



2016 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



SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

This booklet gives you 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. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

Your Health Care Coverage

This plan is offered through the North Carolina State Health Plan for Teachers and State Employees.

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

It is important to understand the State Health Plan'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 the State Health Plan, or a request to end your membership in our plan.

For more information please call UnitedHealthcare Group Medicare Advantage (PPO) at the number listed below.

If you want information 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.

Sections in this booklet

- Things to Know About UnitedHealthcare Group Medicare Advantage (PPO)
- Monthly Premium and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

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**.

THINGS TO KNOW ABOUT UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (PPO)

Hours of Operation

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time.

UnitedHealthcare Group Medicare Advantage (PPO) Phone Numbers and Website

- Call toll-free at **1-866-747-1014**.
- Our website: www.UHCRetiree.com/ncshp

Who can join?

To join UnitedHealthcare Group Medicare Advantage (PPO) you must be entitled to Medicare Part A, enrolled in Medicare Part B, live in our service area and you meet the eligibility requirements of the State Health Plan.

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

Which doctors, hospitals and pharmacies can I use?

UnitedHealthcare Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies and other providers. You can see any provider (in-network or out-of-network) that participates in Medicare and accepts the plan at the same cost share. Your copays or coinsurance will be the same.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider directory and pharmacy directory at our website www.UHCRetiree.com/ncshp. Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare Advantage health plans, we cover everything that Original Medicare covers — and more.

- **Our plan members get all of the benefits covered by Original Medicare.**
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can learn about the complete plan formulary (list of Part D prescription drugs) and any restrictions by calling us.

How will I determine my drug costs?

Our plan groups each medication into one of four “tiers.” You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug’s tier and what stage of the benefit you have reached.

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.

The State Health Plan 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.

SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

	Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
MONTHLY PREMIUM AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Is there any limit on how much I will pay for my covered services?	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none">• \$4,000 combined in-network and out-of-network out-of-pocket limit. <p>If you reach \$4,000 in 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 if applicable.</p>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none">• \$3,300 combined in-network and out-of-network out-of-pocket limit. <p>If you reach \$3,300 in 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 if applicable.</p>
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.

Base Plan

In-Network and Out-of-Network

Enhanced Plan

In-Network and Out-of-Network

COVERED MEDICAL AND HOSPITAL BENEFITS OUTPATIENT CARE AND SERVICES**Ambulance**

- In-network: \$75 copay
- Out-of-network: \$75 copay

- In-network: \$75 copay
- Out-of-network: \$75 copay

Chiropractic Care

Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):

- In-network: \$20 copay
- Out-of-network: \$20 copay

Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):

- In-network: \$20 copay
- Out-of-network: \$20 copay

Dental Services

Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):

- In-network: \$40 copay
- Out-of-network: \$40 copay

Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):

- In-network: \$35 copay
- Out-of-network: \$35 copay

Diabetes Supplies and Services

Diabetes monitoring supplies:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Diabetes self-management training:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Therapeutic shoes or inserts:

- In-network: 20% of the cost
- Out-of-network: 20% of the cost

For diabetes monitoring supplies, the plan covers the following brands of blood glucose monitors and test strips: OneTouch® Ultra® 2, OneTouch® Verio™, OneTouch® UltraMini™, ACCU-CHEK® Aviva, ACCU-CHEK® Compact, ACCU-CHEK® SmartView. Other brands are not covered by our plan. If you use a brand of supplies that is not covered by our plan, you should speak with your doctor to get a new prescription for a covered brand.

Diabetes monitoring supplies:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Diabetes self-management training:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Therapeutic shoes or inserts:

- In-network: 20% of the cost
- Out-of-network: 20% of the cost

For diabetes monitoring supplies, the plan covers the following brands of blood glucose monitors and test strips: OneTouch® Ultra® 2, OneTouch® Verio™, OneTouch® UltraMini™, ACCU-CHEK® Aviva, ACCU-CHEK® Compact, ACCU-CHEK® SmartView. Other brands are not covered by our plan. If you use a brand of supplies that is not covered by our plan, you should speak with your doctor to get a new prescription for a covered brand.

Base Plan

In-Network and Out-of-Network

Diagnostic Tests, Lab and Radiology Services, and X-Rays

(Costs for services may differ if received as a result of outpatient surgery)

Diagnostic radiology services (such as MRIs, CT scans):

- In-network: \$100 copay
- Out-of-network: \$100 copay

Diagnostic tests and procedures:

- In-network: \$40 copay
- Out-of-network: \$40 copay

If a diagnostic test is performed in a doctor's office, and after you pay the doctor's office copay:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Lab services:

- In-network: \$40 copay
- Out-of-network: \$40 copay

If a lab test is performed and processed in a doctor's office:

- In-network: \$0 copay*
- Out-of-network: \$0 copay*

*If a lab test is not processed in the doctor's office, a separate copay will apply.

Outpatient X-rays:

- In-network: \$40 copay
- Out-of-network: \$40 copay

If you receive a X-ray service in a doctor's office, and after you pay the doctor's office copay:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Therapeutic radiology services (such as radiation treatment for cancer):

- In-network: \$40 copay
- Out-of-network: \$40 copay

Enhanced Plan

In-Network and Out-of-Network

Diagnostic radiology services (such as MRIs, CT scans):

- In-network: \$100 copay
- Out-of-network: \$100 copay

Diagnostic tests and procedures:

- In-network: \$10 copay
- Out-of-network: \$10 copay

If a diagnostic test is performed in a doctor's office, and after you pay the doctor's office copay:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Lab services:

- In-network: \$20 copay
- Out-of-network: \$20 copay

If a lab test is performed and processed* in a doctor's office:

- In-network: \$0 copay*
- Out-of-network: \$0 copay*

*If a lab test is not processed in the doctor's office, a separate copay will apply.

Outpatient X-rays:

- In-network: \$25 copay
- Out-of-network: \$25 copay

If you receive a X-ray service in a doctor's office, and after you pay the doctor's office copay:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Therapeutic radiology services (such as radiation treatment for cancer):

- In-network: \$10 copay
- Out-of-network: \$10 copay

	Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Doctor's Office Visits	Primary care physician visit: <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: \$20 copay Specialist visit: <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: \$40 copay 	Primary care physician visit: <ul style="list-style-type: none"> • In-network: \$15 copay • Out-of-network: \$15 copay Specialist visit: <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: \$35 copay
Durable Medical Equipment (wheelchairs, oxygen, etc.)	<ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 20% of the cost 	<ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 20% of the cost
Emergency Care	<ul style="list-style-type: none"> • \$65 copay <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p>	<ul style="list-style-type: none"> • \$65 copay <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p>
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: <ul style="list-style-type: none"> • In-network: \$40 copay • Out-of-network: \$40 copay <p>Additional benefit not covered by Original Medicare</p> Routine foot care (for up to 6 visits every year): <ul style="list-style-type: none"> • In-network: \$40 copay for each visit • Out-of-network: \$40 copay for each visit <p>Benefit is combined in and out-of-network.</p>	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: <ul style="list-style-type: none"> • In-network: \$35 copay • Out-of-network: \$35 copay <p>Additional benefit not covered by Original Medicare</p> Routine foot care (for up to 6 visits every year): <ul style="list-style-type: none"> • In-network: \$35 copay for each visit • Out-of-network: \$35 copay for each visit <p>Benefit is combined in and out-of-network.</p>

Base Plan

In-Network and Out-of-Network

Enhanced Plan

In-Network and Out-of-Network

Hearing Services

Exam to diagnose and treat hearing and balance issues:

- In-network: \$40 copay
- Out-of-network: \$40 copay

Additional benefit not covered by Original Medicare

Routine hearing exam (for up to 1 every year):

- In-network: \$0 copay for each visit
- Out-of-network: \$0 copay for each visit

Benefit is combined in and out-of-network

Hearing aids:

- In-network: Our plan pays up to a \$500 allowance for unlimited hearing aids every 3 years
- Out-of-network: Our plan pays up to a \$500 allowance for unlimited hearing aids every 3 years

Benefit is combined in and out-of-network

Exam to diagnose and treat hearing and balance issues:

- In-network: \$35 copay
- Out-of-network: \$35 copay

Additional benefit not covered by Original Medicare

Routine hearing exam (for up to 1 every year):

- In-network: \$0 copay for each visit
- Out-of-network: \$0 copay for each visit

Benefit is combined in and out-of-network

Hearing aids:

- In-network: Our plan pays up to a \$500 allowance for unlimited hearing aids every 3 years
- Out-of-network: Our plan pays up to a \$500 allowance for unlimited hearing aids every 3 years

Benefit is combined in and out-of-network

Base Plan

In-Network and Out-of-Network

Home Health Care

- In-network: You pay nothing
- Out-of-network: You pay nothing

Additional benefit not covered by Original Medicare

We cover nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state where services are received.

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.

Note: Custodial and domestic services are not covered.

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.

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.

Enhanced Plan

In-Network and Out-of-Network

- In-network: You pay nothing
- Out-of-network: You pay nothing

Additional benefit not covered by Original Medicare

We cover nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state where services are received.

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.

Note: Custodial and domestic services are not covered.

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.

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.

Base Plan

In-Network and Out-of-Network

Enhanced Plan

In-Network and Out-of-Network

Mental Health Care**Inpatient visit:**

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

- In-network:
 - \$140 copay for days 1 through 10
 - \$0 copay for days 11 through 190
- Out-of-network:
 - \$140 copay for days 1 through 10
 - \$0 copay for days 11 through 190

Outpatient group or individual therapy visit:

- In-network: \$20 copay
- Out-of-network: \$20 copay

Inpatient visit:

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

- In-network:
 - \$150 copay for days 1 through 10
 - \$0 copay for days 11 through 190
- Out-of-network:
 - \$150 copay for days 1 through 10
 - \$0 copay for days 11 through 190

Outpatient group or individual therapy visit:

- In-network: \$10 copay
- Out-of-network: \$10 copay

Outpatient Rehabilitation

Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):

- In-network: \$20 copay
- Out-of-network: \$20 copay

Occupational therapy visit:

- In-network: \$20 copay
- Out-of-network: \$20 copay

Physical therapy and speech and language therapy visit:

- In-network: \$20 copay
- Out-of-network: \$20 copay

Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):

- In-network: \$20 copay
- Out-of-network: \$20 copay

Occupational therapy visit:

- In-network: \$20 copay
- Out-of-network: \$20 copay

Physical therapy and speech and language therapy visit:

- In-network: \$20 copay
- Out-of-network: \$20 copay

	Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Outpatient Substance Abuse	Outpatient group or individual therapy visit: <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: \$20 copay 	Outpatient group or individual therapy visit: <ul style="list-style-type: none"> • In-network: \$10 copay • Out-of-network: \$10 copay
Outpatient Surgery	Ambulatory surgical center: <ul style="list-style-type: none"> • In-network: \$250 copay • Out-of-network: \$250 copay Outpatient hospital: <ul style="list-style-type: none"> • In-network: \$125 copay • Out-of-network: \$125 copay 	Ambulatory surgical center: <ul style="list-style-type: none"> • In-network: \$250 copay • Out-of-network: \$250 copay Outpatient hospital: <ul style="list-style-type: none"> • In-network: \$100 copay • Out-of-network: \$100 copay
Prosthetic Devices (braces, artificial limbs, etc.)	Prosthetic devices: <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 20% of the cost 	Prosthetic devices: <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 20% of the cost
Renal Dialysis	<ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 20% of the cost 	<ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 20% of the cost
Urgently Needed Services	<ul style="list-style-type: none"> • \$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services. See the “Inpatient Hospital Care” section of this booklet for other costs.	<ul style="list-style-type: none"> • \$40 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services. See the “Inpatient Hospital Care” section of this booklet for other costs.

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:

- In-network: \$40 copay
- Out-of-network: \$40 copay

Yearly glaucoma screening:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Eyeglasses or contact lenses after cataract surgery:

- In-network: You pay nothing
- Out-of-network: You pay nothing

Additional benefit not covered by Original Medicare

Routine eye exam (for up to 1 every year):

- In-network: \$40 copay
- Out-of-network: \$40 copay

Benefit is combined in and out-of-network.

Exam to diagnose and treat diseases and conditions of the eye:

- In-network: \$35 copay
- Out-of-network: \$35 copay

Yearly glaucoma screening:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Eyeglasses or contact lenses after cataract surgery:

- In-network: You pay nothing
- Out-of-network: You pay nothing

Additional benefit not covered by Original Medicare

Routine eye exam (for up to 1 every year):

- In-network: \$35 copay
- Out-of-network: \$35 copay

Benefit is combined in and out-of-network.

Base Plan

In-Network and Out-of-Network

Enhanced Plan

In-Network and Out-of-Network

Preventive Care

- In-network: You pay nothing
- Out-of-network: You pay nothing

Our plan covers many preventive services, including but not limited to:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening 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)
- Yearly “Wellness” visit

Any additional preventive services approved by Medicare during the contract year will be covered.

- In-network: You pay nothing
- Out-of-network: You pay nothing

Our plan covers many preventive services, including but not limited to:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening 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)
- Yearly “Wellness” visit

Any additional preventive services approved by Medicare during the contract year will be covered.

Base Plan

In-Network and Out-of-Network

Enhanced Plan

In-Network and Out-of-Network

Preventive Care
(continued)**Additional benefit not covered by Original Medicare**

Fitness program:

\$0 membership fee.

SilverSneakers® Fitness Program through network fitness centers. There is no visit or use fee for basic membership when you use network service providers.

SilverSneakers® Steps at Home program is available for members living 15 miles away or more from a SilverSneakers® fitness center. Member may select one of four kits that best fit their lifestyle and fitness level – general fitness, strength, walking or yoga.

NurseLineSM:

You may call the NurseLine,SM 24 hours a day, 7 days a week and speak to a registered nurse (RN) about your medical concerns and questions.

Additional benefit not covered by Original Medicare

Fitness program:

\$0 membership fee.

SilverSneakers® Fitness Program through network fitness centers. There is no visit or use fee for basic membership when you use network service providers.

SilverSneakers® Steps at Home program is available for members living 15 miles away or more from a SilverSneakers® fitness center. Member may select one of four kits that best fit their lifestyle and fitness level – general fitness, strength, walking or yoga.

NurseLineSM:

You may call the NurseLine,SM 24 hours a day, 7 days a week and speak to a registered nurse (RN) about your medical concerns and questions.

Hospice

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

Base Plan

In-Network and Out-of-Network

Enhanced Plan

In-Network and Out-of-Network

INPATIENT CARE**Inpatient Hospital Care**

Our plan covers an unlimited number of days for an inpatient hospital stay.

- In-network:
 - \$160 copay per day for days 1 through 10
 - \$0 copay for days 11 and beyond
- Out-of-network:
 - \$160 copay per day for days 1 through 10
 - \$0 copay for days 11 and beyond

Our plan covers an unlimited number of days for an inpatient hospital stay.

- In-network:
 - \$150 copay per day for days 1 through 10
 - \$0 copay for days 11 and beyond
- Out-of-network:
 - \$150 copay per day for days 1 through 10
 - \$0 copay for days 11 and beyond

Inpatient Mental Health Care

For inpatient mental health care, see the “Mental Health Care” section of this booklet.

For inpatient mental health care, see the “Mental Health Care” section of this booklet.

Skilled Nursing Facility (SNF)

Our plan covers up to 100 days in a SNF.

- In-network:
 - \$0 copay per day for days 1 through 20
 - \$50 copay per day for days 21 through 100
- Out-of-network:
 - \$0 copay per day for days 1 through 20
 - \$50 copay per day for days 21 through 100

Our plan covers up to 100 days in a SNF.

- In-network:
 - \$0 copay per day for days 1 through 20
 - \$50 copay per day for days 21 through 100
- Out-of-network:
 - \$0 copay per day for days 1 through 20
 - \$50 copay per day for days 21 through 100

Base Plan**Enhanced Plan****PRESCRIPTION DRUG BENEFITS****How much do I pay?**

For Part B drugs such as chemotherapy drugs:

- In-network: \$50 copay
- Out-of-network: \$50 copay

Other Part B drugs:

- In-network: \$50 copay
- Out-of-network: \$50 copay

For each allergy injection and/or serum received in a doctor's office:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Our plan covers Part D prescription drugs and the following further explains your cost sharing.

Annual Drug Out-of-Pocket Maximum

After your yearly out-of-pocket drug costs reach \$2,500, you pay \$0 copay for covered drugs.

Retail pharmacy

For a one month (31-day) supply

Tier 1: Generic

- \$10 copay

Tier 2: Preferred Brand

- \$40 copay

Tier 3: Non-Preferred Brand

- \$64 copay

Tier 4: Specialty Tier

- 25% coinsurance or a \$100 maximum

For Part B drugs such as chemotherapy drugs:

- In-network: \$50 copay
- Out-of-network: \$50 copay

Other Part B drugs:

- In-network: \$50 copay
- Out-of-network: \$50 copay

For each allergy injection and/or serum received in a doctor's office:

- In-network: \$0 copay
- Out-of-network: \$0 copay

Our plan covers Part D prescription drugs and the following further explains your cost sharing.

Annual Drug Out-of-Pocket Maximum

After your yearly out-of-pocket drug costs reach \$2,500, you pay \$0 copay for covered drugs.

Retail pharmacy

For a one month (31-day) supply

Tier 1: Generic

- \$10 copay

Tier 2: Preferred Brand

- \$35 copay

Tier 3: Non-Preferred Brand

- \$50 copay

Tier 4: Specialty Tier

- 25% coinsurance or a \$100 maximum

	Base Plan	Enhanced Plan
How much do I pay? (continued)	<p>Retail and Mail Order Pharmacy</p> <p>For a three month (90-day) supply</p> <p>Tier 1: Generic</p> <ul style="list-style-type: none"> • \$24 copay <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> • \$80 copay <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$128 copay <p>Tier 4: Specialty Tier</p> <ul style="list-style-type: none"> • 25% coinsurance or a \$300 maximum <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p> <p>The State Health Plan has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see the Additional Drug Coverage list for more information.</p>	<p>Retail and Mail Order Pharmacy</p> <p>For a three month (90-day) supply</p> <p>Tier 1: Generic</p> <ul style="list-style-type: none"> • \$20 copay <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> • \$70 copay <p>Tier 3: Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$100 copay <p>Tier 4: Specialty Tier</p> <ul style="list-style-type: none"> • 25% coinsurance or a \$200 maximum <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p> <p>The State Health Plan has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see the Additional Drug Coverage list for more information.</p>

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: 您對我們的健康或藥物保險可能存有疑問，為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為您提供幫助。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 답해 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 بمساعدتك. هذه . سيقوم شخص ما يتحدث العربية 1-866-747-1014 مترجم فوري، ليس عليك سوى الاتصال بنا على خدمة مجانية.

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 wa 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。

For more information, please contact Customer Service at:



Toll-Free **1-866-747-1014**, TTY **711**

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

A UnitedHealthcare® Medicare Solution

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

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