Benefit Highlights

CS VEBA 13696
Effective January 1, 2018 to December 31, 2018

This is a short description of plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Medical Benefits	In-Network	Out-of-Network
Benefits covered by Original Medicare and your plan		
Doctor's office visit	Primary Care Provider: $5 co-pay	Primary Care Provider: $5 co-pay
	Specialist: $5 co-pay	Specialist: $5 co-pay
Preventive services	$0 co-pay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	$0 co-pay per admission	$0 co-pay per admission
Skilled nursing facility (SNF)	$0 co-pay per day up to 100 days	$0 co-pay per day up to 100 days
Outpatient surgery	$0 co-pay	$0 co-pay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	$5 co-pay	$5 co-pay
Diagnostic radiology services (such as MRIs, CT scans)	$0 co-pay	$0 co-pay
Lab services	$0 co-pay	$0 co-pay
Outpatient x-rays	$0 co-pay	$0 co-pay
Therapeutic radiology services (such as radiation treatment for cancer)	$0 co-pay	$0 co-pay
Ambulance	$0 co-pay	$0 co-pay
Emergency care	$50 co-pay (worldwide)	
Urgently needed services	$5 co-pay (worldwide)	$5 co-pay (worldwide)
Annual medical out-of-pocket maximum	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $6,700 each plan year	
Additional benefits and programs not covered by Original Medicare		
Routine physical	$0 co-pay; 1 per plan year*	$0 co-pay; 1 per plan year*
Chiropractic care	$5 co-pay (Up to 12 visits per plan year)*	$5 co-pay (Up to 12 visits per plan year)*
Hearing - routine exam	$0 co-pay (1 exam every 12 months) *	$0 co-pay (1 exam every 12 months)*
Hearing aids	Plan pays up to $1,000 (every 3 years)*	Plan pays up to $1,000 (every 3 years)*
Vision - routine eye exams	$5 co-pay (1 exam every 12 months)*	$5 co-pay (1 exam every 12 months)*
Vision – eyewear	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.*

Medical Benefits	In-Network	Out-of-Network
Fitness program through SilverSneakers® Fitness program	Stay active with a basic membership at a participating location at no extra cost to you	
NurseLine℠	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Doctor Visits	Speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com.	

*Benefits are combined in and out-of-network

Prescription Drugs	Your Cost	
Initial Coverage Stage	Network Pharmacy (30-day retail supply)	Mail Service Pharmacy (90-day supply)
Tier 1: Generic	$5 co-pay	$10 co-pay
Tier 2: Preferred brand	$20 co-pay	$40 co-pay
Tier 3: Non-preferred drug	$40 co-pay	$80 co-pay
Tier 4: Specialty tier	$40 co-pay	$80 co-pay
Coverage gap stage	After your total drug costs reach $3,750, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost	
Catastrophic coverage stage	After your total out-of-pocket costs reach $5,000, you will pay a $3.35 co-pay for generic (including brand drugs treated as generic), a $8.35 co-pay for brand name	

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.

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.

Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply.

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

UnitedHealthcare® Group Medicare Advantage (PPO)

Benefits		In-Network	Out-of-Network
Inpatient Hospital		$0 copay per admit	$0 copay per admit
		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)	

Benefits		In-Network	Out-of-Network
		Any additional preventive services approved by Medicare during the contract year will be covered. 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*
Emergency Care		$50 copay (worldwide) 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.	
Urgently Needed Services		$5 copay (worldwide) 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.	$5 copay (worldwide) 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.
Diagnostic Tests, Lab and Radiology Services, and X-Rays	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

Benefits		In-Network	Out-of-Network
Hearing Services	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)*
	Hearing Aids	Plan pays up to $1,000 (every 3 years)*	Plan pays up to $1,000 (every 3 years)*
Vision Services	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.*
Mental Health	Inpatient visit	$0 copay per admit, up to 190 days	$0 copay per admit, 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
Skilled Nursing Facility (SNF)		$0 copay per day: days 1-100	$0 copay per day: days 1-100
		Our plan covers up to 100 days in a SNF.	

Benefits		In-Network	Out-of-Network
Physical Therapy and speech and language therapy visit		$5 copay	$5 copay
Ambulance		$0 copay	$0 copay
Routine Transportation		Not covered	
Medicare Part B Drugs	Chemotherapy drugs	$0 copay	$0 copay
	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.

Stage 1: Annual Prescription Deductible	Since you have no deductible, this payment stage doesn't apply.	
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing**	**Mail Order Cost-Sharing**
	One-month supply	Three-month supply
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
Stage 3: Coverage Gap Stage	After your total drug costs reach $3,750, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay $3.35 copay for generic (including brand drugs treated as generic), and a $8.35 copay for all other drugs.	

Additional Benefits		In-Network	Out-of-Network
Chiropractic Care	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)*
Diabetes Management	Diabetes monitoring supplies	$0 copay We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio® IQ, OneTouch Verio® Flex, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Guide, and ACCU-CHEK® Aviva Connect. Other brands are not covered by our plan.	$0 copay We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio® IQ, OneTouch Verio® Flex, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Guide, and ACCU-CHEK® Aviva Connect. Other brands are not covered by our plan.
	Diabetes Self-management training	$0 copay	$0 copay
	Therapeutic shoes or inserts	$0 copay	$0 copay
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	$0 copay	$0 copay
	Prosthetics (e.g., braces, artificial limbs)	$0 copay	$0 copay

Additional Benefits		In-Network	Out-of-Network
Fitness program through SilverSneakers® Fitness program		$0 membership fee. Monthly basic membership for SilverSneakers through network fitness centers. 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.	
Foot Care (podiatry services)	Foot exams and treatment	$5 copay	$5 copay
Home Health Care		$0 copay	$0 copay
Hospice		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.	
NurseLine		Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Occupational Therapy Visit		$5 copay	$5 copay
Outpatient Substance Abuse	Outpatient group therapy visit	$5 copay	$5 copay
	Outpatient individual therapy visit	$5 copay	$5 copay
Outpatient surgery		$0 copay	$0 copay
Renal Dialysis		$5 copay	$5 copay
Virtual Doctor Visits		Speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com.	

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