

**Hello**

**SIMPLICITY**

## **Important Information about Your New Plan**

**STATE OF RHODE ISLAND**

UnitedHealthcare Group Medicare Advantage (HMO)

---

Effective January 1, 2014 through December 31, 2014

---

Group Number: 50003

# Benefit highlights

State of Rhode Island 50003

Effective January 1, 2014 to December 31, 2014

This is a short description of plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage.

<b>Medical Benefits (Medicare-Covered)</b>	<b>Your In-Network Cost (unless otherwise noted)</b>
<b>Doctor Office Visits</b>	
Primary care physician (PCP)	\$10 copay
Specialist	\$30 copay
<b>Preventive Care</b>	
Annual wellness visit	\$0 copay
Prostate cancer screening	\$0 copay
Breast cancer screening	\$0 copay
Immunizations	\$0 copay
<b>Inpatient Care</b>	
Inpatient hospital care	\$150 copay per day: days 1 - 4 \$0 copay per day after that
Skilled Nursing Facility (SNF) care	\$50 copay per day: days 1-40 \$0 copay per additional day up to 100 days
<b>Outpatient Services</b>	
Radiation therapy	\$0 copay
Outpatient surgery	\$0 copay
Outpatient rehabilitation services	\$0 copay
<b>Lab Services and Other Tests</b>	
Laboratory tests	\$0 copay
X-rays	\$0 copay
Diagnostic radiology services	\$0 copay
<b>Emergency Services</b>	
Ambulance services	\$100 copay
Emergency room (worldwide)	\$65 copay
Urgently needed care	\$30 copay
<b>Other Medicare-Covered Benefits</b>	
Chiropractic services	\$20 copay
Podiatry services	\$20 copay
Eye exam	\$20 copay
Hearing exam	\$0 copay
<b>Annual out-of-pocket maximum</b>	
Annual out-of-pocket maximum	\$2,000

Medical Benefits	Your In-Network Cost (unless otherwise noted)
<b>Additional Benefits and Programs Not Covered Under Medicare</b>	
Preventive dental services	Included. See your Summary of Benefits or Evidence of Coverage for more details
Routine podiatry services	\$20 copay (Up to 6 visits per plan year)
Routine hearing exams	\$0 copay (1 exam every 12 months)
Hearing aids	Plan pays up to \$500 (every 3 years)
Routine eye exam (refraction)	\$20 copay (1 exam every 12 months)
Routine eyewear or contact lenses	Plan pays up to \$70 eyewear allowance every year. Plan pays up to \$105 contact lens allowance in lieu of eyewear allowance every year.
Fitness program	Stay active with a basic membership at a participating location at no extra cost to you
NurseLine <sup>SM</sup>	Speak with a registered nurse (RN) 24 hours a day, 7 days a week
UnitedHealth Passport <sup>®</sup>	Your health care coverage travels with you within the UnitedHealth Passport service area
Solutions for Caregivers <sup>**</sup>	Provides support for caregivers
Behavioral/Mental Health <sup>**</sup>	Get support during one-to-one calls with a behavioral health specialist

<sup>\*\*</sup>The products and services described above 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<sup>®</sup> Group Medicare Advantage (HMO) grievance process.

Prescription Drugs	Your Cost	
Initial coverage stage	Network Pharmacy (30-day retail supply)	Mail Service Pharmacy (90-day supply)
Tier 1: Preferred generic	\$3 copay	\$6 copay
Tier 2: Preferred brand (includes some generic)	\$28 copay	\$56 copay
Tier 3: Non-preferred brand (includes some generic)	\$58 copay	\$116 copay
Tier 4: Specialty tier	25% coinsurance	25% coinsurance
Coverage gap stage (after prescription costs reach \$2,850)	You pay 47.5% of the price (plus the dispensing fee) for brand name drugs and 72% of the price for generic drugs	
Catastrophic coverage stage (after you have paid \$4,550 out-of-pocket)	The greater of \$2.55 copay for generic, \$6.35 copay for brand name, or 5% coinsurance	

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in UnitedHealthcare plans depends on contract renewal.

# 2014 Summary of

# BENEFITS

January 1, 2014 - December 31, 2014

## UnitedHealthcare<sup>®</sup> Group Medicare Advantage (HMO)

Group Name (Plan Sponsor): State of Rhode Island  
Group Number: 50003  
H4102-801



# Section I

## Introduction to Summary of Benefits

Thank you for your interest in UnitedHealthcare® Group Medicare Advantage (HMO). Our plan is offered by UNITEDHEALTHCARE OF NEW ENGLAND, INC. a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the federal government.

This plan is designed for people who meet the eligibility requirements of their former employer, union group or trust administrator (plan sponsor).

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call UnitedHealthcare® Group Medicare Advantage (HMO) and ask for the "Evidence of Coverage."

### **Your Health Care Coverage**

This plan is offered through your plan sponsor.

You may be able to join or leave a plan only at certain times designated by your plan sponsor. If you choose to enroll in a Medicare health plan or Medicare prescription drug plan that is not offered by your plan sponsor, you may lose the option to enroll in a plan offered by your plan sponsor in the future. You could also lose coverage for other plan sponsor retirement benefits you may currently have. Once enrolled in our plan, if you choose to end your membership outside of your plan sponsor's open enrollment period, re-enrollment in any plan your plan sponsor offers may not be permitted, or you may have to wait until their next open enrollment period.

It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other benefits before submitting a request to enroll in a plan not offered by your plan sponsor, or a request to end your membership in our plan.

Please call UnitedHealthcare® Group Medicare Advantage (HMO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### **Where is UnitedHealthcare® Group Medicare Advantage (HMO) available?**

The service area for this plan includes Rhode Island: Bristol, Kent, Newport, Providence, Washington.

You must live in the service area to join the plan.

### **Who is eligible to join UnitedHealthcare® Group Medicare Advantage (HMO)?**

You can join UnitedHealthcare® Group Medicare Advantage (HMO) if you are entitled to Medicare Part A, enrolled in Medicare Part B, live in the service area and you meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

If you are not entitled to Medicare Part A, please refer to your plan sponsor's enrollment materials, or contact your plan sponsor directly to determine if you are eligible to enroll in our plan. Some plan sponsors have made arrangements with us to purchase Medicare Part A on your behalf.

Individuals with End Stage Renal Disease (ESRD) or who receive routine kidney dialysis may still be eligible to enroll through a plan sponsored Medicare Advantage (MA) health plan or as an individual, in some instances. Please call Customer Service at the phone number listed at the end of this introduction for more information.

**Note:** If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you likely **are not** considered to have ESRD and you likely **are** eligible to enroll in UnitedHealthcare® Group Medicare Advantage (HMO).

### **Can I choose my doctors?**

UnitedHealthcare® Group Medicare Advantage (HMO) has formed a network of doctors, specialists, and hospitals.

You can only use doctors who are part of our network.

The health providers in our network can change at any time. You can ask for a current provider directory. For an updated list, visit us at [www.UHCRetiree.com](http://www.UHCRetiree.com).

Our Customer Service phone number is listed at the end of this introduction.

### **What happens if I go to a doctor who's not in your network?**

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

### **Does my plan cover Medicare Part B or Part D drugs?**

UnitedHealthcare® Group Medicare Advantage (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

### **Where can I get my prescriptions if I join this plan?**

UnitedHealthcare® Group Medicare Advantage (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current pharmacy directory or visit us at [www.UHCRetiree.com](http://www.UHCRetiree.com). Our Customer Service number is listed at the end of this introduction.

### **What if my doctor prescribes less than a month's supply?**

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a “daily cost-sharing rate” will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month’s supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

## **What is a prescription drug formulary?**

UnitedHealthcare® Group Medicare Advantage (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members’ ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a Part D Abridged Formulary to you and you can search our complete formulary on our Web site at [www.UHCRetiree.com](http://www.UHCRetiree.com).

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician’s help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **How can I get extra help with my prescription drug plan costs or get extra help with other Medicare costs?**

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day / 7 days a week and see [www.medicare.gov](http://www.medicare.gov) ‘Programs for People with Limited Income and Resources’ in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

## **What are my protections in this plan?**

All Medicare Advantage Plans agree to stay in the program for a full plan year at a time. Plan benefits and cost-sharing may change from plan year to plan year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area, and your plan sponsor will notify you of their options for your coverage.

As a member of UnitedHealthcare® Group Medicare Advantage (HMO) you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance.

You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of UnitedHealthcare® Group Medicare Advantage (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered.

An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

### **What is a Medication Therapy Management (MTM) program?**

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact UnitedHealthcare® Group Medicare Advantage (HMO) for more details.

### **What types of drugs may be covered under Medicare Part B?**

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact UnitedHealthcare® Group Medicare Advantage (HMO) for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable osteoporosis drugs for some women.
- **Erythropoietin:** By injection if you have end-stage renal disease (permanent kidney failure

requiring either dialysis or transplantation) and need this drug to treat anemia.

- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs administered through Durable Medical Equipment.**

**Please call UnitedHealthcare for more information about UnitedHealthcare® Group Medicare Advantage (HMO).**

Visit us at [www.UHCRetiree.com](http://www.UHCRetiree.com) or, call us:

**Current members** should call toll-free at **1-800-457-8506**, 8 a.m. - 8 p.m., local time, Monday through Friday, for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program. (TTY/TDD **711**)

**Prospective members** should call toll-free **1-877-714-0178**, 8 a.m. - 8 p.m., local time, 7 days a week, for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program. (TTY/TDD **711**)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

This document may be available in other formats such as Braille, large print or other alternate formats. This document may be available in a non-English language.

For additional information, call Customer Service at the phone number listed above.

If you have any questions about this plan's benefits or costs, please contact UnitedHealthcare for details.

# Section II

## Summary of Benefits

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>Important Information</b>		
<p><b>1 Premium and Other Important Information</b></p>	<p>In 2013 the monthly Part B Standard Premium was \$104.90 and may change for 2014 and the annual Part B deductible amount was \$147 and may change for 2014.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>Contact your group plan benefit administrator to determine your actual premium amount, if applicable.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>\$2,000 out-of-pocket maximum limit.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<p><b>2 Doctor and Hospital Choice</b>            (For more information, see Emergency Care - #15 and Urgently Needed Care - #16)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p>
<b>Inpatient Care</b>		
<p><b>3 Inpatient Hospital Care</b></p>	<p>In 2013 the amounts for each benefit period were:</p> <ul style="list-style-type: none"> <li>• Days 1 - 60: \$1,184 deductible</li> <li>• Days 61 - 90: \$296 per day</li> <li>• Days 91 - 150: \$592 per lifetime reserve day</li> </ul> <p>These amounts may change for 2014.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 to 4: \$150 copay per day</p> <p>\$0 copay for each additional day.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<p><b>4 Inpatient Mental Health Care</b> (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2013 the amounts for each benefit period were:</p> <ul style="list-style-type: none"> <li>• Days 1 - 60: \$1,184 deductible</li> <li>• Days 61 - 90: \$296 per day</li> <li>• Days 91 - 150: \$592 per lifetime reserve day.</li> </ul> <p>These amounts may change for 2014.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p>	<p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 to 4: \$150 copay per day.</p> <p>\$0 copay for each additional day, up to 190 days.</p>
<p><b>5 Skilled Nursing Facility (SNF)</b> (in a Medicare-certified skilled nursing facility)</p>	<p>In 2013 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <ul style="list-style-type: none"> <li>• Days 1 - 20: \$0 per day</li> <li>• Days 21 - 100: \$148 per day.</li> </ul> <p>These amounts may change for 2014.</p> <p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the</p>	<p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays:</p> <p>Days 1 to 40: \$50 copay per day.</p> <p>Days 41 to 100: \$0 copay per day, up to 100 days.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>5 Skilled Nursing Facility (SNF) (continued)</b>	hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	
<b>6 Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	\$0 copay for each Medicare-covered home health visit.
<b>7 Hospice</b>	You pay part of the cost for outpatient drugs and inpatient respite care.  You must get care from a Medicare-certified hospice.	<b>General</b> You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.
<b>Outpatient Care</b>		
<b>8 Doctor Office Visits</b>	20% coinsurance	\$10 copay for each Medicare-covered primary care doctor visit.  \$30 copay for each Medicare-covered specialist visit.

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>9 Chiropractic Services</b>	<p>Supplemental routine care not covered</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).</p>	<p>\$20 copay for each Medicare-covered chiropractic visit.</p>
<b>10 Podiatry Services</b>	<p>Supplemental routine care not covered</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>\$20 copay for each Medicare-covered podiatry visit.</p> <p>See Section III for information about Routine Podiatry Services.</p>
<b>11 Outpatient Mental Health Care</b>	<p>20% coinsurance for most outpatient mental health services.</p> <p>Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC).</p> <p>Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>\$20 copay for each Medicare-covered individual therapy visit.</p> <p>\$10 copay for each Medicare-covered group therapy visit.</p> <p>\$40 copay each day for Medicare-covered partial hospitalization program services.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>12 Outpatient Substance Abuse Care</b>	20% coinsurance	<p>\$20 copay for each Medicare-covered individual substance abuse outpatient treatment visit.</p> <p>\$10 copay for each Medicare-covered group substance abuse outpatient treatment visit.</p>
<b>13 Outpatient Services</b>	<p>20% coinsurance for the doctor's services.</p> <p>Specified copay for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility services.</p>	<p>\$50 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p>
<b>14 Ambulance Services</b> (medically necessary ambulance services)	20% coinsurance	\$100 copay for Medicare-covered ambulance benefits.
<b>15 Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>20% coinsurance for the doctor's services.</p> <p>Specified copay for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p>	<p>\$65 copay for each Medicare-covered emergency room visit.</p> <p>If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the emergency room visit.</p> <p>Worldwide coverage.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>15 Emergency Care (continued)</b>	<p>You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	
<b>16 Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)	<p>20% coinsurance, or a set copay</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>\$30 copay for each Medicare-covered urgently needed care visit.</p> <p>If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the urgently needed care visit.</p> <p>Worldwide coverage.</p>
<b>17 Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	<p>20% coinsurance</p> <p>Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered</p>	<p>\$0 copay for each Medicare-covered occupational therapy visit.</p> <p>\$0 copay for each Medicare-covered physical therapy and/or speech and language pathology visit.</p> <p>\$0 copay for each Medicare-covered comprehensive outpatient rehabilitation facility (CORF) visit.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>Outpatient Medical Services and Supplies</b>		
<b>18 Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	20% coinsurance	20% coinsurance for Medicare-covered durable medical equipment.
<b>19 Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	20% coinsurance 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	20% coinsurance for Medicare-covered prosthetic devices. 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.
<b>20 Diabetes Programs and Supplies</b>	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts.	\$0 copay for Medicare-covered Diabetes self-management training. 20% coinsurance for each Medicare-covered Diabetes monitoring supply. 20% coinsurance for Medicare-covered Therapeutic shoes or inserts.
<b>21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b>	20% coinsurance for diagnostic tests and x-rays. \$0 copay for Medicare-covered lab services.	\$0 copay for Medicare-covered lab services. \$0 copay for each Medicare-covered diagnostic procedure and

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services (continued)</b>	<p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare.</p> <p>Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.</p>	<p>test.</p> <p>\$0 copay for each Medicare-covered X-ray.</p> <p>\$0 copay for each Medicare-covered diagnostic radiology service (not including X-rays).</p> <p>\$0 copay for each Medicare-covered therapeutic radiology service.</p>
<b>22 Cardiac and Pulmonary Rehabilitation Services</b>	<p>20% coinsurance for Cardiac Rehabilitation services</p> <p>20% coinsurance for Pulmonary Rehabilitation services</p> <p>20% coinsurance for Intensive Cardiac Rehabilitation services</p>	<p>\$0 copay for each Medicare-covered cardiac rehabilitation service.</p> <p>\$0 copay for each Medicare-covered pulmonary rehabilitation service.</p> <p>\$0 copay for each Medicare-covered intensive cardiac rehabilitation service.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>Preventive Services</b>		
<p><b>23 Preventive Services</b></p>	<p>No coinsurance, copayment or deductible for the following:</p> <p>Abdominal Aortic Aneurysm Screening</p> <p>Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p> <p>Cardiovascular Screening</p> <p>Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>Colorectal Cancer Screening</p> <p>Diabetes Screening</p> <p>Influenza Vaccine</p> <p>Hepatitis B Vaccine for people with Medicare who are at risk</p> <p>HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including</p>	<p>\$0 copay for all preventive services covered under Original Medicare at zero cost sharing.</p> <p>Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<p><b>23 Preventive Services (continued)</b></p>	<p>anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> <p>Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35 and 39.</p> <p>Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p> <p>Personalized Prevention Plan Services (Annual Wellness Visits)</p> <p>Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p> <p>Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.</p>	

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<p><b>23 Preventive Services (continued)</b></p>	<p>Smoking and Tobacco Use Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>Screening and behavioral counseling interventions in primary care to reduce alcohol misuse</p> <p>Screening for depression in adults</p> <p>Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling to prevent STIs</p> <p>Intensive behavioral counseling for Cardiovascular Disease (bi-annual)</p> <p>Intensive behavioral therapy for obesity</p> <p>Welcome to Medicare Preventive Visits (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visit or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.</p>	

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>24 Kidney Disease and Conditions</b>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Kidney Disease Education Services</p>	<p>20% coinsurance for Medicare-covered renal dialysis.</p> <p>\$0 copay for Medicare-covered kidney disease education services.</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network

**PRESCRIPTION DRUGS BENEFITS**

**25 Outpatient Prescription Drugs**

Most drugs are not covered under Original Medicare.

You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.

**Drugs Covered Under Medicare Part B**

General

20% of the cost for Medicare Part-B drugs (not including Medicare Part B chemotherapy drugs).

20% of the cost for Medicare Part B chemotherapy drugs.

**Drugs Covered Under Medicare Part D**

This plan uses a formulary. The plan will send you the Abridged Formulary. You can also see the formulary at [www.UHCRetiree.com](http://www.UHCRetiree.com) on the web.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service) providers.

The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia.

This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO) In-Network
<p><b>25 Outpatient Prescription Drugs (continued)</b></p>		<p>(for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from UnitedHealthcare® Group Medicare Advantage (HMO) for certain drugs.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and UnitedHealthcare® Group Medicare Advantage (HMO) approves the exception, you will</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO) In-Network
<p><b>25 Outpatient Prescription Drugs (continued)</b></p>		<p>pay the Tier 3: Non-Preferred Brand cost-sharing for that drug.</p> <p>Your Plan Sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D prescription drug benefit and your supplemental drug coverage. Once you are enrolled in this plan, you will receive a separate document called the “<b>Certificate of Coverage</b>” with more information about this supplemental drug coverage.</p> <p><b>Initial Coverage</b></p> <p>You pay the following until total yearly drug costs reach \$2,850.</p> <p><b>Retail Pharmacy</b></p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> <li>• \$3.00 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Tier 2: Preferred Brand Drugs (includes some Generics)</p> <ul style="list-style-type: none"> <li>• \$28.00 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Tier 3: Non-Preferred Brand Drugs (includes some Generics)</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO) In-Network
<b>25 Outpatient Prescription Drugs (continued)</b>		<ul style="list-style-type: none"> <li>• \$58.00 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Mail Order</b></p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> <li>• \$6.00 copay for a three-month (90-day) supply of drugs in this tier from the plan's preferred mail order pharmacy, OptumRx™</li> </ul> <p>Tier 2: Preferred Brand Drugs (includes some Generics)</p> <ul style="list-style-type: none"> <li>• \$56.00 copay for a three-month (90-day) supply of drugs in this tier from the plan's preferred mail order pharmacy, OptumRx</li> </ul> <p>Tier 3: Non-Preferred Brand Drugs (includes some Generics)</p> <ul style="list-style-type: none"> <li>• \$116.00 copay for a three-month (90-day) supply of drugs in this tier from the plan's preferred mail order pharmacy, OptumRx</li> </ul> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a three-month (90-day)</li> </ul>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO) In-Network
<p><b>25 Outpatient Prescription Drugs (continued)</b></p>		<p>supply of drugs in this tier from the plan's preferred mail order pharmacy, OptumRx</p> <p><b>Coverage Gap</b></p> <p>After your total yearly drug costs reach \$2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% coinsurance,</li> </ul> <p>or</p> <ul style="list-style-type: none"> <li>• \$2.55 copay for generic (including brand drugs treated as generic) and \$6.35 copay for all other drugs.</li> </ul> <p><b>Out-of-Network</b></p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay</p>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>25 Outpatient Prescription Drugs (continued)</b>		<p>more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from UnitedHealthcare® Group Medicare Advantage (HMO).</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> <li>• \$3.00 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Tier 2: Preferred Brand Drugs (includes some Generics)</p> <ul style="list-style-type: none"> <li>• \$28.00 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Tier 3: Non-Preferred Brand Drugs (includes some Generics)</p> <ul style="list-style-type: none"> <li>• \$58.00 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> <li>• 25% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network

**Outpatient Medical Services and Supplies**

<b>26 Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<p>\$20 copay for Medicare-covered dental benefits.</p> <p>See Section III for information about Preventive Dental Services.</p>
<b>27 Hearing Services</b>	<p>Supplemental routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>\$0 copay for each Medicare-covered diagnostic hearing exam.</p> <p>See Section III for information about Routine Hearing Exam.</p> <p>See Section III for information about Hearing Aids.</p>
<b>28 Vision Services</b>	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk.	<p>\$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.</p> <p>\$20 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.</p> <p>\$0 copay for an annual Medicare-covered glaucoma screening for people at risk.</p> <p>See Section III for information about Routine Vision Exam.</p> <p>See Section III for information about Routine Eyewear.</p>

# Section III

## Additional Benefits

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>Routine Hearing Exam</b>	Not covered.	\$0 copay for each supplemental routine hearing exam, limited to one exam every 12 months.
<b>Hearing Aids</b>	Not covered.	Plan pays up to a \$500 allowance for hearing aids every 3 years.
<b>Routine Vision Exam</b>	Not covered.	\$20 copay for a supplemental routine eye exam, limited to one exam every 12 months.
<b>Routine Eye Wear</b>	Not covered.	Plan covers up to a \$70 eyeglasses allowance for one pair of standard frames with standard lenses every year. You are covered for up to a \$105 allowance for contact lenses in lieu of eyeglasses, every year.
<b>Preventive Dental Services</b>	Not covered.	Preventive dental services are covered limited to the following: \$0 copay for: <ul style="list-style-type: none"> <li>● Oral exams once every six months</li> <li>● Routine teeth cleanings once every six months</li> </ul>

Benefit	Original Medicare	UnitedHealthcare® Group Medicare Advantage (HMO)
		In-Network
<b>Preventive Dental Services (continued)</b>		<ul style="list-style-type: none"> <li>• Bitewing X-rays once every 12 months</li> </ul> <p>60% of eligible expenses covered out-of-network</p> <p>\$500 combined in-network and out-of-network plan year maximum</p>
<b>Routine Podiatry</b>	Not covered.	\$20 copay for each supplemental routine podiatry visit up to 6 visits each year.
<b>Fitness Program</b>	Not covered.	<p>\$0 membership fee.</p> <p>SilverSneakers® Fitness Program through network fitness centers. There is no visit or use fee for basic membership when you use network service providers.</p> <p>SilverSneakers® Steps at Home program is available for members living 15 miles away or more from a SilverSneakers® fitness center. Includes a self-directed pedometer-based physical activity and walking program.</p>
<b>Nurseline<sup>SM</sup></b>	Not covered.	You may call the Nurseline, 24 hours a day, 7 days a week and speak to a registered nurse (RN) about your medical concerns and questions.



ةي ن ا ح م ة م د خ ه ذ ه . ك ت د ع ا س م ب ة ي ب ر ع ل ا ث د ح ت ي ا م

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-457-8506. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

**Português:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-457-8506. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-457-8506. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-457-8506. Ta usługa jest bezpłatna.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-457-8506 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-457-8506にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。