# 2018 SUMMARY OF BENEFITS

## Overview of your plan

**Senior Dimensions® Southern Nevada (HMO)**

H2931-002

Look inside to learn more about the health services and drug coverages the plan provides. Call Customer Service or go online for more information about the plan.

Toll-Free **1-800-555-5757**, TTY **711**
**8 a.m. - 8 p.m. local time, 7 days a week**

**www.SeniorDimensions.com**

SENIOR DIMENSIONS®
from UnitedHealthcare®

Y0066_SB_H2931_002_2018 CMS Accepted

Our service area includes these counties in:

**Nevada:** Clark, Nye.

# Summary of Benefits

## January 1st, 2018 - December 31st, 2018

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. You can see it online at www.SeniorDimensions.com or you can call Customer Service with questions you may have. You get an EOC when you enroll in the plan.

## About this plan.

Senior Dimensions® Southern Nevada (HMO) is a Medicare Advantage HMO 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 inside the cover, and be a United States citizen or lawfully present in the United States.

## Use network providers and pharmacies.

Senior Dimensions® Southern Nevada (HMO) 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 those services or drugs, or you may pay more than you pay at an in-network pharmacy.

You can go to www.SeniorDimensions.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.

# Senior Dimensions® Southern Nevada (HMO)

| Premiums and Benefits | In-Network |
|---|---|
| **Monthly Plan Premium** | There is no monthly premium for this plan. |
| **Annual Medical Deductible** | This plan does not have a deductible. |
| **Maximum Out-of-Pocket Amount (does not include prescription drugs)** | $2,500 annually for Medicare-covered services you receive from in-network providers. |
| | If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br><br>Please note that you will still need to pay your share of the cost for your Part D prescription drugs. |

# Senior Dimensions® Southern Nevada (HMO)

| Benefits | | In-Network |
|---|---|---|
| **Inpatient Hospital**[1,2] | | $0 copay per day |
| | | Our plan covers an unlimited number of days for an inpatient hospital stay. |
| **Outpatient Hospital, Including Observation**[1,2] | | $0 copay |
| **Doctor Visits** | Primary | $0 copay |
| | Specialists[1,2] | $0 copay |
| **Preventive Care** | Medicare-covered | $0 copay |
| | | Abdominal aortic aneurysm screening<br>Alcohol misuse counseling<br>Annual “Wellness” visit<br>Bone mass measurement<br>Breast cancer screening (mammogram)<br>Cardiovascular disease (behavioral therapy)<br>Cardiovascular screening<br>Cervical and vaginal cancer screening<br>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>Depression screening<br>Diabetes screenings and monitoring<br>Hepatitis C screening<br>HIV screening<br>Lung cancer with low dose computed tomography (LDCT) screening<br>Medical nutrition therapy services<br>Medicare Diabetes Prevention Program (MDPP)<br>Obesity screenings and counseling<br>Prostate cancer screenings (PSA)<br>Sexually transmitted infections screenings and counseling<br>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>Vaccines, including flu shots, hepatitis B shots, pneumococcal shots<br>“Welcome to Medicare” preventive visit (one-time) |

| Benefits | | In-Network |
|---|---|---|
| | | 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. |
| | Routine physical | $0 copay; 1 per year |
| **Emergency Care** | | $80 copay (worldwide) per visit |
| **Urgently Needed Services** | | $10 - $40 copay |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays** | Diagnostic radiology services (e.g. MRI)[1,2] | $5-200 copay per service |
| | Lab services[1,2] | $0 copay - 20% coinsurance |
| | Diagnostic tests and procedures[1,2] | 20% coinsurance |
| | Therapeutic Radiology[1,2] | 20% coinsurance |
| | Outpatient X-rays[1,2] | $5 copay per service |
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues[1,2] | $0 copay |
| | Routine hearing exam | $0 copay; 1 per year |
| | Hearing aid | $330-$380 copay for each hi HealthInnovations™ hearing aid, up to 2 per year (Additional fees with Power Max model) |
| **Routine Dental Services** | Optional Dental Rider | Additional dental benefits available with a separate premium. Please see optional benefits section below for details. |
| | Preventive | $0 copay for covered services (exam, cleaning, x-rays) |

| Benefits | | In-Network |
|---|---|---|
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the eye[2] | $0 copay |
| | Eyewear after cataract surgery[1] | $0 copay |
| | Routine eye exam | $0 copay<br>Up to 1 every year |
| | Eyewear | $0 copay every 2 years; up to $30 for lenses/frames |
| **Mental Health** | Inpatient visit[1,2] | $0 copay per day: for days 1-90 |
| | | Our plan covers 90 days for an inpatient hospital stay. |
| | Outpatient group therapy visit[2] | $30 copay |
| | Outpatient individual therapy visit[2] | $40 copay |
| **Skilled Nursing Facility (SNF)[1,2]** | | $0 copay per day: for days 1-20<br>$125 copay per day: for days 21-40<br>$0 copay per day: for days 41-100 |
| | | Our plan covers up to 100 days in a SNF. |
| **Physical therapy and speech and language therapy visit[1,2]** | | $0 copay |
| **Ambulance** | | $180 copay for ground<br>$295 copay for air |
| **Routine Transportation** | | $0 copay; 24 one-way trips per year to or from approved locations |
| **Medicare Part B Drugs** | Chemotherapy drugs[2] | 20% coinsurance |
| | Other Part B drugs[2] | 20% coinsurance |

## Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

| | | | | |
|---|---|---|---|---|
| **Stage 1: Annual Prescription Deductible** | Since you have no deductible for Part D drugs, this payment stage doesn't apply. | | | |
| **Stage 2: Initial Coverage (After you pay your deductible, if applicable)** | **Retail** | | **Mail Order** | |
| | **Standard** | | **Preferred** | **Standard** |
| | **30-day supply** | **100-day supply** | **100-day supply** | **100-day supply** |
| Tier 1: Preferred Generic Drugs | $2 copay | $6 copay | $0 copay | $6 copay |
| Tier 2: Generic Drugs | $8 copay | $24 copay | $0 copay | $24 copay |
| Tier 3: Preferred Brand Drugs | $47 copay | $141 copay | $131 copay | $141 copay |
| Tier 4: Non-Preferred Drugs | $100 copay | $300 copay | $290 copay | $300 copay |
| Tier 5: Specialty Tier Drugs | 33% coinsurance | 33% coinsurance | 33% coinsurance | 33% coinsurance |
| **Stage 3: Coverage Gap Stage** | Tier 1 and Tier 2 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach $3,750, you pay 44% coinsurance for generic drugs and 35% coinsurance for brand name drugs during the coverage gap. | | | |
| **Stage 4: Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of:<br>• 5% coinsurance, or<br>• $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copay for all other drugs. | | | |

| Additional Benefits | | In-Network |
|---|---|---|
| **Chiropractic Care** | Manual manipulation of the spine to correct subluxation[1,2] | $0 copay |
| **Diabetes Management** | Diabetes monitoring supplies [2] | $0 copay<br>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® Nano SmartView, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Guide, and ACCU-CHEK® Aviva Connect |
| | Diabetes Self-management training | $0 copay |
| | Therapeutic shoes or inserts[2] | 20% coinsurance |
| **Durable Medical Equipment (DME) and Related Supplies** | Durable Medical Equipment (e.g., wheelchairs, oxygen)[2] | 20% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs)[2] | 20% coinsurance |
| **Fitness program through Fit for Life Club and SilverSneakers® Fitness program** | | Access participating fitness locations, exercise classes and equipment. |
| **Foot Care (podiatry services)** | Foot exams and treatment[1,2] | $0 copay |
| | Routine foot care | $0 copay; for each visit up to 4 visits every year |
| **Home Health Care**[1,2] | | $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. |
| **Nursing hotline** | | Speak with a registered nurse (RN) 24 hours a day, 7 days a week |

| Additional Benefits | | In-Network |
|---|---|---|
| **Occupational therapy visit**[1,2] | | $0 copay |
| **Outpatient Substance Abuse** | Outpatient group therapy visit[2] | $30 copay |
| | Outpatient individual therapy visit[2] | $40 copay |
| **Outpatient Surgery**[1,2] | | $0 copay |
| **Over-the-Counter Essentials** | | $50 credit per quarter to use on approved health products that can be ordered online or by mail. |
| **Renal Dialysis**[1,2] | | 20% coinsurance |
| **Virtual Doctor Visits** | | Speak to specific doctors using your computer or mobile device. |

**Services with a 1 may require a referral from your doctor.**

**Services with a 2 may require you to obtain prior authorization from the plan.**

## Optional Supplemental Benefits

| Premiums and Benefits | | In-Network |
|---|---|---|
| **Dental Platinum Rider** | Premium | Additional $34.00 per month |
| | Description | The Dental Platinum Rider includes preventive and comprehensive dental benefits. |

## Required Information

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

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

Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

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.

Plans are 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.

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.