2021	Neighborhood Integrity	United Health Care Special Needs Plan (UHC-SNP)	PACE	Medicare Fee for Service (FFS)	Medicaid Fee for Service	WellCare Imperial (PPO D-SNP) Plan ID: H4699-003-0

NOT FOR PUBLIC DISTRIBUTION

Purpose	A Medicare - Medicaid Plan that is a fully integrated plan providing coordinated Medicare Medicaid and Part D drug benefits for dually eligible individuals. Additional benefits include long-term services and supports (LTSS) for members who need them and qualify. Members are also offered Care Managers and a Care team to help manage all providers and services.	Medicare Advantage Plan that provides and coordinates Medicare and prescription drug benefits specifically designed for individuals who have Medicare and Medicaid. The plan offers additional benefits such as Dental, Hearing, Vision, Fitness, Meals, and a Personal Emergency Response System; and access to the United Healthcare Provider Network.	A fully integrated plan that assists individuals to stay independent and engaged in life.	Health insurance for individuals age 65 or older or people under age 65 with certain disabilities or people of any age with End-Stage Renal Disease (ESRD). Referred to also as Original Medicare.	Medicaid is a federal and State-funded program that pays medical and health related services for eligible Rhode Islanders.	Medicare Advantage Plan that provides and coordinates Medicare and prescription drug benefits specifically designed for individuals who have Medicare and Medicaid. The plan offers additional benefits such as Dental, Hearing, Vision, Fitness, Meals.
Eligibility	• Live in RI. • Age 21 or older. • Have Medicare Part A & B and be eligible for Part D. • Have full Medicaid benefits. **Neighborhood Contact Numbers:** General Questions: 1-844-812-6896 (TDD/TTY 711) Enrollment Line: 1-844-602-3469 (TTY 711)	• Have Medicare Part A and B • Full Medicaid benefits. Also open to QMB, SLMB, QI, QDWI individuals - (may have to assume copays, deductibles, and co-insurance). **Contact United Health Care Dual Complete with any questions at** 1-855-277-4716	• Age 55 or older. • Live in RI (excluding Block Island & Prudence Island). • Meet clinical level of care requirements. • Be able to live safely in the community at the time of enrollment. *** PACE is not only a health plan, but they provide services. These services are not unbundled and, as such, there is no individual cost associated with each service. A care plan is created based upon medical necessity and assessments for most of their services.* **Contact PACE at:** 401-654-4176	• Turning 65. • Receiving SSDI for more than 24 months. • ESRD at time of diagnosis.	• Must be a resident of the state of Rhode Island, a U.S. national, citizen, permanent resident, or legal alien. • Must meet income qualifications. • You must also be either preg- nant, a parent or relative caretaker of a dependent child(ren) under age 19, blind, have a disability or a family member in your household with a disability, or be 65 years of age or older • Income Guidelines: • $1,073 single • $1,452 couple • $4,000 resource limit	• Have Medicare Part A, B, & D. • Full Medicaid benefits/QMB. • SLMB, QI, QDWI – may have to assume copays, deductibles, and co-insurance.
Monthly Part A Premium	$0	$0	$0	Most people don't pay a monthly premium for Part A. Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a premium rate of $259 a month. Certain uninsured aged individuals who have less than 30 quarters of coverage and certain individuals with disabilities who have exhausted other entitlement will pay the full premium of $471 a month.	N/A	$0
Monthly Part B Premium	$0	$0	$0	$148.50 (or higher depending on your in-come - the max is $504.90 for $500,000+ income)	N/A	$148.50
Annual Medical Deductible	$0	$0	$0	$203	N/A	$0 copay
Out-Of-Pocket Maximum	N/A	$0	$0	None	N/A	In-Network: $3,450 annually Combined and/or Out-of-Network: $5,100 annually ** Does not include prescription drugs*
Primary Doctor Visits	$0	$0	$0	20% Co-Insurance after Part B $203 deductible has been met.	Covered	$0 copay
Specialists Doctor Visits	$0	$0	$0	20% Co-Insurance after Part B $203 deductible has been met.	Covered	$0 copay
Part A - Inpatient Hospital Deductible & Coinsurance (includes Mental Health & Hospital)	$0 copay (prior authorization required for hospital stay)	$0	$0	**$1,484 deductible** for each benefit period. **Days 1-60:** $0 coinsurance for each benefit period. **Days 61-90:** $371 coinsurance per day of each benefit period. **Days 91-150:** $742 coinsurance per day "lifetime reserve day" after 90 for each benefit period (up to 60 days over your lifetime.) **Beyond lifetime reserve days:** All costs.	Covered	$0 copay
Long Term Services and Supports	Plan covers LTSS for members who need them and qualify under Rhode Island Medicaid.	Not covered	Covered provided beneficiary meets state LTSS guidelines.	Not covered	Covered provided beneficiary meets income guidelines.	Not covered
Skilled Nursing Facility	$0 copay (3-day hospitalization stay not required but prior authorization is required).	$0 copay per day: days 1-100	$0	**Days 1-20:** $0 per day. **Days 21-100:** $185.50 per day. (Must have 3 consecutive inpatient day stays) **Days 100 plus:** All costs each d.ay.	Covered when ordered by your health plan provider.	$0 copay
Home Health Care	$0 copay (may require prior authorization for some services). Includes personal care services and homemaking services.	$0 copay	$0	$0 copay	Covered when ordered by your health plan provider.	$0 copay up to 24 visits every year. You can receive Core and Personal Care Services if you meet certain clinical criteria.
Diagnostic Procedures and Tests/Diagnostic radiology services (X-Rays, Lab Services)	$0 copay (may require prior authorization for some services).	$0 copay per service	$0	20% Co-Insurance after Part B $203 deductible has been met. **Lab Services:** $0 copay.	Covered	$0 copay for Medicaid-covered services. Coveed when ordered by a Health Care Professional.
Emergency Room (if not admitted to hospital)	$0 copay. Coverage is limited to the US and its territories.	$0 copay	$0	20% Co-Insurance after Part B $203 deductible has been met.	Covered	$0 copay for Medicaid-covered services. Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Care Professional, or in order to assess whether a condition warrants treatment as an Emergency Service.
Ambulance	$0 copay. Prior authorization may be required for some services.	$0 copay for ground or air transport.	$0	20% Co-Insurance after Part B $203 deductible has been met.	Covered	$0 copay - ground/air
Urgent Care	$0 copay. (Services are covered if you need to use an urgent care center that is not in network. Coverage is limited to US and its territories only.)	$0 copay	$0	20% Co-Insurance after Part B $203 deductible has been met.	Covered	In-Network and Out-of-Network: $0 copay
Outpatient Services (Ambulatory Surgical Center/ Outpatient Hospital)	$0 copay for medically necessary services received in outpatient hospital stays. Prior authorization may be required for some services.	$0 copay	$0	20% Co-Insurance after Part B $203 deductible has been met.	Covered	$0 copay. Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
Durable Medical Equipment	$0 copay. (Prior authorization required for some equipment. Will generally cover any DME covered by Medicare and Medicaid from a selection of certain brands. Other brands may be covered with a prior authorization.)	$0 copay	$0	20% Co-Insurance after Part B $203 deductible has been met.	Covered. Benefit limits and prior authorization rules may apply.	$0 copay for Medicaid-covered services. Covered as ordered by a Health Care Professional as medically necessary.
Preventative Services	$0 copay	$0 copay	$0	$0 copay	Covered	In-Network and Out-of-Network: $0 copay
Diabetes Management	$0 copay, prior authorization may be required. Includes education, nutrition counseling, glucometers, lancets, test strips, and insulin.	$0 copay, prior authorization may be required	$0	20% Co-Insurance after Part B $203 deductible has been met.	Covered	In-Network and Out-of-Network: $0 copay

For assistance with cases involving dual beneficiaries, contact the UWRI MME Program Counselors. MME Counselors specialize in dual cases and will travel statewide if needed to provide unbiased and person centered options counseling to dual beneficiaries.

Sylvia Bernal, Senior Program Officer, MME
Email: Sylvia.Bernal@unitedwayri.org, Phone: (401) 519-0363, Fax: (401) 272-1707

Elizabeth Woolley, Options Counselor MME
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Medicare Part B Drugs	$0 copay	$0 copay, prior authorization may be required.	$0	20% Co-Insurance after Part B $198 deductible has been met for doctor's office or pharmacy. For hospital outpatient a copayment is applied. For drugs that are not covered under Part B or Part D, you pay 100% of costs.	N/A	In-Network and Out-of-Network: $0 copay
Prescription Drugs	$0 copay for a 30-day supply for generic and brand name. (May be limitations on the types of drugs covered. Refer to Neighborhood Integrity's Drug List for more information.)	Generic - $0 All Other Drugs - $0 Deductible amount is $0 90 day supply available by mail order. Applies to Tier 1 and Tier 2 drugs.	$0	Based on Stand-alone Part D Plan enrolled in.	Covered. Generic prescriptions are required.	Generics: $0 / $1.30 / $3.70 /15% Brands: $0 / $4.00 / $9.20 / 15% *30-day supply for pharmacy * 90-day supply for mail-order
Over-the-Counter Drugs	$0 copay with a prescription. (May be limitations on the types of drugs covered. Refer to Neighborhood Integrity's Drug List for more information.)	Over the counter/health product benefit of $205 per quarter. Products can be ordered online or purchased at a retail store with a preloaded debit card. Also provides a $25 per month healthy food benefit – applicable to milk, eggs, bread, spices, fruit/vegetables. Benefits do not roll over.	$0	Not covered	Some over-the-counter drugs are covered, such as routine nicotine cessation, aspirin and cold medicines. Nutritional supplements are covered when medically necessary	The maximum total annual benefit is $1,200. Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.
Fitness	Not covered	Free gym benefit through Renew Active gives members access to participating gym locations.	Available on site when ordered by healthcare provider.	Not covered	Not covered	$0 copay. This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost.
Dental	Most dental coverage provided by RI Medicaid. Non-routine dental care required to treat illness or injury may be covered by the plan as inpatient or outpatient care.	$0 copay (preventive and comprehensive) $3,000 yearly limit on all covered dental services.	$0	Not covered	Covered with a dentist that accepts Medicaid.	$0 copay. This plan includes coverage of preventive and comprehensive services up to $1,500, including but not limited to cleanings, x-ray(s), oral exams, fluoride treatments, fillings, dentures or a bridge or a crown and a root canal.
Hearing Services	$0 copay	$0 copay for annual exam	$0	Limited	Not covered	In-Network and Out-of-Network: $0 copay
Hearing Aids	$0 copay for hearing aids and fittings for hearing aids once every three years.	Up to a $2500 credit every 2 years.	$0	Not covered	Not covered	In-Network: $0 copay 2 hearing aids per year, $2,000 value Out-of-Network: 40% coinsurance 2 hearing aids per year, $2,000 value
Vision Services	$0 copay	$0 copay for annual exam	$0	Limited	Covered. One eye exam covered every 2 years. Diabetic eye exams every year.	In-Network and Out-of-Network: $0 copay
Glasses or Contact Lenses	$0 copay, may require prior authorization. Eyeglass lenses are limited to 1 pair every 2 years, additional may be covered with prior authorization. Eyeglass frames are limited to 1 pair every 2 years. Contact lenses are limited to 1 pair every 2 years - always requires prior authorization	$0 copay every year (up to $150 for lenses/frames and contacts per year).	$0	Not covered	Covered. One pair of glasses every 2 years.	In-Network: $0 copay Unlimited contacts Unlimited glasses (lenses and/or frames) per year, up to $300 Out-of-Network: 40% coinsurance Unlimited contacts Unlimited glasses (lenses and/or frames) per year, up to $300 *You pay nothing for eyeglasses or contact lenses after cataract surgery at an in-network provider.
Substance Use Treatment	$0 copay	$0 copay	$0	20% Co-Insurance after Part B $198 deductible has been met.	Covered	In-Network and Out-of-Network: $0 copay
Adult Day Services	$0 copay, prior authorization may be required. This covers two levels of adult day services: basic level of service and enhanced level of service. Examples, social and recreational activities, meals, nursing or wound care.	Not Covered beyond Original Medicare.	$0	Not covered	Covered. Prior authorization is required.	$0 copay for Medicaid-covered services.
Routine Podiatry Services	$0 copay	$0 copay (for each visit up to 4 visits a year).	$0	Most cases you pay 100% for routine foot care. Pay 20% of Medicare approved amount for medically necessary treatment provided by your doctor – Part B deductible applies. In hospital outpatient you also pay a copayment for medically necessary treatment.	Covered when ordered by your health plan provider.	In-Network and Out-of-Network: $0 copay
Group and Individual Education Programs	$0 copay	Not covered	$0	Not covered	Covered	$0 copay for Medicaid-covered services. Including healthy lifestyles/weight management, wellness/weight loss and tobacco cessation programs and services.
Mental Health - Inpatient	$0 copay (prior authorization may be required for long-term health services).	$0 copay per day	$0	20% Co-Insurance after Part B $198 deductible has been met.	Covered	In-Network and Out-of-Network: $0 copay up to 90 days per admission
Mental Health - Outpatient	$0 copay	$0 copay for group and individual therapy.	$0	20% Co-Insurance after Part B $198 deductible has been met.	Covered	In-Network and Out-of-Network: $0 copay
Non-Emergency Transportation	No coverage through plan, service provided by RI Medicaid.	Up to 48 one way trips to approved locations such as physician appointments, pharmacies, and medical centers. Each one way trip may not exceed 50 miles.	$0	Not covered	Covered. Current vendor is MTM.	In-Network: $0 copay, 24 one-way trips every year Out-of-Network: 75% coinsurance, 24 one-way trips every year
Physical Therapy, Speech and Language Therapy Visit	$0 copay, prior authorization may be required.	$0 copay	$0	20% Co-Insurance after Part B $198 deductible has been met.	Covered when ordered by your health plan provider.	In-Network and Out-of-Network: $0 copay
Hospice Care Services	$0 copay (some services covered).	$0 copay for hospice care from any Medicare approved hospice. May have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of UHC plan.	$0	$0 copay	Covered when ordered by your health plan provider.	$0 copay for Medicaid-covered services. Covered as ordered by a Health Care Professional. Services limited to those covered by Medicare.
Chiropractic Care	$0 copay, covered if medically necessary with a prior authorization.	$0 copay for 12 chiropractor and 12 acupuncture visits per year.	$0	20% Co-Insurance after Part B $198 deductible has been met.	Not covered	In-Network and Out-of-Network: $0 copay
Fitness Through Fitbit	Not covered	$0 copay. (Get a free activity tracker to help maintain good health.)	Available on site when ordered by health-care provider.	Not covered	Not covered	$0 copay. A Fitbit fitness tracker is included in the home kit.
Health Product Benefit	Certain health products, such as incontinence products and environmental/home modification products are covered.	Over the counter/health product benefit of $205 per quarter. Products can be ordered online or purchased at a retail store. Also provides a $25 per month healthy food benefit – applicable to milk, eggs, bread, spices, fruit/vegetables. Benefits do not roll over.	Available on site when ordered by health-care provider.	Not covered	Not covered	$1,000 yearly benefit **Flex Card** - The Flex Card benefit is a debit card that may be used to reduce out of pocket costs at a dental, vision or hearing providers that accepts the card carrier. **Grocery Delivery** - $50 every month
Renal Dialysis	$0 copay	$0 copay	$0	$0 copay	Covered	In-Network and Out-of-Network: $0 copay