



# Summary of Benefits 2024

## **UnitedHealthcare® Group Medicare Advantage (PPO)**

Group Name (Plan Sponsor): SAMBA Health Plan / High Option

Group Number: 13473

H2001-879-000

Look inside to learn more about the plan and the health and drug services it covers.  
Call Customer Service or go online for more information about the plan.



Toll-free **1-866-794-6791**, TTY **711**

8 a.m.-8 p.m. local time, Monday-Friday



**[retiree.uhc.com/samba](https://retiree.uhc.com/samba)**

**United  
Healthcare®**  
Group Medicare Advantage

# Summary of Benefits

**January 1, 2024 - December 31, 2024**

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can see it online at [retiree.uhc.com/samba](https://retiree.uhc.com/samba) or you can call Customer Service for help. When you enroll in the plan, you will get more information on how to view your plan details online.

## UnitedHealthcare® Group Medicare Advantage (PPO)

Medical premium and limits	
	In-network and out-of-network
<b>Monthly plan premium</b>	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
<b>Part B premium reduction</b>	\$100.00
<b>Maximum out-of-pocket amount</b> (does not include prescription drugs)	\$0 for Medicare-covered services from any provider  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 plan year.  Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.

Medical benefits		
	In-network and out-of-network	
<b>Inpatient hospital care<sup>1</sup></b>		\$0 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.
<b>Outpatient hospital<sup>1</sup></b>	Ambulatory surgical center (ASC)	\$0 copay
Cost sharing for additional plan covered services will apply.	Outpatient surgery	\$0 copay
	Outpatient hospital services, including observation	\$0 copay
<b>Doctor visits</b>	Primary care provider	\$0 copay
	Virtual doctor visits	\$0 copay
	Specialists <sup>1</sup>	\$0 copay
<b>Preventive services</b>	Routine physical	\$0 copay; 1 per plan year*
	Medicare-covered	\$0 copay
	<ul style="list-style-type: none"> <li>□ Abdominal aortic aneurysm screening</li> <li>□ Alcohol misuse counseling</li> <li>□ Annual wellness visit</li> <li>□ Bone mass measurement</li> <li>□ Breast cancer screening (mammogram)</li> <li>□ Cardiovascular disease (behavioral therapy)</li> <li>□ Cardiovascular screening</li> <li>□ Cervical and vaginal cancer screening</li> <li>□ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> </ul>	<ul style="list-style-type: none"> <li>□ Depression screening</li> <li>□ Diabetes screenings and monitoring</li> <li>□ Diabetes – Self-Management training</li> <li>□ Dialysis training</li> <li>□ Glaucoma screening</li> <li>□ Hepatitis C screening</li> <li>□ HIV screening</li> <li>□ Kidney disease education</li> <li>□ Lung cancer with low dose computed tomography (LDCT) screening</li> <li>□ Medical nutrition therapy services</li> </ul>

## Medical benefits

### In-network and out-of-network

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>□ Medicare Diabetes Prevention Program (MDPP)</li> <li>□ Obesity screenings and counseling</li> <li>□ Prostate cancer screenings (PSA)</li> <li>□ Sexually transmitted infections screenings and counseling</li> <li>□ Tobacco use cessation counseling (counseling for</li> </ul> | <ul style="list-style-type: none"> <li>people with no sign of tobacco-related disease)</li> <li>□ Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</li> <li>□ “Welcome to Medicare” preventive visit (one-time)</li> </ul> |
|---|--|

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%.

### Emergency care

\$0 copay (worldwide)

If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.

### Urgently needed services

\$0 copay (worldwide)

If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing 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, CT scan)<sup>1</sup> \$0 copay

Lab services<sup>1</sup> \$0 copay

Diagnostic tests and procedures<sup>1</sup> \$0 copay

Therapeutic radiology<sup>1</sup> \$0 copay

Outpatient X-rays<sup>1</sup> \$0 copay

Medical benefits		
		In-network and out-of-network
<b>Hearing services</b>	Exam to diagnose and treat hearing and balance issues <sup>1</sup>	\$0 copay
	Routine hearing exam	\$0 copay, 1 exam per plan year*
	Hearing Aids UnitedHealthcare Hearing	Through UnitedHealthcare Hearing, the plan pays a \$1,000 allowance for hearing aids (combined for both ears) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.
<b>Routine dental services</b> See Evidence of Coverage for more details.	Oral exams	\$0 copay, 2 procedures per plan year.
	Routine cleaning	\$0 copay, 2 procedures per plan year.
	Dental bitewing X-rays	\$0 copay, 1 procedure per plan year.
	Minor Services (Includes Fillings and Nitrous Oxide)	20% coinsurance
	Major Services (Includes Crowns, Root Canals, and other restorative services)	50% coinsurance
	Benefit Limit	\$50 yearly deductible \$1,000 combined in and out-of-network plan year maximum. Preventive and diagnostic procedures do not count toward this maximum. If you receive 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.
<b>Vision services</b>	Exam to diagnose and treat diseases and conditions of the eye <sup>1</sup>	\$0 copay

<b>Medical benefits</b>		
		<b>In-network and out-of-network</b>
	Eyewear after cataract surgery	\$0 copay
	Routine eye exam	\$0 copay, 1 exam every 12 months *
	Routine eyewear	Plan pays up to \$200 for eyeglasses, or up to \$200 for contact lenses instead of eyeglasses, every 12 months.*
<b>Mental Health</b>	Inpatient visit <sup>1</sup>	\$0 copay per stay  Our plan covers an unlimited number of days for an inpatient hospital stay.
	Outpatient group therapy visit <sup>1</sup>	\$0 copay
	Outpatient individual therapy visit <sup>1</sup>	\$0 copay
	Virtual behavioral visits	\$0 copay
	<b>Skilled nursing facility (SNF)<sup>1</sup></b>	\$0 copay per day: days 1-20 \$0 copay per day: days 21-100  Our plan covers up to 100 days in a SNF per benefit period.
	<b>Outpatient Rehabilitation (physical, occupational, or speech/language therapy)<sup>1</sup></b>	\$0 copay
	<b>Ambulance<sup>2</sup></b>	\$0 copay
<b>Medicare Part B Drugs</b>	Chemotherapy drugs <sup>1</sup>	\$0 copay
	Other Part B drugs <sup>1</sup>	\$0 copay
Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.		

## 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 [retiree.uhc.com/samba](http://retiree.uhc.com/samba) or call Customer Service to have a hard copy sent to you.

Your plan sponsor offers additional prescription drug coverage. 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.

<b>Stage 1: Annual prescription (Part D) deductible</b>	Since you have no deductible, this payment stage doesn't apply.	
<b>Stage 2: Initial coverage (After you pay your deductible, if applicable)</b>	<b>Retail Cost-Sharing</b>	<b>Mail Order or Retail Cost-Sharing</b>
	<b>30-day supply</b>	<b>90-day supply</b>
<b>Tier 1:</b> Preferred Generic	\$5 copay	\$10 copay
<b>Tier 2:</b> Preferred Brand <sup>1</sup>	\$30 copay	\$60 copay
<b>Tier 3:</b> Non-preferred Drug <sup>1</sup>	\$75 copay	\$150 copay
<b>Tier 4:</b> Specialty Tier <sup>1</sup>	\$110 copay (limited to a 30-day supply)	\$110 copay (limited to a 30-day supply)
<b>Stage 3: Coverage Gap Stage</b>	After your total drug costs reach \$5,030, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	
<b>Stage 4: Catastrophic coverage</b>	During this payment stage, the plan pays the full cost for your covered drugs. You pay nothing.	

<sup>1</sup> You will pay a maximum of \$35 for a 1-month supply of each Part D insulin product covered by our plan. Most adult Part D vaccines are covered at no cost to you.

**Pharmacy out-of-pocket maximum**

When your **total** out-of-pocket costs (what you pay) reach \$5,000 you will not pay any copay or coinsurance.



Additional benefits		
		In-network and out-of-network
<b>Acupuncture services</b>	Medicare-covered acupuncture (for chronic low back pain)	\$0 copay
	Routine acupuncture services	\$0 copay, up to 26 visits per plan year*
<b>Chiropractic services</b>	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>1</sup>	\$0 copay
	Routine chiropractic services	\$0 copay, up to 26 visits per plan year*
<b>Diabetes management</b>	Diabetes monitoring supplies <sup>1</sup>	<p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch® Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p>
	Medicare covered Continuous Glucose Monitors (CGMs) and supplies <sup>1</sup>	\$0 copay
	Diabetes self-management training	\$0 copay

<b>Additional benefits</b>		
		<b>In-network and out-of-network</b>
	Therapeutic shoes or inserts <sup>1</sup>	\$0 copay
<b>Durable Medical Equipment (DME) and Related Supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>1</sup>	\$0 copay
	Prosthetics (e.g., braces, artificial limbs) <sup>1</sup>	\$0 copay
<b>Fitness program</b> Renew Active® by UnitedHealthcare		<p>\$0 copay for Renew Active® by UnitedHealthcare, the gold standard in Medicare fitness programs for body and mind. It includes a free gym membership at a fitness location you select from our nationwide network, online classes, content about brain health and fun social activities. Visit <a href="http://UHCRenewActive.com">UHCRenewActive.com</a> to learn more today.</p> <p>Once you become a member you will need a confirmation code. Log in to your plan website, go to Health &amp; Wellness and select Renew Active or call the number on your UnitedHealthcare member ID card to obtain your code.</p>
<b>Foot care (podiatry services)</b>	Foot exams and treatment <sup>1</sup>	\$0 copay
	Routine foot care	\$0 copay, 6 visits per plan year*
<b>Over-the-counter (OTC) card</b> Healthy Benefits Plus		<p>\$0 copay</p> <p>\$40 credit each quarter to purchase approved OTC items from network retail locations or through the OTC catalog. Credits expire at the end of each quarter. Shop in store, call or go online. 1-833-818-8693, TTY 711, visit <a href="http://HealthyBenefitsPlus.com/UHCRetireeOTC">HealthyBenefitsPlus.com/UHCRetireeOTC</a>, or download the Healthy Benefits Plus app.</p>

Additional benefits		
		In-network and out-of-network
<b>UnitedHealthcare</b> Healthy at Home		<p>\$0 copay for the following benefits for up to 30 days after each inpatient and SNF discharge:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 28 home-delivered meals*</li> <li><input type="checkbox"/> 12 one-way trips to medically related appointments and the pharmacy*</li> <li><input type="checkbox"/> 6 hours of non-medical personal care services - a professional caregiver can help with preparing meals, companionship, medication reminders, and more. No referral required.</li> </ul> <p>Call the customer service number on your UnitedHealthcare member ID card for more information and to use your benefits.</p> <p>*Call Customer Service to request a referral for each discharge.</p> <p>Some restrictions and limitations may apply.</p>
<b>Home health care</b> <sup>1</sup>		\$0 copay
<b>Hospice</b>		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.
<b>Personal emergency response system (PERS)</b> Lifeline		<p>\$0 copay for a personal emergency response system.</p> <p>Help is only a button press away. A PERS wearable device can quickly connect you to the help you need, 24 hours a day in any situation. Call or go online to order your device. 1-855-595-8485, TTY 711 or <a href="http://lifeline.com/uhcgroup">lifeline.com/uhcgroup</a></p>
<b>24/7 Nurse Support</b>		Receive access to nurse consultations and additional clinical resources at no additional cost.
<b>Opioid treatment program services</b> <sup>1</sup>		\$0 copay
<b>Outpatient substance abuse</b>	Outpatient group therapy visit <sup>1</sup>	\$0 copay
	Outpatient individual therapy visit <sup>1</sup>	\$0 copay

Additional benefits	
	In-network and out-of-network
<b>Private duty nursing<sup>1</sup></b>	<p>We cover medically necessary skilled 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. Services are covered when provided through a Medicare-certified or Accreditation Commission for Health Care (ACHC) accredited provider that can provide services safely in the home.</p> <p>The services requested must be ordered by a treating practitioner or specialist after a face-to-face evaluation takes place with a written treatment plan and letter of medical necessity. The face-to-face evaluation must occur no more than 90 days prior to the service request.</p> <p>The services requested must require the professional proficiency and skills of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) due to a complex medical need and/or unstable condition. Caregiver or other appropriate support must be available to assume a portion of care.</p> <p>Note: Custodial and domestic services are not covered.</p> <p>\$0 copayment for each visit, up to \$5,000 per plan year</p>
<b>Rally Coach™ Programs</b>	<p>\$0 copay for Rally Coach™ programs: Real Appeal® Weight Management, Real Appeal Diabetes Prevention, Wellness Coaching and a tobacco cessation program.</p> <p>Call or go online to get started today.  <a href="http://rallyhealth.com/retiree">rallyhealth.com/retiree</a></p> <ul style="list-style-type: none"> <li>• Real Appeal 1-844-924-7325, TTY 711</li> <li>• Rally Wellness Coaching 1-800-478-1057, TTY 711</li> <li>• Tobacco Cessation 1-866-784-8454, TTY 711</li> </ul> <p>* Refer to your Evidence of Coverage for eligibility requirements</p>
<b>Renal Dialysis<sup>1</sup></b>	\$0 copay

<sup>1</sup> 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.

<sup>2</sup> 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

## 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, pharmacies 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 [retiree.uhc.com/samba](https://retiree.uhc.com/samba) 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.

## Required Information

UnitedHealthcare® Group Medicare Advantage (PPO) is 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 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](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.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

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

Benefits, features and/or devices vary by plan/area. Limitations and exclusions may apply.

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 five 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.

24/7 Nurse Support 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.

Participation in the Renew Active® program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership and other offerings. Fitness membership, equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Certain services, classes, events and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. AARP® Staying Sharp is the registered trademark of AARP. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. The Renew Active program varies by plan/area. Access to gym and fitness location network may vary by location and plan.

## Civil Rights Notice

**The company complies with applicable federal civil rights laws and does not treat members differently because of sex, age, race, color, disability, or national origin.**

If you think you were treated unfairly because of your sex, age, race, color, disability, or national origin, you can send a complaint to our Civil Rights Coordinator.

- **Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)
- **Mail:** Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on the front of the booklet or your membership identification card (TTY **711**).

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- **Online:** <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>
- **Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)
- **Mail:** U.S. Department of Health and Human Services  
200 Independence Ave SW  
HHH Building, Room 509F  
Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on the front of the booklet or your membership identification card (TTY **711**), Monday through Friday, 8 a.m. to 8 p.m. ET.



## 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, please call us using the toll-free number listed on the front of the booklet. Someone who speaks your language can help you. This is a free service.

**Spanish:** Contamos con servicios gratuitos de intérprete para responder cualquier pregunta que pudiera tener sobre nuestro plan de salud o de medicamentos. Para obtener los servicios de un intérprete, llámenos al número de teléfono gratuito que figura en la portada del folleto. Una persona que habla su idioma podrá ayudarle. Es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费口译服务，解答您对我们的健康或药物计划的任何疑问。如需寻找一名口译员，请使用宣传册前面列出的免费电话号码联系我们。一名与您讲相同语言的人可以为您提供帮助。这是一项免费服务。

**Chinese Cantonese:** 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打本手冊正面的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo ng interpreter para sagutin anumang tanong na maaaring mayroon ka tungkol sa kalusugan o plano ng gamot. Para makakuha ng interpreter, pakitawagan kami gamit ang libreng numerong nakalista sa harapan ng booklet. Sinumang nagsasalita ng wika mo ay puwedeng makatulong sa iyo. Ang serbisyonang ito ay libre.

**French:** Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser sur notre régime d'assurance maladie ou d'assurance-médicaments. Pour recevoir l'aide d'un interprète, veuillez nous appeler en composant le numéro gratuit figurant sur votre carte d'identification de membre. Quelqu'un parlant votre langue peut vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi mà bạn có về chương trình sức khỏe hay thuốc của chúng tôi. Để gặp thông dịch viên, vui lòng gọi cho chúng tôi theo số điện thoại được liệt kê ở mặt trước của quyển sách nhỏ (booklet). Người nói cùng ngôn ngữ với bạn có thể giúp bạn. Đây là dịch vụ miễn phí.

**German:** Wir verfügen über kostenlose Dolmetscherdienste, um alle Fragen zu beantworten, die Sie über unseren Gesundheits- oder Medikamentenplan haben mögen. Um einen Dolmetscher zu erhalten, rufen Sie uns bitte unter der kostenfreien Nummer an, die auf der Vorderseite der Broschüre aufgeführt ist. Jemand, der Ihre Sprache spricht, kann Ihnen helfen. Dies ist eine kostenlose Dienstleistung.

**Korean:** 건강 또는 의약품 플랜에 관한 질문에 답변해드리기 위해 무료 통역 서비스를 제공합니다. 통역 서비스를 이용하려면, 책자 앞면에 있는 수신자 부담 전화번호로 전화해 주십시오. 한국어를 사용하는 통역사가 도움을 드릴 수 있습니다. 이 서비스는 무료입니다.

**Russian:** Если у Вас возникнут какие-либо вопросы о нашем плане медицинского страхования или плане по приобретению препаратов, мы предоставим Вам бесплатные услуги устного перевода. Для того чтобы воспользоваться услугами устного перевода, пожалуйста, свяжитесь с нами по бесплатному номеру телефона, указанному на лицевой стороне брошюры. Сотрудник, который говорит на Вашем языке, сможет Вам помочь. Данная услуга предоставляется бесплатно.

**Arabic:** لدينا خدمات ترجمة فورية للرد على أي أسئلة قد تكون لديك حول الخطة الصحية أو خطة الأدوية الخاصة بنا . للحصول على مترجم، من فضلك اتصل بنا باستخدام رقم الهاتف المجاني الموجود على الجزء الأمامي من الكتيب . سيساعدك شخص ما يتحدث لغتك . هذه خدمة مجانية .

**Hindi:** हमारे स्वास्थ्य या दवा प्लान के बारे में आपके किसी भी परश्च का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं मौजूद हैं। दुभाषिया पाने के लिए, कृपया इस बुकलेट के सामने वाले भाग में सूचीबद्ध टोल- फ्री नंबर का उपयोग करके हमें कॉल करें। आपकी भाषा बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

**Italian:** Mettiamo a disposizione un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per avvalersi di un interprete, si prega di chiamare il numero verde riportato nella parte anteriore dell'opuscolo. Una persona che parla italiano potrà fornire l'assistenza richiesta. Il servizio è gratuito.

**Portuguese:** Dispomos de serviços de intérprete gratuitos para esclarecer quaisquer dúvidas que tenha sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número gratuito indicado na parte da frente da brochura. Alguém que fala a sua língua pode ajudá-lo(a). Este é um serviço gratuito.

**French Creole:** Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou gendwa genyen konsènan plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, tanpri rele nou apati nimewo gratis pou apèl ki sou lis devan livrè an. Yon moun ki pale lang ou ka ede ou. Sa se yon sèvis gratis.

**Polish:** Oferujemy bezpłatne usługi tłumaczeniowe, aby odpowiedzieć na wszelkie pytania dotyczące naszego planu ubezpieczenia zdrowotnego lub planu refundacji leków. Aby skorzystać z pomocy tłumacza, proszę zadzwonić pod bezpłatny numer telefonu podany na pierwszej stronie broszury. Osoba posługująca się Pana/Pani językiem Panu/Pani pomoże. Usługa ta jest bezpłatna.

**Japanese:** 当社の医療または処方薬プランに関する質問にお答えするために、無料の通訳サービスをご利用いただけます。通訳が必要な場合には、本冊子の表面に記載されているフリーダイヤル番号を使用して、当社までお問い合わせください。お客様の言語を話す通訳者がお手伝いいたします。これは無料のサービスです。

# Additional Drug Coverage

## Additional prescription drug coverage

Your plan includes extra coverage for certain drugs as shown below. These drugs are either not generally covered under Medicare Part D or are covered at a different cost level than the one shown on your plan's Drug List (Formulary).

This is not a complete list of prescription drugs covered by our plan. For a complete list, please call Customer Service using the information on the cover of this book.

## Lower-cost Medicare prescription drugs and supplies

These drugs are part of your Medicare prescription drug coverage.<sup>1</sup>

**The following drugs have a \$0 copayment.**

<b>Allergic Reaction</b>	PEG-3350/NaCl/Na Bicarbonate/KCl
Epinephrine Injection	<b>Breast Cancer Preventive Medications</b>
Symjepi	Anastrozole 1mg Tablet
<b>Asthma</b>	Exemestane 25mg Tablet
Albuterol MDI (generic ProAir HFA)	Raloxifene 60mg Tablet
Albuterol MDI (generic Proventil HFA)	Tamoxifen 10mg & 20mg Tablet
Albuterol Nebulized Solution	<b>HIV PrEP (pre-exposure prophylaxis)</b>
<b>Birth Control</b>	Apretude 600mg ER Injection
All oral contraceptives (generic only)	Descovy 200-25mg Tablet
Annovera (vaginal ring)	Emtricitabine-Tenofovir Disoproxil Fumarate 200-300mg Tablet
Kyleena (intrauterine device)	<b>Hypoglycemia (low blood sugar)</b>
Liletta (intrauterine device)	Baqsimi
Medroxyprogesterone 150mg/mL injection	Glucagon
Mirena (intrauterine device)	Zegalogue
Nexplanon (contraceptive implant)	<b>Insulin</b>
EluRyng (vaginal ring)	Humalog
Haloette (vaginal ring)	Humulin
Skyla (intrauterine device)	Lantus
Xulane (patch)	Lyumjev
Zafemy (patch)	Toujeo
<b>Bowel Prep Products</b>	<b>Opioid Overdose Treatment</b>
GaviLyte-C	Kloxxado
GaviLyte-G	Naloxone Cartridge, Injection, Nasal Spray & Prefilled Syringe
GaviLyte-N	
PEG-3350/Electrolytes	

Narcan Nasal Spray

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Zimhi

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**Statins for High Cholesterol**

Atorvastatin 10mg, 20mg, 40mg & 80mg Tablet

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Lovastatin 10mg, 20mg & 40mg Tablet

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Simvastatin 5mg, 10mg, 20mg & 40mg Tablet

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**Tobacco Cessation Medications**

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Bupropion 150mg Tablet SR

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Nicotrol Inhaler

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Nicotrol Nasal Spray

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Varenicline 0.5mg & 1mg Tablet

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## Lower-cost non-Medicare prescription drugs

These preventive drugs are covered in addition to the drugs in your plan's Drug List (Formulary).<sup>2</sup>

The amount you pay for these additional preventive drugs **does not apply to your Medicare Part D out-of-pocket costs**. Payments made for these drugs (made by you or the plan) are treated differently from payments made for the drugs in your plan's Drug List (Formulary).

**The following drugs have a \$0 copayment.**

### Colon preparation products

Bisacodyl Tablet

Bisacodyl Suppository

Magnesium Citrate Solution

Polyethylene Glycol Powder

### Blood Clot Prevention

Aspirin (generic only)

### Tobacco cessation medications

Nicotine Gum

Nicotine Lozenges

Nicotine Patches

### Vitamins

Folic Acid 0.4mg, 0.8mg & 1mg Tablet

<sup>1</sup>Information about the appeals and grievance process for these prescription drugs can be found in your Evidence of Coverage.

<sup>2</sup>This non-Medicare drug coverage is in addition to your Medicare drug coverage. Unlike your Medicare drug coverage, you cannot file a Medicare appeal or grievance for non-Medicare drug coverage. If you have questions, please call Customer Service using the information on the cover of this book.

## **Bonus drug list**

Your employer group or plan sponsor offers a bonus drug list. The prescription drugs on this list are covered in addition to the drugs on the plan's Drug List (Formulary).

The drug tier for each prescription drug is shown on the list.

Although you pay the same copay or coinsurance for these drugs as shown in the Summary of Benefits and Evidence of Coverage, the amount you pay for these additional prescription drugs **does not apply to your Medicare Part D out-of-pocket costs**. However, these costs will apply to your annual drug out-of-pocket maximum.

Coverage for the prescription drugs on the bonus drug list is in addition to your Part D drug coverage. Unlike your Part D drug coverage, you are unable to file a Medicare appeal or grievance for drugs on the bonus drug list. If you have questions, please call Customer Service using the information on the cover of this book.

If you get Extra Help from Medicare to pay for your prescription drugs, it will not apply to the drugs on this bonus drug list.

This is not a complete list of the prescription drugs available to you or the restrictions and limitations that may apply through the bonus drug list. If your drug has any coverage rules or limits, there will be code(s) in the "Coverage rules or limits on use" column of the chart. The codes and what they mean are shown below. If you have questions about drug coverage, please call Customer Service using the information on the cover of this book.

### **QL - Quantity limits**

The plan only covers a certain amount of this drug for one copay or over a certain number of days. These limits may be in place to ensure safe and effective use of the drug.

### **MME - Morphine milligram equivalent**

Additional quantity limits may apply across all drugs in the opioid class used for the treatment of pain. This additional limit is called a cumulative morphine milligram equivalent (MME), and is designed to monitor safe dosing levels of opioids for individuals who may be taking more than one opioid drug for pain management. If your doctor prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor can ask the plan to cover the additional quantity.

### **7D - 7-day limit**

An opioid drug used for the treatment of acute pain may be limited to a 7-day supply for members with no recent history of opioid use. This limit is intended to minimize long-term opioid use. For members who are new to the plan and have a recent history of using opioids, the limit may be overridden by the pharmacy when appropriate.

### **DL - Dispensing limit**

Dispensing limits apply to this drug. This drug is limited to a one-month supply per prescription.

<b>Drug name</b>	<b>Drug tier</b>	<b>Coverage rules or limits on use</b>
<b>Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions</b>		
<b>Inflammation</b>		
Salsalate	1	
<b>Urinary Tract Pain</b>		
Phenazopyridine	1	
<b>Anticoagulants - drugs to prevent clotting</b>		
Heparin Lock Flush	1	
<b>Anti-obesity agents - drugs to promote weight loss</b>		
<b>Alli</b>	3	QL (maximum of 3 capsules per day)
<b>Contrave</b>	3	QL (maximum of 4 tablets per day)
<b>Imcivree</b>	3	QL (maximum of 9 vials (9 mL) per 30 days)
Phentermine	1	QL (maximum of 1 capsule/tablet per day)
<b>Qsymia</b>	3	QL (maximum of 1 capsule per day)
<b>Saxenda</b>	3	QL (maximum of 5 pens per 30 days)
<b>Wegovy</b>	3	QL (maximum of 4 pens per 28 days)
<b>Dermatological agents - drugs to treat skin conditions</b>		
<b>Dry, Itchy Skin</b>		
Sulfacetamide Sodium Liquid Wash 10%	1	
Sulfacetamide Sodium w/Sulfur Cream 10-5%	1	
<b>Itching or Pain</b>		
Pramoxine/Hydrocortisone Cream 1-2.5%	1	
<b>Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions</b>		
<b>Hemorrhoids</b>		
Hydrocortisone Acetate Suppository 25 mg	1	

**Bold type = Brand name drug** Plain type = Generic drug

<b>Drug name</b>	<b>Drug tier</b>	<b>Coverage rules or limits on use</b>
Lidocaine/Hydrocortisone Perianal Cream 3%-0.5%	1	
<b>Irritable Bowel or Ulcers</b>		
Hyoscyamine Sulfate	1	
<b>Levbid</b>	3	
<b>Genitourinary agents - drugs to treat bladder, genital and kidney conditions</b>		
<b>Erectile Dysfunction</b>		
<b>Edex</b>	3	QL (maximum of 6 cartridges per month)
Sildenafil (25 mg, 50 mg, 100 mg)	1	QL (maximum of 6 tablets per month)
Tadalafil	1	QL (maximum of 6 tablets per month)
Vardenafil	1	QL (maximum of 6 tablets per month)
<b>Sexual Desire Disorder</b>		
<b>Addyi</b>	3	QL (maximum of 1 tablet per day)
<b>Vyleesi</b>	3	QL (maximum of 8 injections per 30 days)
<b>Urinary Tract Infection</b>		
<b>Uro-MP 118 mg</b>	3	
<b>Urinary Tract Spasm and Pain</b>		
Belladonna Alkaloids & Opium Suppositories	1	MME, 7D, DL
<b>Hormonal agents - hormone replacement/modifying drugs</b>		
<b>Thyroid Supplement</b>		
<b>Armour Thyroid</b>	3	
NP Thyroid	1	
<b>Nutritional supplements - drugs to treat vitamin &amp; mineral deficiencies</b>		
<b>Potassium Supplement</b>		

**Bold type = Brand name drug** Plain type = Generic drug



<b>Drug name</b>	<b>Drug tier</b>	<b>Coverage rules or limits on use</b>
<b>K-Phos Tab</b>	3	
Potassium Bicarbonate Effervescent Tab 25 mEq	1	
<b>Vitamins and Minerals</b>		
Cyanocobalamin Injection (Vitamin B12) 1000 mcg	1	
Folic Acid 1 mg (Rx only)	1	
Folic Acid-Vitamin B6-Vitamin B12 Tablet 2.5-25-1 mg	1	
Phytonadione Tab	1	
Reno Cap	1	
Vitamin D 50,000 unit (Rx only)	1	
<b>Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions</b>		
<b>Cough and Cold</b>		
Benzonatate (100 mg, 200 mg)	1	
Brompheniramine/Pseudoephedrine/ Dextromethorphan Syrup	1	
Guaifenesin/Codeine Syrup	1	DL
Hydrocodone Polst/Chlorpheniramine ER Susp (generic for Tussionex)	1	DL
Hydrocodone/Homatropine	1	DL
Promethazine/Codeine Syrup	1	DL
Promethazine/Dextromethorphan Syrup	1	

**Bold type = Brand name drug** Plain type = Generic drug

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

Benefits and/or copayments/coinsurance may change each plan/benefit year.

The Drug List may change at any time. You will receive notice when necessary.

This information is available for free in other languages. Please call our Customer Service number on the cover.

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