabetes management • Diabetes monitoring supplies • Therapeutic shoes or inserts	**Diabetes management** • Diabetes monitoring supplies • Diabetes self-management training • Therapeutic shoes or inserts
Durable medical equipment (DME) and related supplies • Durable medical equipment (e.g. wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs)	**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	**Foot care** • Foot exams and treatment
	Occupational therapy visit
Opioid treatment program services	**Opioid treatment program services**
Outpatient substance use disorder services • Outpatient group therapy visit • Outpatient individual therapy visit	**Outpatient substance use disorder services** • Outpatient group therapy visit • 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 WA-F001 (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 WA-F001 (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 these counties in:

Washington: Benton, Clark, Cowlitz, Franklin, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, Yakima.

Use network providers and pharmacies

UHC Nursing Home Plan WA-F001 (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 WA-F001 (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.