2017 Summary of BENEFITS

UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (Plan Sponsor): GREATER NJ ANNUAL CONF UMC
Group Number: 12369

H2001-816

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

This is a summary of drug coverages and health services provided by UnitedHealthcare® Group Medicare Advantage (PPO)
January 1, 2017 - December 31, 2017.

For more information, please contact Customer Service at:

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

www.UHCRetiree.com

UnitedHealthcare®

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Summary of Benefits

January 1, 2017 - December 31, 2017

We're dedicated to providing clear and simple information about your plan so you always stay fully informed. The following information is a breakdown of what we cover and what you pay. This is called "cost-sharing" or "out-of-pocket" costs. Cost-sharing includes co-pays, co-insurance and deductibles. This will help you control your health care costs throughout the plan year.

Keep in mind that this isn't a full list of benefits we provide, it's just an overview. To get a complete list, visit our website at www.UHCRetiree.com to see the "Evidence of Coverage" or call customer service with any questions.

About this plan.

UnitedHealthcare® Group Medicare Advantage (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join UnitedHealthcare® Group Medicare Advantage (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed on the cover, and 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).

What's inside?

Plan Premiums and Benefits

See plan costs including information about the monthly premium, deductible and maximum out-of-pocket limit.

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies, and other providers. You can see any provider (in-network or out-of-network) that participates in Medicare and accepts the plan at the same cost share. Your copays or coinsurance will be the same.

You can search for a network provider and pharmacy in the online directories at www.UHCRetiree.com.

Drug Coverage

Look to see what drugs are covered along with any restrictions in our plan formulary (list of Part D prescription drugs) found at www.UHCRetiree.com.

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 $1,250 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 Coverage		$0 co-pay per admit	$0 co-pay per admit
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Doctor Visits	Primary	$5 co-pay	$5 co-pay
	Specialists	$10 co-pay	$10 co-pay
Preventive Care	Medicare-covered	$0 co-pay	$0 co-pay
	Routine physical	$0 co-pay; 1 per plan year*	$0 co-pay; 1 per plan year*
Emergency care		$0 co-pay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Emergency co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.	
Urgently needed services		$0 co-pay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Urgently Needed Services co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.	$0 co-pay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Urgently Needed Services co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.

Benefits		In-Network	Out-of-Network
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)	$0 co-pay	$0 co-pay
	Lab services	$0 co-pay	$0 co-pay
	Diagnostic tests and procedures	$0 co-pay	$0 co-pay
	Therapeutic radiology	$0 co-pay	$0 co-pay
	Outpatient x-rays	$0 co-pay	$0 co-pay
Hearing Services	Exam to diagnose and treat hearing and balance issues	$10 co-pay	$10 co-pay
	Routine hearing exam	$0 co-pay (1 exam every 12 months)*	$0 co-pay (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	$10 co-pay	$10 co-pay
	Eyewear after cataract surgery	$0 co-pay	$0 co-pay
	Routine eye exams	$10 co-pay (1 exam every 12 months)*	$10 co-pay (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.*

Benefits		In-Network	Out-of-Network
Mental Health Care	Inpatient visit	$0 co-pay per admit, up to 190 days	$0 co-pay per admit, up to 190 days
		Our plan covers 190 days for an inpatient hospital stay.	
	Outpatient group therapy visit	$5 co-pay	$5 co-pay
	Outpatient individual therapy visit	$10 co-pay	$10 co-pay
Skilled nursing facility (SNF)		$0 co-pay per day: days 1-100	$0 co-pay per day: days 1-100
		Our plan covers up to 100 days in a SNF	
Rehabilitation Services	Occupational therapy visit	$0 co-pay	$0 co-pay
	Physical therapy and speech and language therapy visit	$0 co-pay	$0 co-pay
Ambulance		$0 co-pay	$0 co-pay
Routine Transportation		Not covered	
Foot Care (podiatry services)	Foot exams and treatment	$10 co-pay	$10 co-pay
	Routine foot care*	$10 co-pay for each visit (Up to 6 visits per plan year)*	$10 co-pay for each visit (Up to 6 visits per plan year)*

Benefits		In-Network	Out-of-Network
Medical Equipment / Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	$0 co-pay	$0 co-pay
	Prosthetics (e.g., braces, artificial limbs)	$0 co-pay	$0 co-pay
	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.*
Wellness Programs	Fitness program through SilverSneakers	$0 membership fee. Monthly basic membership for SilverSneakers through network fitness centers. 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.	
Medicare Part B Drugs	Chemotherapy drugs	$0 co-pay	$0 co-pay
	Other Part B drugs	$0 co-pay	$0 co-pay

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 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 co-pay	$20 co-pay
Tier 2: Preferred Brand	20% of the cost, with a $45 co-pay maximum	20% of the cost, with a $120 co-pay maximum
Tier 3: Non-Preferred Drugs	20% of the cost, with a $90 co-pay maximum	25% of the cost, with a $225 co-pay maximum
Tier 4: Specialty Tier	20% of the cost, with a $90 co-pay maximum	25% of the cost, with a $225 co-pay maximum
Stage 3: Coverage Gap Stage	After your total drug costs reach $3,700, 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	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of $3.30 co-pay for generic (including brand drugs treated as generic), $8.25 co-pay for all other drugs.	

Additional Benefits		In-Network	Out-of-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation	$10 co-pay	$10 co-pay
	Routine Chiropractic Care	$10 co-pay (Up to 12 visits per plan year)*	$10 co-pay* (Up to 12 visits per plan year)
Diabetes Management	Diabetes monitoring supplies	$0 co-pay We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2 System, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio® Sync, OneTouch Verio® IQ, OneTouch Verio® Flex System Kit, ACCU-CHEK® Nano SmartView, and ACCU-CHEK® Aviva Plus.	$0 co-pay We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2 System, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio® Sync, OneTouch Verio® IQ, OneTouch Verio® Flex System Kit, ACCU-CHEK® Nano SmartView, and ACCU-CHEK® Aviva Plus.
	Diabetes Self-management training	$0 co-pay	$0 co-pay
	Therapeutic shoes or inserts	$0 co-pay	$0 co-pay
Home health care		$0 co-pay	$0 co-pay
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
Private duty nursing		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. 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. Note: Custodial and domestic services are not covered. If covered private duty nursing services are received before you reach the out-of-pocket maximum, you pay 20% of the cost 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.	
NurseLine℠		Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Outpatient surgery		$0 co-pay	$0 co-pay
Outpatient Substance Abuse	Outpatient group therapy visit	$5 co-pay	$5 co-pay
	Outpatient individual therapy visit	$10 co-pay	$10 co-pay
Renal Dialysis		$0 co-pay	$0 co-pay
Virtual Doctor Visits		Speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com.	

*Benefits are combined in and out-of-network

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 on January 1 of each year.

You must continue to pay your Medicare Part B premium.

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.

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 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.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-877-714-0178.

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, just call us at 1-877-714-0178. Someone who speaks English/ Language can help you. This is a free service

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-714-0178. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-877-714-0178。 我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電1-877-714-0178。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-714-0178. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-714-0178. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-714-0178 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-714-0178. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-877-714-0178번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-714-0178. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-778-417-8710 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-714-0178 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-714-0178. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-714-0178. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-714-0178. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-714-0178. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-714-0178 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。