UCLA Health | Medicare ADVANTAGE PLAN

Summary of Benefits and Coverage

Coverage period 01/01/2027 – 12/31/2027
Principal Plan (HMO)
H4647-001

This Summary of Benefits and Coverage 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. To get a complete list of services we cover, call Member Services or visit us at **uclahealthmedicareadvantage.org/resources** to view the Evidence of Coverage.

About this plan

The plan service area is Los Angeles County, California.

For more information about the plan, call Member Services toll-free at 1-833-627-8252 (TTY 711) or go online to **uclahealthmedicareadvantage.org**. Hours are 8am - 8pm PT, Monday - Friday, April 1 through September 30, except on all federal holidays. Hours are 8am - 8pm PT, 7 days a week, October 1 through March 31, except Thanksgiving Day and Christmas Day.

You can go to **uclahealthmedicareadvantage.org/providers** to search for an in-network provider or **uclahealthmedicareadvantage.org/pharmacy** to search for an in-network pharmacy using the online directories. You can also view the plan Drug Formulary at **uclahealthmedicareadvantage.org/formulary** to see what drugs are covered and if there are any restrictions.

UCLA Health Medicare Advantage Plan has a network of doctors, hospitals, pharmacies, and other providers. Except in emergency or urgent situations, if you use providers that are not in our network, the plan will not cover those services.

You can find additional information about Medicare benefits, rights and protections as well as a list of available health and drug plans in the "Medicare & You" handbook. The “Medicare & You” handbook is sent to Medicare-eligible households every September, and you can download the latest copy of the handbook at **Medicare.gov/medicare-and-you**. View it online at **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.

UCLA Health Medicare Advantage Principal Plan (HMO)

Premium, Deductible and Limits This plan does not cover services from out-of-network providers, except in emergency or urgent situations. Refer to the Provider Directory for a list of in-network providers.	
Monthly plan premium (including Part C and Part D premium, combined)	**$0** You need to continue to pay your Medicare Part B premium.
Annual medical deductible	This plan does not have a medical deductible.
Maximum out-of-pocket amount (does not include prescription drugs)	**$2,499** 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.

Medical Benefits This plan does not cover services from out-of-network providers, except in emergency or urgent situations. Refer to the Provider Directory for a list of in-network providers.		
Inpatient hospital coverage*	$200 copay per stay Our plan covers an unlimited number of days for an inpatient hospital stay (per admission).	
Outpatient hospital coverage*	Outpatient hospital, including surgery	$100 copay for outpatient surgery; $0 copay for all other services in the outpatient setting
	Outpatient hospital observation services	$0 copay
Ambulatory surgical center (ASC) coverage*	$0 copay	

* May require referral and/or prior authorization from the plan

Medical Benefits

This plan does not cover services from out-of-network providers, except in emergency or urgent situations. Refer to the Provider Directory for a list of in-network providers.

Doctor visits	Primary care provider	$0 copay
	Specialists*	$0 copay
	Virtual medical visits	$0 copay to speak with a network telehealth provider online through live audio and video.
Preventive care	Routine physical	$0 copay; 1 per year
	Medicare-covered preventive care	$0 copay
	Our plan covers many preventive services including: • 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 screening*, screening colonoscopy*, FOBT and FIT kit • Depression screening • Diabetes screenings and monitoring • Hepatitis C screening • HIV screening • Immunizations** • Lung cancer screening with low dose computed tomography (LDCT) • Medical nutrition therapy services • Medicare diabetes prevention program (MDPP) • Obesity screenings and counseling • Prostate screening exams • Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling • 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.	

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** Your plan does not cover immunizations received for the purpose of travel, work or school purposes

Medical Benefits This plan does not cover services from out-of-network providers, except in emergency or urgent situations. Refer to the Provider Directory for a list of in-network providers.		
Emergency care	$150 copay If you are admitted to the hospital within 36 hours, you pay the inpatient hospital copay instead of the Emergency Care copay. See the "Inpatient hospital coverage" section of this booklet. $150 copay per visit for emergency care outside the United States. The Emergency Care copay is not waived even if you are admitted to the hospital, if you receive emergency care outside of the United States. Worldwide coverage is provided up to $50,000 for all worldwide services combined.	
Urgently needed services	$15 copay $50 copay per visit for urgently needed services outside the United States. Worldwide coverage is provided up to $50,000 for all worldwide services combined.	
Diagnostic tests, lab and radiology services, and X-rays*	**Diagnostic radiology services (e.g., MRI, CT scan)**	$0 copay for each diagnostic mammogram $10 copay for MRI or CT $50 copay for PET
	Lab services	$0 copay
	Diagnostic tests and procedures	$0 copay
	Therapeutic radiology	20% coinsurance
	Outpatient X-rays	$0 copay
Hearing services	**Exam to diagnose and treat hearing and balances issues***	$0 copay
	Routine hearing exam†	$0 copay; 1 per year
	Routine hearing aids† Up to 2 hearing aids every 2 years. Limited to 1 hearing aid per ear.	Copays per hearing aid: $295 Basic /$695 Standard / $1,095 Advanced /$1,495 Premium

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† Benefits are available exclusively through the plan's designated vendor

Medical Benefits This plan does not cover services from out-of-network providers, except in emergency or urgent situations. Refer to the Provider Directory for a list of in-network providers.		
Dental services	**Dental services that are part of treatment for a medical condition***	$0 copay
	Routine Dental - Preventive and Comprehensive† No annual deductible or plan maximum.	$0 copay for covered preventive services like cleanings. $7 to $410 copay for covered services like fillings and crowns. $16 to $656 copay for services like dentures, root canals, and more. Refer to the Delta Dental Evidence of Coverage for a full list of covered services and plan limitations.
Vision care	**Exam to diagnose and treat diseases and conditions of the eye***	$0 copay
	Routine eye exam†	$0 copay; 1 per year
	Routine eyewear†	$150 per year allowance for eyeglasses or contacts
	Eyewear after cataract surgery*	$0 copay
Mental health services*	**Inpatient visit**	$200 copay per admission
	Outpatient individual therapy visit	$15 copay
	Outpatient group therapy visit	$15 copay
Skilled nursing facility (SNF)*	$0 copay per day: days 1 - 20 $100 copay per day: days 21 - 100 Our plan covers up to 100 days in a SNF.	

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Medical Benefits This plan does not cover services from out-of-network providers, except in emergency or urgent situations. Refer to the Provider Directory for a list of in-network providers.		
Outpatient rehabilitation services*	**Physical therapy and speech and language therapy visit**	$0 copay
	Occupational Therapy Visit	$0 copay
Ambulance Your provider must obtain prior authorization for non-emergency transportation.	$200 copay for ground 20% coinsurance for air	
Transportation (Routine)†	12 rides to or from plan-approved health-related locations. Each ride counts as one-way and each one-way ride cannot exceed 40 miles.	
Medicare Part B prescription drugs Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	**Chemotherapy drugs***	0% - 20% coinsurance
	Part B covered insulin*	$0 copay
	Other Part B drugs*	0% - 20% coinsurance for all others

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Prescription Drug Coverage

This plan does not cover prescription drugs from out-of-network pharmacies, except in emergency or urgent situations. Refer to the Pharmacy Directory for a list of in-network pharmacies at uclahealthmedicareadvantage.org/pharmacy and the Evidence of Coverage at uclahealthmedicareadvantage.org/resources for more information.

Annual Prescription Deductible	$300 annual prescription deductible applies to drugs on Tiers 3, 4 and 5 only.			
Initial Coverage	In this stage, the plan pays its share of the cost, and you pay your copay or coinsurance. You stay in this stage until your year-to-date total drug cost reaches $2,400. Then you move to the Catastrophic phase.			
Tier Drug Coverage	**Retail**		**Mail Order**	
	30-day supply††	100-day supply	30-day supply	100-day supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 3: Preferred Brand	$47 copay	$141 copay	$47 copay	$117.50 copay
Tier 3: Covered Insulin Drugs	$35 copay	$105 copay	$35 copay	$87.50 copay
Tier 4: Non-preferred Drug	27% coinsurance	27% coinsurance (90-day supply limit)	27% coinsurance	27% coinsurance (90-day supply limit)
Tier 5: Specialty Tier	30% coinsurance	Not covered	30% coinsurance	Not covered
Catastrophic Coverage	After your total out-of-pocket drug reaches $2,400, you won't pay anything for Medicare Part D covered drugs for the rest of the plan year.			
Additional covered drugs These drugs are not covered by Original Medicare.	This plan covers this additional drug as a Tier 2 medication. • Sildenafil (generic Viagra)			

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

Additional Benefits Some benefits are available exclusively through the plan's designated vendor. Refer to the footnote and the plan's Evidence of Coverage at uclahealthmedicareadvantage.org/resources for more information.		
Acupuncture services	**Medicare-covered acupuncture for chronic low back pain*** Includes 12 visits in 90 days. Additional sessions as warranted based on medical necessity. Maximum of 20 visits annually.	$0 copay
	Routine acupuncture benefit† Up to 12 visits per year. May be subject to medical necessity review.	$0 copay
Chiropractic services	**Medicare-covered chiropractic care*** Manual manipulation of the spine to correct subluxation.	$0 copay
	Routine chiropractic benefit† Up to 12 visits per year. May be subject to medical necessity review.	$0 copay
Diabetes management	Diabetes monitoring supplies*	20% coinsurance for Continuous Glucose Monitors $0 copay for all other diabetic supplies
	Diabetes self-management training*	$0 copay
	Therapeutic shoes or inserts*	$0 copay

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Additional Benefits Some benefits are available exclusively through the plan's designated vendor. Refer to the footnote and the plan's Evidence of Coverage at uclahealthmedicareadvantage.org/resources for more information.		
Durable medical equipment (DME) and related supplies	DME (e.g., wheelchairs, oxygen)*	50% coinsurance for power scooters 20% coinsurance for all other DME
	Prosthetics (e.g., braces, artificial limbs)*	0% coinsurance for ostomy devices 20% coinsurance for all other devices and supplies
Fitness benefit†	$0 copay for the SilverSneakers® fitness benefit including a standard monthly membership at a participating fitness center, online classes, workshops, and more.	
Foot care (podiatry services)*	Medicare-covered foot exams and treatment, and routine foot care for members with certain medical conditions.	$0 copay
Home health care*	$0 copay	
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.	
In-home care services†	$0 copay for up to 48 hours per year of professional caregiver services including companionship, meal preparation, medication reminders and more. Some restrictions and limitations apply.	
Opioid treatment program services*	$15 copay	
Outpatient substance abuse disorder services*	Outpatient individual therapy visit	$15 copay
	Outpatient group therapy visit	$15 copay
Over-the-Counter (OTC) allowance - Smart Benefits Card &more†	$60 allowance every 3 months on the Smart Benefits Card, for plan-approved OTC products like pain relievers, cold remedies, and vitamins in-store or online. Any unused allowance does not rollover to the next quarter.	

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Additional Benefits	
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Personalized meal planning†	$0 copay for online medically tailored recipe development and meal planning services.
Post-discharge meals*,†	$0 copay for 28 home-delivered prepared meals or meal kits for up to 30 days following inpatient hospitalizations or skilled nursing facility (SNF) stays, with qualifying referrals.
Renal Dialysis*	20% coinsurance for Medicare-covered dialysis.
Telehealth†	24/7 access to virtual non-emergency medical consultations with a licensed provider.

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Required Information
UCLA Health Medicare Advantage Health Plan (HMO) has a contract with Medicare and enrollment in the plan depends on contract renewal. UCLA Health Medicare Advantage Plan includes Part D drug coverage. To enroll in UCLA Health Medicare Advantage Plan, you must have both Medicare Parts A and B and reside in the plan service area, Los Angeles County. **In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium.**

Limitations, exclusions and/or network restrictions may apply. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Out-of-network/non-contracted providers are under no obligation to treat Plan 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.

&more Benefits Prepaid Mastercard® is issued by Avidia Bank, pursuant to a license from Mastercard Incorporated. Use of this card is subject to the terms and conditions of the Cardholder Agreement. You will receive a PIN upon activation.

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