UnitedHealthcare

Group Medicare Advantage PPO
Prepared for PEBA

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Description	Package 1 — Medicare Advantage PPO 1 (with PDP) In-Network Services	Package 1 — Medicare Advantage PPO 1 (with PDP) Out-of-Network Services	Package 2 & 3 — Medicare Advantage PPO 2 (with PDP) In-Network Services	Package 2 & 3 — Medicare Advantage PPO 2 (with PDP) Out-of-Network Services
Annual Medical Deductible	None		None	
Annual Medical Out-of-Pocket Maximum	$0		$2,400	
Is Annual Medical Out-of-Pocket Maximum combined for IN and OUT of network?	Yes		Yes	
PHYSICIAN SERVICES				
Primary Care Physician Office Visit (includes Non-MD office visits)	$0	$0	$10	$10
Specialist Office Visit	$0	$0	$20	$20
Virtual Office Visit	$0	$0	$0	$0
Telemedicine	$0	$0	$0	$0
INPATIENT SERVICES				
Inpatient Hospital Stay	$0 Per Admit	$0 Per Admit	$500 Per Admit	$500 Per Admit
Skilled Nursing Facility Care - prior hospital stay requirement waived	Yes	Yes	Yes	Yes
Skilled Nursing Facility Care - Benefit Period (In days)	100 Days		100 Days	
Skilled Nursing Facility Care	$0 Per Day (Days 1-100)	$0 Per Day (Days 1-100)	$0 Per Day (Days 1-20) $75 Per Day (Days 21-100)	$0 Per Day (Days 1-20) $75 Per Day (Days 21-100)
Inpatient Mental Health Lifetime Maximum number of days	190 Days		190 Days	
Inpatient Mental Health in a Psychiatric Hospital	$0 Per Admit	$0 Per Admit	$500 Per Admit	$500 Per Admit
OUTPATIENT SERVICES				
Outpatient Surgery	$0	$0	$250	$250
Outpatient Hospital Services	$0	$0	$250	$250
Outpatient Mental Health/Substance Abuse (Individual Visit)	$0	$0	$20	$20
Outpatient Mental Health/Substance Abuse (Group Visit)	$0	$0	$10	$10
Partial Hospitalization (Mental Health Day Treatment) per day	$0	$0	$55	$55
Comprehensive Outpatient Rehabilitation Facility (CORF)	$0	$0	$25	$25
Occupational Therapy	$0	$0	$25	$25
Physical Therapy and Speech/Language Therapy	$0	$0	$25	$25
Cardiac/Pulmonary Rehabilitation	$0	$0	$25	$25
Kidney Dialysis	$0	$0	20%	20%
MEDICARE-COVERED SPECIALIST VISITS				
Chiropractic Visit (Medicare-covered)	$0	$0	$20	$20
Podiatry Visit (Medicare-covered)	$0	$0	$20	$20
Eye Exam (Medicare-covered)	$0	$0	$20	$20
Eyewear (Medicare-covered Frames and Lenses after cataract surgery)	$0	$0	$0	$0
Hearing Exam (Medicare-covered)	$0	$0	$20	$20
Dental Services (Medicare-covered)	$0	$0	$20	$20

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	Package 1		Package 2 & 3	
	Medicare Advantage PPO 1 (with PDP)		**Medicare Advantage PPO 2** (with PDP)	
AMBULANCE/EMERGENCY ROOM/URGENT CARE				
Ambulance Services	$0	$0	$100	$100
Ambulance Copay Waived if Admitted	No	No	No	No
Emergency Room (Includes Worldwide Coverage)	$0	$0	$90	$90
Emergency Room Copay Waived if Admitted within 24 hours	Yes	Yes	Yes	Yes
Urgently Needed Care (Includes Worldwide Coverage)	$0	$0	$35	$35
Urgent Care Copay Waived if Admitted within 24 hours	Yes	Yes	Yes	Yes
PART B DRUGS AND BLOOD				
Part B Drugs - Immunosuppressives, Anti-nausea, Inhalation Solutions, Hemophilia Clotting Factors, Antigens, Outpatient Injectable medications administered in a Physician's Office	$0	$0	20%	20%
Chemotherapy Drugs	$0	$0	20%	20%
Blood	$0	$0	$0	$0
Blood 3 pint deductible waived	Yes	Yes	Yes	Yes
DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES				
Durable Medical Equipment	$0	$0	20%	20%
Prosthetics	$0	$0	20%	20%
Orthotics	$0	$0	20%	20%
Diabetic Shoes and Inserts	$0	$0	20%	20%
Medical Supplies	$0	$0	20%	20%
Diabetes Monitoring Supplies	$0	$0	$0	$0
Insulin Pumps & Supplies	$0	$0	20%	20%
HOME HEALTHCARE AGENCY & HOSPICE				
Home Health Services	$0	$0	$0	$0
Hospice (Medicare-covered)	$0	$0	$0	$0
PROCEDURES				
Clinical Laboratory Services	$0	$0	$10	$10
Outpatient X-ray Services	$0	$0	$10	$10
Diagnostic Procedure/Test (includes non-radiological diagnostic services)	$0	$0	10%	10%
Diagnostic Radiology Service	$0	$0	$25	$25
Therapeutic Radiology Service	$0	$0	$25	$25
PREVENTIVE SERVICES (MEDICARE-COVERED)				
Cardiovascular Screenings	$0	$0	$0	$0
Immunizations (Flu, Pneumococcal, Hepatitis B Vaccines)	$0	$0	$0	$0
Pap Smears and Pelvic Exams	$0	$0	$0	$0
Prostate Cancer Screening	$0	$0	$0	$0
Colorectal Cancer Screenings	$0	$0	$0	$0
Bone Mass Measurement (Bone Density)	$0	$0	$0	$0
Mammography	$0	$0	$0	$0
Diabetes - Self-Management Training	$0	$0	$0	$0
Medical Nutrition Therapy and Counseling	$0	$0	$0	$0
Annual Wellness Exam and One-time Welcome-to-Medicare Exam	$0	$0	$0	$0
Smoking Cessation Visit	$0	$0	$0	$0

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	Package 1		Package 2 & 3	
	Medicare Advantage PPO 1 (with PDP)		**Medicare Advantage PPO 2** (with PDP)	
Abdominal Aortic Aneurysm (AAA) Screenings	$0	$0	$0	$0

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	Package 1		Package 2 & 3	
	Medicare Advantage PPO 1 (with PDP)		**Medicare Advantage PPO 2** (with PDP)	
Diabetes Screening	$0	$0	$0	$0
HIV Screening	$0	$0	$0	$0
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	$0	$0	$0	$0
Screening for Depression in Adults	$0	$0	$0	$0
Screening for Sexually Transmitted Infections (STIs) and high intensity Behavioral Counseling to prevent STIs	$0	$0	$0	$0
Intensive Behavioral Therapy to reduce Cardiovascular Disease Risk	$0	$0	$0	$0
Screening and Counseling for Obesity	$0	$0	$0	$0
Glaucoma Screening	$0	$0	$0	$0
Kidney Disease Education	$0	$0	$0	$0
Dialysis Training	$0	$0	$0	$0
Hepatitis C Screening	$0	$0	$0	$0
Lung Cancer Screening	$0	$0	$0	$0
ADDITIONAL BENEFITS/PROGRAMS (Non Medicare-covered)				
Routine Podiatry	$0	$0	$20	$20
Routine Podiatry - Number of visits per year	6 Visits		6 Visits	
Routine Eye Exam Refraction - every 12 months	$0	$0	$20	$20
Routine Hearing Exam for Hearing Aids - every 12 months	$0	$0	$0	$0
Hearing Aid Allowance - includes Digital Hearing Aids	$500		$500	
Benefit per ear or combined	Combined		Combined	
Number of Hearing Aids	Unlimited		Unlimited	
Hearing Aid period in months	36 Months		36 Months	
Annual Routine Physical Exam	$0	$0	$0	$0
WELLNESS / CLINICAL PROGRAMS				
Fitness Program	Included		Included	
Caregiver	Included		Included	
NurseLine	Included		Included	
Access Support	Included		Included	
Condition Management - Chronic Heart Failure (CHF)	Included		Included	
Condition Management - Coronary Artery Disease (CAD) / Diabetes	Included		Included	
Condition Management - End Stage Renal Disease (ESRD)	Included		Included	
Group Retiree Case Management	Included		Included	
Advanced Illness Care Management	Included		Included	
Preferred Diabetic Supply Program	Included		Included	
Hi Health Hearing Aid Discount Program. Please note: *Not available in American Samoa, Guam, Northern Mariana Islands and Puerto Rico*	Included		Included	
HouseCalls Program	Included		Included	

UnitedHealthcare
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	Package 1 Medicare Advantage PPO 1 (with PDP)	Package 2 & 3 Medicare Advantage PPO 2 (with PDP)
OUTPATIENT PRESCRIPTION DRUG COVERAGE		
Prescription Drug Plan	Custom Plan	Custom Plan
Part D Gap Coverage	**Full Gap Coverage**	**Tier 1 Only Gap Coverage**
Formulary	Standard Formulary H	Standard Formulary H
Bonus Drug List	None	None
Formulary Edits (step therapy, quantity limits, prior authorization)	Standard: Edits On	Standard: Edits On
Rx Deductible	**None**	**None**
Part D Retail Copay (up to a 30 day supply) Note: 90 day retail supply is available for 3X copay amount		
Tier 1: Generic	**$5**	**$5**
Tier 2: Preferred Brand	**$25**	**$25**
Tier 3: Non-Preferred Brand	**$60**	**$60**
Tier 4: Specialty Tier	**33%**	**33%**
Part D Preferred Mail Order Copay (up to a 90 day supply)		
Tier 1: Generic	**$10**	**$10**
Tier 2: Preferred Brand	**$50**	**$50**
Tier 3: Non-Preferred Brand	**$120**	**$120**
Tier 4: Specialty Tier	**33%**	**33%**
Initial Coverage Limit	$3,820	$3,820
TrOOP Threshold	$5,100	$5,100
Catastrophic Coverage over TrOOP (greater amount of)	2019 Standard CMS Values	2019 Standard CMS Values
Copay for generics	$3.40	$3.40
Copay for all other drugs	$8.50	$8.50
OR Coinsurance	5%	5%

UnitedHealthcare

Group Senior Supplement Plan F
Prepared for PEBA TAC IEBP

This Plan may be purchased with or without a Medicare Prescsritpion Drug Plan (Part D).

		Package 1		Package 2		Package 3	
		Senior Supplement Plan F		Senior Supplement - Plan K		Senior Supplement Plan D	
BENEFITS	ORIGINAL MEDICARE PAYS:	PLAN F PAYS:	MEMBER PAYS:	PLAN K PAYS:	MEMBER PAYS:	PLAN D PAYS:	MEMBER PAYS:
HOSPITALIZATION (All Covered Inpatient Hospitalization including Inpatient Mental Health, Alcohol/Drug/Substance Abuse): Semiprivate room and board, general nursing and miscellaneous services and supplies.							
Part A Deductible	Not Covered	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Part A Hospital - Days 1 - 60	Medicare Pays 100% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	$0
Part A Hospital - Days 61 - 90	Medicare Pays Medicare Allowable Amount Except for Published Copayment Per Day Rate.	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	$0
Part A Hospital - Days 91 - 150 *(These are Medicare's 60 Lifetime Reserve Days)*	Medicare Pays Medicare Allowable Amount Except for Published Copayment Per Day Rate.	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	$0
Part A Hospital - Days 151 + *(These are Non-Medicare- covered 365 Additional Lifetime Reserve Days)*	Not Covered	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	$0
Part A Hospital - Unlimited Days Coverage *(Beyond 365 Additional Lifetime Reserve Days)*	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
SKILLED NURSING FACILITY CARE The Member must meet all Medicare requirements, including a prior hospital stay of at least 3 days and admittance to a Medicare- approved SNF facility within 30 days after leaving the hospital.							
SNF Days 1 - 20	Medicare Pays 100% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	$0
Days 21 - 100 (Part A Coinsurance)	Medicare Pays Medicare Allowable Amount Except for Published Per Day Rate.	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Day 101 - and after (Part A Coinsurance)	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
HOSPICE CARE Part A Medicare Covered Expenses and Inpatient Respite Care	Generally Medicare Pays 100% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
HOME HEALTH CARE	Generally Medicare Pays 100% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	$0
OUTPATIENT BENEFITS							
Medicare Part B Deductible	Not Covered	Plan Pays Remaining After Member Cost Share	0%	Plan Pays Remaining After Member Cost Share	50%	50%	50%
Durable Medical Equipment	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Physician Office Visit	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Specialist Office Visit	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Virtual Office Visit	Not Covered	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	$0
Telemedicine	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	$0
Emergency Room	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Ambulance Services	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Medical and Surgical Services	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Medical and Surgical Supplies	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Physical and Speech Therapy	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0
Diagnostic Procedures and Tests	Generally Medicare Pays 80% of Medicare Allowable Amount	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Plan Pays Remaining After Member Cost Share	$0

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Group Senior Supplement Plan F
Prepared for PEBA TAC IEBP

This Plan may be purchased with or without a Medicare Prescsritpion Drug Plan (Part D).

		Package 1		Package 2		Package 3	
		Senior Supplement Plan F		Senior Supplement - Plan K		Senior Supplement Plan D	
BENEFITS	**ORIGINAL MEDICARE PAYS:**	**PLAN F PAYS:**	**MEMBER PAYS:**	**PLAN K PAYS:**	**MEMBER PAYS:**	**PLAN D PAYS:**	**MEMBER PAYS:**
MEDICARE PREVENTIVE CARE SERVICES:	**Medicare Pays 100% of Medicare Allowable Amounts for the following Preventive Benefits:** 1. Abdominal Aortic Aneurysm Screening 2. Alcohol Misuse Counseling 3. Annual Wellness Visit 4. Bone Mass Measurement 5. Breast Cancer Screening (Mammograms) 6. Cardiovascular Screenings 7. Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) 8. Colon Cancer Screening (Colorectal) 9. Depression Screening 10. Diabetes Screenings 11. Diabetes Self-Management Training 12. Flu Shots 13. Glaucoma Tests 14. HIV Screening 15. Hepatitis B Shots 16. Medical Nutrition Therapy Services 17. Obesity Screening and Counseling 18. Pneumococcal Shot 19. Prostate Cancer Screenings (PSA Test Only) 20. Sexually Transmitted Infections Screening and Counseling 21. Smoking Cessation 22. Welcome to Medicare Physical Exam	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	$0
PART B EXCESS CHARGES: (The Difference Between Medicare Allowable Amount and Up to 115% of Medicare Allowable Amount)	Not Covered	Plan Pays Remaining After Member Cost Share	$0	Plan Pays Remaining After Member Cost Share	50%	Not Covered	100%
Additional Non-Medicare-Covered Benefits							
FOREIGN TRAVEL: **Benefit Deductible** $250 *(Does Not Apply Towards either Plan Deductible or Towards OOP Annual Maximum)*	Not Covered	Not Covered	$250	Not Covered	100%	Not Covered	$250
FOREIGN TRAVEL: Remainder of Covered Costs after Foreign Travel Benefit Deductible is met. *(Note:This benefit has a Lifetime Maximum Coverage Amount)*	Not Covered	After $250 deductible, Covers balance at 80% payment, up to lifetime maximum benefit of $50,000	20%	Not Covered	100%	After $250 deductible, Covers balance at 80% payment, up to lifetime maximum benefit of $50,000	20%
FITNESS	Not Covered	Included	$0	Included	$0	Included	$0
CAREGIVER	Not Covered	Included	$0	Included	$0	Included	$0
NURSELINE	Not Covered	Included	$0	Included	$0	Included	$0
Annual Routine Physical Exam (not covered by Medicare)	Not Covered	Included	$0	Included	$0	Included	$0
Hi Health Hearing Aid Discount Program: *Please note: Not available in American Samoa, Guam, Northern Mariana Islands and Puerto Rico*	Not Covered	Included	Included	Included	Included	Included	Included
Preventive Care Services: (Non-Medicare-Covered)	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Home Health Recovery (Non-Medicare-Covered)	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Private Duty Nursing	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Routine Hearing Exam	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Hearing Aids	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Routine Eye Exam	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Eyewear: Eyeglasses and Contacts Allowance	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Routine Podiatry	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Acupuncture	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%
Chiropractic Services	Not Covered	Not Covered	100%	Not Covered	100%	Not Covered	100%

UnitedHealthcare
Group Retiree Part D Plan
Prepared for PEBA TAC IEBP

This Plan may only be purchased with a Medicare Senior Suppplemental Plan.

Benefits & Coverage	Package 1 PDP Plan 1	Package 2 PDP Plan 2	Package 3 PDP Plan 3
Plan Information			
Service Area	National	National	National
Prescription Drug Plan	Custom Plan Design	Custom Plan Design	Custom Plan Design
Part D Gap Coverage	**Full Gap Coverage**	**Tier 1 Only Gap Coverage**	**Full Gap Coverage**
Formulary	**Standard Formulary H**	**Standard Formulary G**	**Standard Formulary H**
Bonus Drug List	Not Included	Not Included	Not Included
Non-OptumRx Mail Order Network	Included	Included	Included
Formulary Edits (step therapy, quantity limits, prior authorization)	Standard Edits: On	Standard Edits: On	Standard Edits: On
Rx Deductible	**None**	**None**	**None**
Part D Retail Copay (up to a 30 day supply) Note: 90 day retail supply is available for 3X copay amount			
Tier 1: Generic	$5	$5	$10
Tier 2: Preferred Brand	$25	$25	$30
Tier 3: Non-Preferred Brand	$60	$60	$65
Tier 4: Specialty Tier	33%	33%	33%
Part D Preferred Mail Order Copay (up to a 90 day supply)			
Tier 1: Generic	$10	$10	$20
Tier 2: Preferred Brand	$50	$50	$60
Tier 3: Non-Preferred Brand	$120	$120	$130
Tier 4: Specialty Tier	33%	33%	33%
Initial Coverage Limit	$3,820	$3,820	$3,820
TrOOP Threshold	$5,100	$5,100	$5,100
Catastrophic Coverage over TrOOP (greater amount of)	2019 Standard CMS Values	2019 Standard CMS Values	2019 Standard CMS Values
Copay for generics	$3.40	$3.40	$3.40
Copay for all other drugs	$8.50	$8.50	$8.50
OR Coinsurance	5%	5%	5%
Hi HealthInnovations Discount Hearing Aid Program *Please note: Not available in American Samoa, Guam, Northern Mariana Islands and Puerto Rico.*	**Included**	**Included**	**Included**