

# Summary of Benefits 2021

Medicare Advantage Plan

## UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (Plan Sponsor): NOKIA

Group Number: 12350

H2001-817-000

Look inside to take advantage of the health services the plan provides.  
Call Customer Service or go online for more information about the plan.



Toll-free **1-888-980-8117**, TTY **711**

8 a.m. – 8 p.m. local time, 7 days a week



[www.UHCRetiree.com/nokia](http://www.UHCRetiree.com/nokia)



# Summary of Benefits

## **January 1, 2021 – December 31, 2021**

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.UHCRetiree.com/nokia](http://www.UHCRetiree.com/nokia) or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

### **About this plan.**

UnitedHealthcare® Group Medicare Advantage (PPO) 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 in our service area as listed below, be a United States citizen or lawfully present in the United States, and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all US territories.

### **About providers.**

UnitedHealthcare Group Medicare Advantage (PPO) has a network of doctors, hospitals, and other providers. You can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare Program.

You can go to [www.UHCRetiree.com/nokia](http://www.UHCRetiree.com/nokia) to search for a network provider using the online directory.

# UnitedHealthcare® Group Medicare Advantage (PPO)

## Premiums and Benefits

	In-Network	Out-of-Network
<b>Monthly Plan Premium</b>	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.	
<b>Annual Medical Deductible</b>	\$300 per year for some in-network and out-of-network services.	
<b>Maximum Out-of-Pocket Amount</b>	<p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$1,700 each plan year.</p> <p>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.</p> <p>Please note that you will still need to pay your monthly premiums, if applicable.</p>	

# UnitedHealthcare® Group Medicare Advantage (PPO)

## Benefits

		In-Network	Out-of-Network
<b>Inpatient Hospital<sup>1</sup></b>		10% coinsurance per stay	10% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
<b>Outpatient Hospital</b> Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC) <sup>1</sup>	10% coinsurance	10% coinsurance
	Outpatient surgery <sup>1</sup>	10% coinsurance	10% coinsurance
	Outpatient hospital services, including observation <sup>1</sup>	10% coinsurance	10% coinsurance
<b>Doctor Visits</b>	Primary	20% coinsurance	20% coinsurance
	Specialists <sup>1</sup>	20% coinsurance	20% coinsurance
	Virtual Doctor Visits	\$0 copay	\$0 copay

## Benefits

		In-Network	Out-of-Network
<b>Preventive Care</b>	Medicare-covered	\$0 copay	\$0 copay
		<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            Diabetes – Self-Management training            Dialysis training            Glaucoma screening            Hepatitis C screening            HIV screening            Kidney disease education            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 flu shots, hepatitis B shots, pneumococcal shots            “Welcome to Medicare” preventive visit (one-time)</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>This plan covers preventive care screenings and annual physical exams at 100%.</p>	
	Routine physical	\$0 copay; 1 per plan year*	\$0 copay; 1 per plan year*
<b>Emergency Care</b>		<p>\$60 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital coinsurance instead of the Emergency copay. See the “Inpatient Hospital” section of this booklet for other costs.</p>	

## Benefits

		In-Network	Out-of-Network
<b>Urgently Needed Services</b>		\$30 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital coinsurance instead of the Urgently Needed Services copay. See the “Inpatient Hospital” section of this booklet for other costs.	\$30 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital coinsurance instead of the Urgently Needed Services copay. See the “Inpatient Hospital” section of this booklet for other costs.
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b>	Diagnostic radiology services (e.g., MRI) <sup>1</sup>	10% coinsurance	10% coinsurance
	Lab services <sup>1</sup>	10% coinsurance	10% coinsurance
	Diagnostic tests and procedures <sup>1</sup>	20% coinsurance	20% coinsurance
	Therapeutic radiology <sup>1</sup>	10% coinsurance	10% coinsurance
	Outpatient x-rays <sup>1</sup>	10% coinsurance	10% coinsurance
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues <sup>1</sup>	20% coinsurance	20% coinsurance
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye <sup>1</sup>	20% coinsurance	20% coinsurance
	Eyewear after cataract surgery	\$0 copay	\$0 copay
<b>Mental Health</b>	Inpatient visit <sup>1</sup>	10% coinsurance per stay Our plan covers an unlimited number of days for an inpatient hospital stay.	10% coinsurance per stay
	Outpatient group therapy visit <sup>1</sup>	20% coinsurance	20% coinsurance
	Outpatient individual therapy visit <sup>1</sup>	20% coinsurance	20% coinsurance
	Virtual Behavioral Visits	20% coinsurance	20% coinsurance
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>		10% coinsurance per day: days 1-120 Our plan covers up to 120 days in a SNF.	10% coinsurance per day: days 1-120

## Benefits

		In-Network	Out-of-Network
<b>Physical Therapy and Speech and Language Therapy Visit<sup>1</sup></b>		20% coinsurance	20% coinsurance
<b>Ambulance<sup>2</sup></b>		20% coinsurance	20% coinsurance
<b>Routine Transportation</b>		Not covered	
<b>Medicare Part B Drugs</b>	Chemotherapy drugs <sup>1</sup>	20% coinsurance	20% coinsurance
	Other Part B drugs <sup>1</sup>	20% coinsurance	20% coinsurance

## Additional Benefits

		In-Network	Out-of-Network
<b>Acupuncture</b>	Medicare-covered acupuncture	20% coinsurance	20% coinsurance
	Routine acupuncture	20% coinsurance (Up to 30 visits per plan year).*	20% coinsurance (Up to 30 visits per plan year).*
<b>Chiropractic Care</b>	Manual manipulation of the spine to correct subluxation <sup>1</sup>	20% coinsurance	20% coinsurance
<b>Diabetes Management</b>	Diabetes monitoring supplies <sup>1</sup>	<p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p>	<p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p>
	Medicare covered Therapeutic Continuous Glucose Monitors (CGMs) and supplies <sup>1</sup>	\$0 copay	\$0 copay
	Diabetes self-management training	\$0 copay	\$0 copay
	Therapeutic shoes or inserts <sup>1</sup>	20% coinsurance	20% coinsurance



## Additional Benefits

		In-Network	Out-of-Network
<b>Durable Medical Equipment (DME) and Related Supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>1</sup>	20% coinsurance	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs) <sup>1</sup>	20% coinsurance	20% coinsurance
	Wigs after Chemotherapy (for hair loss that is a result of Chemotherapy)	Up to a \$300 allowance for wigs/hairpieces (cranial prosthesis) per plan year.*	Up to a \$300 allowance for wigs/hairpieces (cranial prosthesis) per plan year.*
<b>Fitness program through SilverSneakers®</b>		<p>\$0 membership fee.</p> <p>Access to a basic fitness membership offered through SilverSneakers® participating locations.</p> <p>If you live 15 miles or more from a SilverSneakers fitness center you may participate in the SilverSneakers Steps Program and select one of four kits that best fits your lifestyle and fitness level – general fitness, strength, walking or yoga.</p>	
<b>Foot Care (podiatry services)</b>	Foot exams and treatment <sup>1</sup>	20% coinsurance	20% coinsurance
<b>Home Health Care<sup>1</sup></b>		\$0 copay	\$0 copay
<b>Hospice</b>		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.	
<b>NurseLine</b>		Receive access to nurse consultations and additional clinical resources at no additional cost.	
<b>Occupational Therapy Visit<sup>1</sup></b>		20% coinsurance	20% coinsurance
<b>Opioid Treatment Program Services<sup>1</sup></b>		\$0 copay	\$0 copay
<b>Outpatient Substance Abuse</b>	Outpatient group therapy visit <sup>1</sup>	20% coinsurance	20% coinsurance
	Outpatient individual therapy visit <sup>1</sup>	20% coinsurance	20% coinsurance

## Additional Benefits

	In-Network	Out-of-Network
<b>Private Duty Nursing</b>	<p>We cover medically necessary nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state where services are received. The services requested must be ordered by a treating practitioner or specialist after a face-to-face evaluation takes place with a written treatment plan and letter of medical necessity. Covered services include nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) delivered to a covered individual who is confined in the home due to a medical condition.</p> <p>Note: Custodial and domestic services are not covered.</p> <p>10% coinsurance</p> <p>There is a \$2,000 limit per plan year for private duty nursing services. Once the plan has paid \$2,000 in a plan year, you are responsible to pay all charges for the remainder of the plan year.</p>	
<b>Renal Dialysis<sup>1</sup></b>	20% coinsurance	20% coinsurance

<sup>1</sup>Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

<sup>2</sup>Authorization is required for Non-emergency Medicare-covered ambulance ground and air transportation. Emergency Ambulance does not require authorization.

\*Benefits are combined in and out-of-network.

## Required Information

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.

Plans may offer supplemental benefits in addition to Part C benefits.

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.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY: 711)。

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

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

Benefits, premium and/or copayments/coinsurance may change each plan year.

The provider network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

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.

The Nurseline service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

Availability of the SilverSneakers program varies by plan/market. Refer to your Evidence of Coverage for more details. Consult a health care professional before beginning any exercise program. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2018. All rights reserved.