# Summary of Benefits 2021

Medicare Advantage Plan

**UnitedHealthcare® Group Medicare Advantage (PPO)**
Group Name (Plan Sponsor): Pfizer
Group Number: 16175

H2001-817-000

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

Toll-free **1-866-868-0329**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

**www.UHCRetiree.com/pfizer**


Y0066_SB_H2001_817_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/pfizer 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.

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.

You can go to www.UHCRetiree.com/pfizer to search for a network provider using the online directory.

# UnitedHealthcare® Group Medicare Advantage (PPO)

## Premiums and Benefits

| | In-Network | Out-of-Network |
|---|---|---|
| **Monthly Plan Premium** | Contact Pfizer to determine your actual premium amount, if applicable. | |
| **Maximum Out-of-Pocket Amount** | Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $2,200 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.<br><br>Please note that you will still need to pay your monthly premiums, if applicable. | |

# UnitedHealthcare® Group Medicare Advantage (PPO)

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Inpatient Hospital**[1] | | $350 copay per stay | $350 copay per stay |
| | | Our plan covers an unlimited number of days for an inpatient hospital stay. | |
| **Outpatient Hospital**[1]<br><br>Cost sharing for additional plan covered services will apply. | Ambulatory Surgical Center (ASC) | $150 copay | $150 copay |
| | Outpatient surgery | $150 copay | $150 copay |
| | Outpatient hospital services, including observation | $150 copay | $150 copay |
| **Doctor Visits** | Primary Care Provider | $15 copay | $15 copay |
| | Specialists[1] | $25 copay | $25 copay |
| | Virtual Doctor Visits | $0 copay | $0 copay |
| **Preventive Care** | Medicare-covered | $0 copay | $0 copay |
| | | Abdominal aortic aneurysm screening<br>Alcohol misuse counseling<br>Annual “Wellness” visit<br>Bone mass measurement<br>Breast cancer screening (mammogram)<br>Cardiovascular disease (behavioral therapy)<br>Cardiovascular screening<br>Cervical and vaginal cancer screening<br>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>Depression screening<br>Diabetes screenings and monitoring<br>Diabetes – Self-Management training<br>Dialysis training<br>Glaucoma screening<br>Hepatitis C screening<br>HIV screening | |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| | | Kidney disease education<br>Lung cancer with low dose computed tomography (LDCT) screening<br>Medical nutrition therapy services<br>Medicare Diabetes Prevention Program (MDPP)<br>Obesity screenings and counseling<br>Prostate cancer screenings (PSA)<br>Sexually transmitted infections screenings and counseling<br>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>Vaccines, including flu shots, hepatitis B shots, pneumococcal shots<br>"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** | | $120 copay (worldwide)<br><br>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. | |
| **Urgently Needed Services** | | $35 copay (worldwide)<br><br>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. | $35 copay (worldwide)<br><br>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** | Diagnostic radiology services (e.g. MRI)[1] | $25 copay | $25 copay |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Services, and X-Rays** | Lab services[1] | $10 copay | $10 copay |
| | Diagnostic tests and procedures[1] | $25 copay | $25 copay |
| | Therapeutic Radiology[1] | $25 copay | $25 copay |
| | Outpatient x-rays[1] | $20 copay | $20 copay |
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues[1] | $25 copay | $25 copay |
| | Routine hearing exam | $0 copay (1 exam per plan year)* | $0 copay (1 exam per plan year)* |
| | Hearing Aids | Through UnitedHealthcare Hearing, the plan pays up to a $1,000 allowance for hearing aid(s) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing. | Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered. |
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the eye[1] | $25 copay | $25 copay |
| | Eyewear after cataract surgery | $0 copay | $0 copay |
| | Routine eye exams | $10 copay (1 exam every 12 months)* | $10 copay (1 exam every 12 months)* |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| | Eye wear | Plan pays up to $400 eyewear allowance every year. Plan pays up to $150 contact lens allowance in lieu of eyewear allowance every year.* | Plan pays up to $400 eyewear allowance every year. Plan pays up to $150 contact lens allowance in lieu of eyewear allowance every year.* |
| **Mental Health** | Inpatient visit[1] | $350 copay per stay, up to 190 days | $350 copay per stay, up to 190 days |
| | | Our plan covers 190 days for an inpatient hospital stay. | |
| | Outpatient group therapy visit[1] | $15 copay | $15 copay |
| | Outpatient individual therapy visit[1] | $15 copay | $15 copay |
| | Virtual Behavioral Visits | $15 copay | $15 copay |
| **Skilled Nursing Facility (SNF)[1]** | | $0 copay per day: days 1-20<br>$75 copay per day: days 21-100 | $0 copay per day: days 1-20<br>$75 copay per day: days 21-100 |
| | | Our plan covers up to 100 days in a SNF per benefit period. | |
| **Physical Therapy and speech and language therapy visit[1]** | | $15 copay | $15 copay |
| **Ambulance[2]** | | $100 copay | $100 copay |

## Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **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, 8:00 a.m.- 5:00 p.m. Monday - Friday Local Time or by visiting www.logisticare.com/BookNow | |
| **Medicare Part B Drugs** | Chemotherapy drugs[1] | $35 copay | $35 copay |
| | Other Part B drugs[1] | $40 copay | $40 copay |

## Additional Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Acupuncture** | Medicare-covered acupuncture | $15 copay | $15 copay |
| | Routine acupuncture | $15 copay (Up to 20 visits per plan year)* | $15 copay (Up to 20 visits per plan year)* |
| **Chiropractic Care** | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[1] | $15 copay | $15 copay |
| | Routine chiropractic care | $15 copay (Up to 20 visits per plan year)* | $15 copay (Up to 20 visits per plan year)* |
| **Diabetes Management** | Diabetes monitoring supplies[1] | $0 copay<br><br>We only cover Accu-Chek® and OneTouch® brands.<br><br>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.<br><br>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.<br><br>Other brands are not covered by your plan. | $0 copay<br><br>We only cover Accu-Chek® and OneTouch® brands.<br><br>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.<br><br>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.<br><br>Other brands are not covered by your plan. |

## Additional Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| | 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] | 20% coinsurance | 20% coinsurance |
| **Durable Medical Equipment (DME) and Related Supplies** | Durable Medical Equipment (e.g., wheelchairs, oxygen)[1] | 20% coinsurance | 20% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs)[1] | 20% coinsurance | 20% coinsurance |
| **Fitness program through SilverSneakers®** | | You have access to SilverSneakers®, a Medicare fitness program. SilverSneakers includes a $0 membership fee for a standard, monthly membership at a participating fitness center.<br><br>To get your SilverSneakers ID number or learn more about this benefit, visit SilverSneakers.com or call 1-888-423-4632, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday. | |
| **Foot Care (podiatry services)** | Foot exams and treatment[1] | $25 copay | $25 copay |
| | Routine foot care | $25 copay for each visit (Up to 6 visits per plan year)* | $25 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. | |

## Additional Benefits

| | | In-Network | Out-of-Network |
|---|---|---|---|
| **Home Delivered Meals** | | $0 copay; Coverage for up to 21 home-delivered meals per year through the provider Mom's Meals. All meals must be ordered in one shipment. Restrictions apply. Contact Mom's Meals for additional details and to place your order: 1-855-428-6667 Hours of Operation: Monday – Friday from 7am to 6pm Central Time | |
| **NurseLine** | | Receive access to nurse consultations and additional clinical resources at no additional cost. | |
| **Occupational Therapy Visit**[1] | | $15 copay | $15 copay |
| **Opioid Treatment Program Services**[1] | | $0 copay | $0 copay |
| **Outpatient Substance Abuse** | Outpatient group therapy visit[1] | $15 copay | $15 copay |
| | Outpatient individual therapy visit[1] | $15 copay | $15 copay |
| **Renal Dialysis**[1] | | 20% coinsurance | 20% coinsurance |

[1] Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

[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. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C 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.

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

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 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. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries. 