

# 2019 SUMMARY OF BENEFITS



## Overview of your plan

### UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (Plan Sponsor): CS VEBA  
Group Number: 13696

H2001-816

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 **1-877-211-6550**, TTY **711**  
8 a.m. - 8 p.m. local time, 7 days a week



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



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

# Summary of Benefits

**January 1, 2019 - December 31, 2019**

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](http://www.UHCRetiree.com) 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 inside the cover, 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).

## **About providers and network pharmacies.**

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies, 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 from Medicare. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at an in-network pharmacy.

You can go to [www.UHCRetiree.com](http://www.UHCRetiree.com) to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

## 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>Maximum Out-of-Pocket Amount (does not include prescription drugs)</b>	<p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$6,700 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, and cost-sharing for your Part D prescription drugs.</p>	

# UnitedHealthcare® Group Medicare Advantage (PPO)

Benefits		In-Network	Out-of-Network
Inpatient Hospital		\$0 copay per stay	\$0 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital, Including Observation		\$0 copay	\$0 copay
Doctor Visits	Primary	\$5 copay	\$5 copay
	Specialists	\$5 copay	\$5 copay
Preventive Care	Medicare-covered	\$0 copay	\$0 copay
		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 Hepatitis C screening HIV screening 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)	
		Any additional preventive services approved by Medicare during the contract year will be covered.	

Benefits		In-Network	Out-of-Network
		This plan covers preventive care screenings and annual physical exams at 100%.	
	Routine physical	\$0 copay; 1 per plan year*	\$0 copay; 1 per plan year*
<b>Emergency Care</b>		<p>\$50 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>	
<b>Urgently Needed Services</b>		<p>\$5 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Urgently Needed Services copay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>	<p>\$5 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Urgently Needed Services copay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b>	Diagnostic radiology services (e.g. MRI)	\$0 copay	\$0 copay
	Lab services	\$0 copay	\$0 copay
	Diagnostic tests and procedures	\$0 copay	\$0 copay
	Therapeutic Radiology	\$0 copay	\$0 copay
	Outpatient x-rays	\$0 copay	\$0 copay
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues	\$5 copay	\$5 copay
	Routine hearing exam	\$0 copay (1 exam every 12 months)*	\$0 copay (1 exam every 12 months)*

<b>Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
	Hearing Aids	Plan pays up to \$1,000 (every 3 years)*	Plan pays up to \$1,000 (every 3 years)*
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye	\$5 copay	\$5 copay
	Eyewear after cataract surgery	\$0 copay	\$0 copay
	Routine eye exams	\$5 copay (1 exam every 12 months)*	\$5 copay (1 exam every 12 months)*
	Eye wear	Plan pays up to \$130 eyewear allowance every 2 years. Plan pays up to \$175 contact lens allowance in lieu of eyewear allowance every 2 years.*	Plan pays up to \$130 eyewear allowance every 2 years. Plan pays up to \$175 contact lens allowance in lieu of eyewear allowance every 2 years.*
<b>Mental Health</b>	Inpatient visit	\$0 copay per stay, up to 190 days	\$0 copay per stay, up to 190 days
		Our plan covers 190 days for an inpatient hospital stay.	
	Outpatient group therapy visit	\$5 copay	\$5 copay
	Outpatient individual therapy visit	\$5 copay	\$5 copay
<b>Skilled Nursing Facility (SNF)</b>		\$0 copay per day: days 1-100	\$0 copay per day: days 1-100
		Our plan covers up to 100 days in a SNF.	
<b>Physical Therapy and speech and language therapy visit</b>		\$5 copay	\$5 copay
<b>Ambulance</b>		\$0 copay	\$0 copay
<b>Routine Transportation</b>		Not covered	
<b>Medicare Part B Drugs</b>	Chemotherapy drugs	\$0 copay	\$0 copay

**Benefits**

		<b>In-Network</b>	<b>Out-of-Network</b>
	Other Part B drugs	\$0 copay	\$0 copay

## Prescription Drugs

If the actual cost for 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.

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 “Certificate of Coverage” with more information about this supplemental drug coverage.

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see your Additional Drug Coverage list for more information.

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

<b>Stage 1: Annual Prescription Deductible</b>	Since you have no deductible, this payment stage doesn't apply.	
<b>Stage 2: Initial Coverage (After you pay your deductible, if applicable)</b>	<b>Retail Cost-Sharing</b>	<b>Mail Order Cost-Sharing</b>
	<b>One-month supply</b>	<b>Three-month supply</b>
Tier 1: Generic	\$5 copay	\$10 copay
Tier 2: Preferred Brand	\$20 copay	\$40 copay
Tier 3: Non-Preferred Drugs	\$40 copay	\$80 copay
Tier 4: Specialty Tier	\$40 copay	\$80 copay
<b>Stage 3: Coverage Gap Stage</b>	After your total drug costs reach \$3,820, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	
<b>Stage 4: Catastrophic Coverage</b>	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,100, you pay \$3.40 copay for generic (including brand drugs treated as generic), and a \$8.50 copay for all other drugs.	

<b>Additional Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Chiropractic Care</b>	Manual manipulation of the spine to correct subluxation	\$5 copay	\$5 copay
	Routine chiropractic care	\$5 copay (Up to 12 visits per plan year)*	\$5 copay (Up to 12 visits per plan year)*
<b>Diabetes Management</b>	Diabetes monitoring supplies	\$0 copay  We only cover ACCU-CHEK® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio®, OneTouch Verio® IQ, OneTouch Verio® Flex, ACCU-CHEK® Guide, ACCU-CHEK® Aviva, and ACCU-CHEK® Nano SmartView. Test strips: OneTouch Verio®, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® SmartView, and OneTouch Ultra®. Other brands are not covered by your plan.	\$0 copay  We only cover ACCU-CHEK® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio®, OneTouch Verio® IQ, OneTouch Verio® Flex, ACCU-CHEK® Guide, ACCU-CHEK® Aviva, and ACCU-CHEK® Nano SmartView. Test strips: OneTouch Verio®, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® SmartView, and OneTouch Ultra®. Other brands are not covered by your plan.
	Diabetes Self-management training	\$0 copay	\$0 copay
	Therapeutic shoes or inserts	\$0 copay	\$0 copay
<b>Durable Medical Equipment (DME) and Related Supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen)	\$0 copay	\$0 copay
	Prosthetics (e.g., braces, artificial limbs)	\$0 copay	\$0 copay

<b>Additional Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<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	\$5 copay	\$5 copay
<b>Home Health Care</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>		Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
<b>Occupational Therapy Visit</b>		\$5 copay	\$5 copay
<b>Outpatient Substance Abuse</b>	Outpatient group therapy visit	\$5 copay	\$5 copay
	Outpatient individual therapy visit	\$5 copay	\$5 copay
<b>Outpatient surgery</b>		\$0 copay	\$0 copay
<b>Renal Dialysis</b>		\$5 copay	\$5 copay
<b>Virtual Behavioral Visits</b>		See and speak to specific mental health professionals using your computer or mobile device. Find participating mental health professionals online at <a href="http://www.UHCRetiree.com">www.UHCRetiree.com</a> .	
<b>Virtual Doctor Visits</b>		See and speak to specific doctors using your computer or mobile device. Find participating doctors online at <a href="http://www.UHCRetiree.com">www.UHCRetiree.com</a> .	

\*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 and a Medicare-approved Part D sponsor. 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.

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 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.

Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, copay amounts may be higher.

You are not required to use OptumRx home delivery for a 90-day supply of your maintenance medication. If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-888-279-1828, TTY 711. OptumRx is an affiliate of UnitedHealthcare Insurance Company.

The Formulary, pharmacy network, and/or 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 the 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.