



2017 Summary of BENEFITS

UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name: North Carolina State Health Plan for Teachers and State Employees
Group Numbers: 12309, 12310, 12311, 12312, 12313, 12314, 12315, 12316

H2001-827

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

This is a summary of drug coverages and health services provided by UnitedHealthcare® Group Medicare Advantage (PPO)

January 1, 2017 – December 31, 2017

For more information, please contact Customer Service at:

 Toll-Free **1-866-747-1014**, TTY **711**
8 a.m. – 8 p.m. ET, Monday – Friday

 **www.UHCRetiree.com/ncshp**



Summary of Benefits

January 1, 2017 – December 31, 2017

We're dedicated to providing clear and simple information about your plan so you always stay fully informed. The following information is a breakdown of what we cover and what you pay. This is called "cost-sharing" or "out-of-pocket" costs. Cost-sharing includes co-pays and co-insurance. This will help you control your health care costs throughout the plan year.

Keep in mind that this isn't a full list of services and drugs we cover, it's just an overview. To get a complete list, visit our website at www.UHCRetiree.com/ncshp to see the "Evidence of Coverage" or call customer service with any questions.

About this plan.

UnitedHealthcare® Group Medicare Advantage (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join UnitedHealthcare® Group Medicare Advantage (PPO) you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed on the cover, be a United States citizen or are lawfully present in the United States and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

What's inside?

Plan Premiums and Benefits

See plan costs including the monthly plan premium and maximum out-of-pocket limit.

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use pharmacies that are not in our network, the plan may not pay for these drugs, or you may pay more than you pay at an in-network pharmacy. You can see any provider (in-network or out-of-network) that participates in Medicare at the same cost share. Your co-pays or co-insurance will be the same.

You can search for a network provider or pharmacy in the online directories at www.UHCRetiree.com/ncshp.

Drug Coverage

Look to see what drugs are covered along with any restrictions in our plan formulary (list of Part D prescription drugs) found at www.UHCRetiree.com/ncshp.

UnitedHealthcare® Group Medicare Advantage (PPO)

| Premiums and Benefits | Base Plan In-Network and Out-of-Network | Enhanced Plan In-Network and Out-of-Network |
|--|---|--|
| Monthly Plan Premium | Contact your group plan benefit administrator to determine your actual premium amount, if applicable. | |
| Maximum Out-of-pocket Amount (does not include prescription drugs) | <p>\$4,000 annually for services you receive from any provider.</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 plan 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> | <p>\$3,300 annually for services you receive from any provider</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 plan 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 | | Base Plan In-Network and Out-of-Network | Enhanced Plan In-Network and Out-of-Network |
|------------------------------------|-----------------------|--|--|
| Inpatient Hospital Coverage | | <p>\$160 co-pay per day: for days 1–10</p> <p>\$0 co-pay per day: for days 11 and beyond</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> | <p>\$150 co-pay per day: for days 1–10</p> <p>\$0 co-pay per day: for days 11 and beyond</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> |
| Doctor Visits | Primary Care Provider | \$20 co-pay | \$15 co-pay |
| | Specialists | \$40 co-pay | \$35 co-pay |
| Preventive Care | Medicare-covered | \$0 co-pay | \$0 co-pay |
| | Routine Physical | \$0 co-pay* | \$0 co-pay* |
| Emergency Care | | <p>\$65 co-pay (worldwide coverage)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Emergency co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p> | <p>\$65 co-pay (worldwide coverage)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Emergency co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p> |
| Urgently Needed Services | | <p>\$50 co-pay (worldwide coverage)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Urgently Needed Services co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p> | <p>\$40 co-pay (worldwide coverage)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Urgently Needed Services co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p> |

| Benefits | | Base Plan In-Network and Out-of-Network | Enhanced Plan In-Network and Out-of-Network |
|---|---|--|--|
| Diagnostic Tests, Lab and Radiology Services, and X-rays (Costs for services may be different if received in an outpatient surgery setting) | Diagnostic radiology services (e.g., MRI) | \$100 co-pay | \$100 co-pay |
| | Lab services | \$40 co-pay If a lab test is performed and processed in a doctor's office: \$0 co-pay | \$20 co-pay If a lab test is performed and processed in a doctor's office: \$0 co-pay |
| | Diagnostic tests and procedures | \$40 co-pay If a diagnostic test is performed and processed in a doctor's office: \$0 co-pay | \$10 co-pay If a diagnostic test is performed and processed in a doctor's office: \$0 co-pay |
| | Therapeutic Radiology | \$40 co-pay | \$10 co-pay |
| | Outpatient x-rays | \$40 co-pay If an outpatient x-ray is performed and processed in a doctor's office: \$0 co-pay | \$25 co-pay If an outpatient x-ray is performed and processed in a doctor's office: \$0 co-pay |
| Hearing Services | Exam to diagnose and treat hearing and balance issues | \$40 co-pay | \$35 co-pay |
| | Routine hearing exam | \$0 co-pay (1 exam every 12 months)* | \$0 co-pay (1 exam every 12 months)* |
| | Hearing Aid | Plan pays up to \$500 (every 3 plan years)* | Plan pays up to \$500 (every 3 plan years)* |

| Benefits | | Base Plan In-Network and Out-of-Network | Enhanced Plan In-Network and Out-of-Network |
|---------------------------------------|---|--|--|
| Vision Services | Exam to diagnose and treat diseases and conditions of the eye | \$40 co-pay | \$35 co-pay |
| | Eyewear after cataract surgery | \$0 co-pay | \$0 co-pay |
| | Routine eye exam | \$40 co-pay (1 exam every 12 months)* | \$35 co-pay (1 exam every 12 months)* |
| Mental Health Care | Inpatient visit | \$140 co-pay per day: for days 1-10 \$0 co-pay per day: for days 11-190 Our plan covers 190 days for an inpatient hospital stay. | \$150 co-pay per day: for days 1-10 \$0 co-pay per day: for days 11-190 Our plan covers 190 days for an inpatient hospital stay. |
| | Outpatient group therapy visit | \$20 co-pay | \$10 co-pay |
| | Outpatient individual therapy visit | \$20 co-pay | \$10 co-pay |
| Skilled Nursing Facility (SNF) | | \$0 co-pay per day: for days 1-20 \$50 co-pay per day: for days 21-100 Our plan covers up to 100 days in a SNF. | \$0 co-pay per day: for days 1-20 \$50 co-pay per day: for days 21-100 Our plan covers up to 100 days in a SNF. |
| Rehabilitation Services | Occupational therapy visit | \$20 co-pay | \$20 co-pay |
| | Physical therapy and speech and language therapy visit | \$20 co-pay | \$20 co-pay |
| Ambulance | | \$75 co-pay | \$75 co-pay |

| Benefits | | Base Plan In-Network and Out-of-Network | Enhanced Plan In-Network and Out-of-Network |
|---|---|---|---|
| Foot Care (podiatry services) | Foot exams and treatment | \$40 co-pay | \$35 co-pay |
| | Routine foot care | \$40 co-pay (6 visits each plan year)* | \$35 co-pay (6 visits each plan year)* |
| Medical Equipment/Supplies | Durable Medical Equipment (e.g., wheelchairs, oxygen) | 20% of the cost | 20% of the cost |
| | Prosthetics (e.g., braces, artificial limbs) | 20% of the cost | 20% of the cost |
| Wellness Programs | Fitness program through SilverSneakers® | <p>\$0 membership fee.</p> <p>Monthly basic membership for SilverSneakers through network fitness centers.</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> | <p>\$0 membership fee.</p> <p>Monthly basic membership for SilverSneakers through network fitness centers.</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> |
| Medicare Part B Drugs | Chemotherapy drugs | \$50 co-pay | \$50 co-pay |
| | Other Part B drugs | \$50 co-pay | \$50 co-pay |
| | Allergy shots and injections | \$0 co-pay, if administered in a physician's office | \$0 co-pay, if administered in a physician's office |

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 co-pays 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.

| | Base Plan | Enhanced Plan |
|--|---|---|
| | Retail Pharmacy For a one-month (31-day) supply | Retail Pharmacy For a one-month (31-day) supply |
| Tier 1: Preferred Generic | \$10 co-pay | \$10 co-pay |
| Tier 2: Preferred Brand | \$40 co-pay | \$35 co-pay |
| Tier 3: Non-preferred drug | \$64 co-pay | \$50 co-pay |
| Tier 4: Specialty Tier | 25% of the cost or a \$100 co-pay maximum | 25% of the cost or a \$100 co-pay maximum |
| | Retail and Mail Order Pharmacy For a three-month (90-day) supply | Retail and Mail Order Pharmacy For a three-month (90-day) supply |
| Tier 1: Preferred Generic | \$24 co-pay | \$20 co-pay |
| Tier 2: Preferred Brand | \$80 co-pay | \$70 co-pay |
| Tier 3: Non-preferred drug | \$128 co-pay | \$100 co-pay |
| Tier 4: Specialty Tier | 25% of the cost or a \$300 co-pay maximum | 25% of the cost or a \$200 co-pay maximum |
| Annual Drug Out-of-Pocket Maximum | After your yearly out-of-pocket drug costs reach \$2,500, you pay \$0 co-pay for covered drugs. | After your yearly out-of-pocket drug costs reach \$2,500, you pay \$0 co-pay for covered drugs. |

| Benefits | | Base Plan In-Network and Out-of-Network | Enhanced Plan In-Network and Out-of-Network |
|----------------------------|---|--|--|
| Chiropractic Care | Manual manipulation of the spine to correct subluxation | \$20 co-pay | \$20 co-pay |
| Diabetes Management | Diabetes monitoring supplies | \$0 co-pay We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra® 2 System, OneTouch UltraMini®, OneTouch Verio® Sync, OneTouch Verio® IQ, OneTouch Verio® Flex System Kit, ACCU-CHEK® Nano SmartView, and ACCU-CHEK® Aviva Plus. | \$0 co-pay We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra® 2 System, OneTouch UltraMini®, OneTouch Verio® Sync, OneTouch Verio® IQ, OneTouch Verio® Flex System Kit, ACCU-CHEK® Nano SmartView, and ACCU-CHEK® Aviva Plus. |
| | Diabetes Self-management training | \$0 co-pay | \$0 co-pay |
| | Therapeutic shoes or inserts | 20% of the cost | 20% of the cost |
| Home Health Care | | \$0 co-pay Restrictions apply | \$0 co-pay Restrictions apply |

| Benefits | Base Plan In-Network and Out-of-Network | Enhanced Plan In-Network and Out-of-Network |
|-------------------------------|---|---|
| Private duty nursing | <p>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>If covered private duty nursing services are received before you reach the out-of-pocket maximum, you pay a 20% of the cost for each visit. The amounts you pay do not apply to the out-of-pocket maximum.</p> <p>There is a \$5,000 limit per plan year for private duty nursing services. Once the plan has paid \$5,000 in a plan year, you are responsible to pay all charges for the remainder of the plan year.</p> | <p>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>If covered private duty nursing services are received before you reach the out-of-pocket maximum, you pay a 20% of the cost for each visit. The amounts you pay do not apply to the out-of-pocket maximum.</p> <p>There is a \$5,000 limit per plan year for private duty nursing services. Once the plan has paid \$5,000 in a plan year, you are responsible to pay all charges for the remainder of the plan year.</p> |
| NurseLineSM | Speak with a registered nurse (RN) 24 hours a day, 7 days a week. | Speak with a registered nurse (RN) 24 hours a day, 7 days a week. |
| Outpatient Surgery | <p>Ambulatory surgical center: \$250 co-pay</p> <p>Outpatient hospital: \$125 co-pay</p> | <p>Ambulatory surgical center: \$250 co-pay</p> <p>Outpatient hospital: \$100 co-pay</p> |

| Benefits | | Base Plan In-Network and Out-of-Network | Enhanced Plan In-Network and Out-of-Network |
|---------------------------------------|-----------------------------|--|--|
| Outpatient Substance Abuse | Group therapy visit | \$20 co-pay | \$10 co-pay |
| | Individual therapy visit | \$20 co-pay | \$10 co-pay |
| Renal Dialysis | | 20% of the cost | 20% of the cost |
| Virtual Doctor Visits | | Speak to specific doctors using your computer or mobile device. Find participating doctors online at www. UHCRetiree.com/ncshp | Speak to specific doctors using your computer or mobile device. Find participating doctors online at www. UHCRetiree.com/ncshp |

*Benefit is combined in and out-of-network.

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

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

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 1-866-394-7218. OptumRx is an affiliate of UnitedHealthcare Insurance Company.

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.

Benefits, premium and/or co-payments/co-insurance may change at the beginning of each plan year.

You must continue to pay your Medicare Part B premium.

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 <http://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.

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-866-747-1014.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-747-1014. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-747-1014. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-747-1014。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 「對我們的健康或藥物保險可能存有疑問，」此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-747-1014。我們講中文的人員將樂意「提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-747-1014. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-747-1014. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-866-747-1014 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-747-1014. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-747-1014 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-747-1014. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 4101-747-668-1 سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

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 1-866-747-1014 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

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 1-866-747-1014. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-866-747-1014. 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 1-866-747-1014. 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 1-866-747-1014. Ta usługa jest bezpłatna.

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、1-866-747-1014 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。

