Benefit Highlights

UnitedHealthcare® Group Medicare Advantage (PPO) with Dental and Vision

For CalPERS Members
Effective January 1, 2021 to December 31, 2021

This is a short description of your 2021 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions and restrictions may apply.

Plan Costs

	In-Network	Out-of-Network
Annual medical deductible	No deductible	
Annual medical out-of-pocket maximum (The most you pay in a plan year for covered medical care)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,500 each plan year	

Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Doctor's office visit	Primary Care Provider: $10 copay Specialist: $10 copay Virtual Doctor Visits: $0	Primary Care Provider: $10 copay Specialist: $10 copay Virtual Doctor Visits: $0
Preventive services	$0 copay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	$0 copay per stay	$0 copay per stay
Skilled nursing facility (SNF)	$0 copay per day up to 100 days	$0 copay per day up to 100 days
Outpatient surgery	$0 copay	$0 copay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	$10 copay	$10 copay
Mental health (outpatient and virtual)	Group therapy: $10 copay Individual therapy: $10 copay Virtual visits: $10 copay	Group therapy: $10 copay Individual therapy: $10 copay Virtual visits: $10 copay
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay	$0 copay

	In-Network	Out-of-Network
Lab services	$0 copay	$0 copay
Outpatient x-rays	$0 copay	$0 copay
Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay	$0 copay
Ambulance	$0 copay	$0 copay
Emergency care	$50 copay (worldwide)	
Urgently needed services	$25 copay (worldwide)	$25 copay (worldwide)

Additional benefits and programs not covered by Original Medicare

	In-Network	Out-of-Network
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Chiropractic care and Acupuncture	$15 copay Combination of 20 chiropractic and acupuncture visits per plan year*	$15 copay Combination of 20 chiropractic and acupuncture visits per plan year*
Dental	Preventive and comprehensive dental services, with $100 yearly deductible and $1,500 Annual Calendar Maximum.*	Preventive and comprehensive dental services, with $100 yearly deductible and $1,500 Annual Calendar Maximum.*
Foot care – routine	$10 copay (up to 6 visits per plan year)*	$10 copay (up to 6 visits per plan year)*
Hearing – routine exam	$0 copay (1 exam every year)*	$0 copay (1 exam every year)*
Hearing aids	Plan pays up to $1,000 (every 3 years)*	Plan pays up to $1,000 (every 3 years)*
Vision – routine eye exams	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*
Vision – eyewear	Plan pays up to $70 eyewear allowance every 24 months. Plan pays up to $105 contact lens allowance in lieu of eyewear allowance every 24 months.*	Plan pays up to $70 eyewear allowance every 24 months. Plan pays up to $105 contact lens allowance in lieu of eyewear allowance every 24 months.*
Fitness program through SilverSneakers®	Stay active with a basic gym membership at a participating location at no extra cost to you	
NurseLine	Receive access to nurse consultations and additional clinical resources at no additional cost.	

	In-Network	Out-of-Network
In-Home Non-Medical Care	$0 copay; Coverage includes 16 hours of in-home, non-medical care per month through provider CareLinx. Unused hours do not roll over. Some restrictions and limitations apply. To access your benefit, contact CareLinx at 1-844-636-4579, 8 a.m. – 9 p.m. CT, Monday – Friday & 10 a.m. – 6 p.m. CT, Saturday and Sunday or by visiting **www.carelinx.com/calpers**.	
Post-Discharge Meals	$0 copay; Coverage for up to 84 home-delivered meals immediately following one inpatient hospitalization or skilled nursing facility stay when referred by a UnitedHealthcare clinical advocate. Benefit is offered one time per year through the provider Mom's Meals. Restrictions apply.	
Routine Transportation	$0 copay; Routine transportation coverage up to 30 one-way trips per year to plan approved medically related appointments (locations) through provider LogistiCare. Restrictions apply.	

*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: Preferred Generic	$5 copay	$10 copay
Tier 2: Preferred Brand	$20 copay	$40 copay
Tier 3: Non-preferred Drug	$50 copay	$100 copay
Tier 4: Specialty Tier	$20 copay	$40 copay
Coverage Gap Stage	After your total drug costs reach $4,130, 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 $6,550, you will pay the lesser of $3.70 copay for generic (including brand drugs treated as generic), $9.20 copay for all other drugs or, 5% coinsurance	
Annual Out-of-Pocket Maximum (for mail order drugs)	Once you've paid $1,000 in a plan year for Tier 1, Tier 2, and Tier 4 formulary drugs through the plan's mail service pharmacy, you will pay $0 for Tier 1, Tier 2, and Tier 4 formulary mail order drugs.	

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

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, copayments, and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change each plan year.

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

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