

2018 SUMMARY OF BENEFITS



Overview of your plan

UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (Plan Sponsor): NEW ENGLAND ANNUAL CONF OF THE METHODIST
CHURCH

Group Number: 13850

H2001-816

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



Toll-Free **1-877-714-0178**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week



www.UHCRetiree.com



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

Summary of Benefits

January 1, 2018 - December 31, 2018

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 or you can call Customer Service with questions you may have. You get an EOC when you enroll in the plan.

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 inside the cover, 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).

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 Medicare. 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 an in-network pharmacy.

You can go to www.UHCRetiree.com to search for a network provider or pharmacy using the online directories. You can also view the plan formulary (drug list) 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.	
Annual Medical Deductible	\$500 per year for some in-network and out-of-network services.	
Maximum Out-of-Pocket Amount (does not include prescription drugs)	<p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$1,500 each plan year.</p> <p>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.</p> <p>Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.</p>	

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	\$15 copay	\$15 copay
	Specialists	\$20 copay	\$20 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		<p>\$0 copay (worldwide)</p> <p>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.</p>	
Urgently Needed Services		<p>\$0 copay (worldwide)</p> <p>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.</p>	<p>\$0 copay (worldwide)</p> <p>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.</p>
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
Hearing Services	Exam to diagnose and treat hearing and balance issues	\$20 copay	\$20 copay

Benefits		In-Network	Out-of-Network
	Routine hearing exam	\$0 copay (1 exam every 12 months)*	\$0 copay (1 exam every 12 months)*
	Hearing Aids	Plan pays up to \$500 (every 3 years)*	Plan pays up to \$500 (every 3 years)*
Vision Services	Exam to diagnose and treat diseases and conditions of the eye	\$20 copay	\$20 copay
	Eyewear after cataract surgery	\$0 copay	\$0 copay
	Routine eye exams	\$20 copay (1 exam every 12 months)*	\$20 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	\$15 copay	\$15 copay
	Outpatient individual therapy visit	\$20 copay	\$20 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.	
Physical Therapy and speech and language therapy visit		\$0 copay	\$0 copay
Ambulance		\$0 copay	\$0 copay
Routine Transportation		Not covered	

Benefits

		In-Network	Out-of-Network
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	\$10 copay	\$20 copay
Tier 2: Preferred Brand	20% coinsurance, with a \$45 copay maximum	20% coinsurance, with a \$120 copay maximum
Tier 3: Non-Preferred Drugs	20% coinsurance, with a \$90 copay maximum	25% coinsurance, with a \$225 copay maximum
Tier 4: Specialty Tier	20% coinsurance, with a \$90 copay maximum	25% coinsurance, with a \$225 copay maximum
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	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,000, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$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	\$20 copay	\$20 copay
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
	Wigs after Chemotherapy (for hair loss that is a result of Chemotherapy)	Up to a \$300 allowance for wigs/hairpieces (cranial prosthesis) every 12 months.*	Up to a \$300 allowance for wigs/hairpieces (cranial prosthesis) every 12 months.*

Additional Benefits		In-Network	Out-of-Network
Fitness program through SilverSneakers® Fitness program		<p>\$0 membership fee.</p> <p>Monthly basic membership for SilverSneakers through network fitness centers.</p> <p>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.</p>	
Foot Care (podiatry services)	Foot exams and treatment	\$20 copay	\$20 copay
	Routine foot care*	\$20 copay for each visit (Up to 6 visits per plan year)*	\$20 copay for each visit (Up to 6 visits per plan year)*
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		\$0 copay	\$0 copay
Outpatient Substance Abuse	Outpatient group therapy visit	\$15 copay	\$15 copay
	Outpatient individual therapy visit	\$20 copay	\$20 copay
Outpatient surgery		\$0 copay	\$0 copay

Additional Benefits	In-Network	Out-of-Network
Private duty nursing	<p>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.</p> <p>Covered services include nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) delivered to a covered individual who is confined in the home due to a medical condition.</p> <p>Note: Custodial and domestic services are not covered.</p> <p>If covered private duty nursing services are received before you reach the out-of-pocket maximum, you pay a 20% coinsurance for each visit. The amounts you pay do not apply to the out-of-pocket maximum. There is a \$5,000 limit per plan year for private duty nursing services. Once the plan has paid \$5,000 in a plan year, you are responsible to pay all charges for the remainder of the plan year.</p>	
Renal Dialysis	\$0 copay	\$0 copay
Virtual Doctor Visits	<p>Speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com.</p>	

*Benefits are combined in and out-of-network

Required Information

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

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

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

You must continue to pay your Medicare Part B premium.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage 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.

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 <https://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.