Summary of Benefits 2021

Medicare Advantage Plan with Prescription Drugs

UnitedHealthcare® Group Medicare Advantage (PPO)
H2001-816-000
Group Name (Plan Sponsor): CalPERS
with Dental and Vision

Look inside to take advantage of the health services and drug coverages the plan provides. Call Customer Service or go online for more information about the plan.

Toll-free **1-888-867-5581**, TTY **711**
7 a.m. – 8 p.m. local time, 7 days a week

www.UHCRetiree.com/calpers

Y0066_SB_H2001_816_000_2021_M

Summary of Benefits

January 1, 2021 – December 31, 2021

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/calpers, 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 below, 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).

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

About providers and network pharmacies

UnitedHealthcare Group Medicare Advantage (PPO) has a network of doctors, hospitals, 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 or precluded from the Medicare Program. 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 a network pharmacy.

You can go to www.UHCRetiree.com/calpers 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
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)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,500 each plan year. 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. Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.	

UnitedHealthcare® Group Medicare Advantage (PPO)

Benefits

		In-Network	Out-of-Network
Inpatient Hospital[1]		$0 copay per stay	$0 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC)[1]	$0 copay	$0 copay
	Outpatient surgery[1]	$0 copay	$0 copay
	Outpatient hospital services, including observation[1]	$0 copay	$0 copay
Doctor Visits	Primary	$10 copay	$10 copay
	Specialists[1]	$10 copay	$10 copay
	Virtual Doctor Visits	$0 copay	$0 copay

Benefits

		In-Network	Out-of-Network
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 Diabetes — Self-Management training Dialysis training Glaucoma screening Hepatitis C screening HIV screening Kidney disease education 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. 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” section of this booklet for other costs.	

Benefits

		In-Network	Out-of-Network
Urgently Needed Services		$25 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" section of this booklet for other costs.	$25 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" section of this booklet for other costs.
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g., MRI)[1]	$0 copay	$0 copay
	Lab services[1]	$0 copay	$0 copay
	Diagnostic tests and procedures[1]	$0 copay	$0 copay
	Therapeutic radiology[1]	$0 copay	$0 copay
	Outpatient x-rays[1]	$0 copay	$0 copay
Hearing Services	Exam to diagnose and treat hearing and balance issues[1]	$10 copay	$10 copay
	Routine hearing exam	$0 copay (1 exam every year)*	$0 copay (1 exam every year)*
	Hearing aids	Plan pays up to $1,000 (every 3 plan years)*	Plan pays up to $1,000 (every 3 plan years)*

Benefits

		In-Network	Out-of-Network
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	$10 copay	$10 copay
	Oral exam	$0 copay (once every 6 months)*	$0 copay (once every 6 months)*
	Routine cleaning	$0 copay (once every 6 months)*	$0 copay (once every 6 months)*
	Dental bitewing x-rays	$0 copay (once every 12 months)*	$0 copay (once every 12 months)*
	Benefit limit	Preventive and comprehensive dental services, with $100 yearly deductible and $1,500 Annual Calendar Maximum. You may also choose an out-of-network dentist for covered dental services. When you receive your covered dental services from an out-of-network dentist, the plan pays according to a maximum allowable fee schedule. You pay all fees in excess of this amount.	
Vision Services	Exam to diagnose and treat diseases and conditions of the eye[1]	$10 copay	$10 copay
	Eyewear after cataract surgery	$0 copay	$0 copay
	Routine eye exam	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*
	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.

Benefits

		In-Network	Out-of-Network
Mental Health	Inpatient visit[1]	$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[1]	$10 copay	$10 copay
	Outpatient individual therapy visit[1]	$10 copay	$10 copay
	Virtual Behavioral Visits	$10 copay	$10 copay
Skilled Nursing Facility (SNF)[1]		$0 copay per day: for days 1 – 100	$0 copay per day: for days 1 – 100
		Our plan covers up to 100 days in a SNF	
Physical Therapy and Speech and Language Therapy Visit[1]		$10 copay	$10 copay
Ambulance[2]		$0 copay	$0 copay
Medicare Part B Drugs	Chemotherapy drugs[1]	$0 copay	$0 copay
	Other Part B drugs[1]	$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. You can view the Certificate of Coverage at www.UHCRetiree.com/calpers, or call Customer Service to have a hard copy sent to you.

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.

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.

Initial Coverage	**Retail Cost-Sharing** One-month supply	**Mail Order Cost-Sharing** Three-month 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	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the lesser of: • 5% coinsurance, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs.	

Annual Mail Order Drug Out-of-Pocket Maximum

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.

Additional Benefits

		In-Network	Out-of-Network
Acupuncture	Medicare-covered acupuncture[1]	$15 copay	$15 copay
	Routine acupuncture	$15 copay for each acupuncture visit (Up to 20 visits each plan year)* Visits are combined with routine chiropractic care benefit.	$15 copay for each acupuncture visit (Up to 20 visits each plan year)* Visits are combined with routine chiropractic care benefit.
Chiropractic Care	Manual manipulation of the spine to correct subluxation[1]	$10 copay	$10 copay
	Routine chiropractic care	$15 copay for each chiropractic visit (Up to 20 visits each plan year)* Visits are combined with routine acupuncture care benefit.	$15 copay for each chiropractic visit (Up to 20 visits each plan year)* Visits are combined with routine acupuncture care benefit.

Additional Benefits

		In-Network	Out-of-Network
Diabetes Management	Diabetes monitoring supplies[1]	$0 copay	$0 copay
		We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan.	We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan.
	Medicare covered Therapeutic Continuous Glucose Monitors (CGMs) and supplies[1]	$0 copay	$0 copay
	Diabetes Self-management training	$0 copay	$0 copay
	Therapeutic shoes or inserts[1]	$0 copay	$0 copay
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	$0 copay	$0 copay
	Prosthetics (e.g., braces, artificial limbs)[1]	$0 copay	$0 copay

Additional Benefits

		In-Network	Out-of-Network
Fitness program through SilverSneakers®		$0 membership fee. Access to a basic fitness membership offered through SilverSneakers® participating locations. 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[1]	$10 copay	$10 copay
	Routine foot care	$10 copay for each visit (Up to 6 visits per plan year)*	$10 copay for each visit (Up to 6 visits per plan year)*
Home Health Care[1]		$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.	
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.	
NurseLine		Receive access to nurse consultations and additional clinical resources at no additional cost.	
Occupational Therapy Visit[1]		$10 copay	$10 copay
Opioid Treatment Program Services[1]		$0 copay	$0 copay
Outpatient Substance Abuse	Outpatient group therapy visit[1]	$10 copay	$10 copay
	Outpatient individual therapy visit[1]	$10 copay	$10 copay
Outpatient Surgery[1]		$0 copay	$0 copay

Additional Benefits

	In-Network	Out-of-Network
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. Contact Mom's Meals for additional details if you have been referred into the program. 1-855-428-6667 Hours of Operation: Monday – Friday from 7 a.m. to 6 p.m. Central Time. Or if you have been recently discharged from the hospital or a skilled nursing facility and would like to learn more, call the phone number located on the back of your UnitedHealthcare member ID card.	
Post-Discharge Routine Transportation	$0 copay; Post-Discharge Routine Transportation coverage for unlimited rides up to 30 days upon referral from a UnitedHealthcare Clinical Advocate, immediately following inpatient hospital discharges or skilled nursing facility stays. Benefit is offered through LogistiCare to plan approved, medically related appointments (locations). Restrictions apply. Contact LogistiCare for additional details and to schedule your trips: (833) 219-1182, TTY: 844-488-9724, 8 a.m. – 5 p.m., local time, Monday – Friday or by visiting www.logisticare.com/BookNow	
Renal Dialysis[1]	$0 copay	$0 copay

[1]Services with a [1] require your provider to obtain prior authorization from the plan for in-network benefits.

[2]Authorization is required for Non-emergency Medicare-covered ambulance ground and air transportation. Emergency Ambulance does not require authorization.

*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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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 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 information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

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 our 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. SilverSneakers is a registered trademark of Tivity Health, Inc.

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