Summary of Benefits 2021

Medicare Advantage Plan with Prescription Drugs

UnitedHealthcare® Group Medicare Advantage (PPO)
Group Name (Plan Sponsor): Illinois Department of Central Management Services
State Employees Group Insurance Program (State)
Group Number: 12810

H2001-816-000

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

Toll-free **1-888-223-1092**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.UHCRetiree.com/soi

United Healthcare®

Total Retiree Advantage Illinois
Your Trail to Better Health

Y0066_SB_H2001_816_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/soi 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 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 www.UHCRetiree.com/soi 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.

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	$110 per year for some in-network and out-of-network services.	
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 $1,300 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		15% coinsurance per stay	15% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC)	15% coinsurance	15% coinsurance
	Outpatient surgery	15% coinsurance	15% coinsurance
	Outpatient hospital services, including observation	15% coinsurance	15% coinsurance
Doctor Visits	Primary Care Provider	15% coinsurance	15% coinsurance
	Specialists	15% coinsurance	15% coinsurance
	Virtual Doctor Visits	$0 copay	$0 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 Diabetes – Self-Management training Dialysis training Glaucoma screening Hepatitis C screening	

Benefits

		In-Network	Out-of-Network
		HIV screening Kidney disease education 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)	
		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) 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		15% coinsurance (worldwide) 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.	15% coinsurance (worldwide) 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.

Benefits

		In-Network	Out-of-Network
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)	15% coinsurance	15% coinsurance
	Lab services	15% coinsurance	15% coinsurance
	Diagnostic tests and procedures	15% coinsurance	15% coinsurance
	Therapeutic Radiology	15% coinsurance	15% coinsurance
	Outpatient x-rays	15% coinsurance	15% coinsurance
Hearing Services	Exam to diagnose and treat hearing and balance issues	15% coinsurance	15% coinsurance
	Routine hearing exam	$0 copay (1 exam every 2 plan years)*	$0 copay (1 exam every 2 plan years)*
	Hearing aids (Includes any wearable non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold but excluding batteries and cords.)	Through UnitedHealthcare Hearing, the plan pays up to a $2,500 allowance for hearing aid(s) per ear every 2 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	15% coinsurance	15% coinsurance

Benefits

		In-Network	Out-of-Network
	Eyewear after cataract surgery	$0 copay	$0 copay
Mental Health	Inpatient visit	15% coinsurance per stay	15% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
	Outpatient group therapy visit	15% coinsurance	15% coinsurance
	Outpatient individual therapy visit	15% coinsurance	15% coinsurance
	Virtual Behavioral Visits	15% coinsurance	15% coinsurance
Skilled Nursing Facility (SNF)		15% coinsurance per day	15% coinsurance per day
		Our plan covers unlimited days in a SNF per benefit period.	
Physical Therapy and speech and language therapy visit		15% coinsurance	15% coinsurance
Ambulance[1]		15% coinsurance	15% coinsurance
Routine Transportation		Not covered	
Medicare Part B Drugs	Chemotherapy drugs	15% coinsurance	15% coinsurance
	Other Part B drugs	15% coinsurance	15% coinsurance

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 www.UHCRetiree.com/soi or call Customer Service to have a hard copy sent to you.

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Drug List (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	$125		
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Network retail pharmacy and the plan's mail-order service** (up to a 30-day supply)	**Network retail pharmacy and the plan's mail-order service** (a 31- to 60-day supply)	**Network retail pharmacy and the plan's mail-order service** (a 61- to 90-day supply)
Tier 1: Preferred Generic	$10 copay	$20 copay	$25 copay
Tier 2: Preferred Brand (includes some generics)	$30 copay	$60 copay	$75 copay
Tier 3: Non-preferred Drug (includes some generics)	$60 copay	$120 copay	$150 copay
Tier 4: Specialty Tier	$60 copay	$120 copay	$150 copay
Stage 3: Coverage Gap Stage	After your total drug costs reach $4,130, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost. Your cost is the same as it was in the Initial Coverage Stage.		

Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay whichever is the **greater** amount for up to a 30-day, 60-day or 90-day supply: □ 5% coinsurance (not to exceed $60), or □ $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs.

Additional Benefits

		In-Network	Out-of-Network
Acupuncture	Medicare-covered acupuncture	$12 copay	$12 copay
Chiropractic Care	Manual manipulation of the spine to correct subluxation	$12 copay	$12 copay
Diabetes Management	Diabetes monitoring supplies	$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan.	$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan.
	Medicare covered Therapeutic Continuous Glucose Monitors (CGMs) and supplies	$0 copay	$0 copay
	Diabetes Self-management training	$0 copay	$0 copay

Additional Benefits

		In-Network	Out-of-Network
	Therapeutic shoes or inserts	15% coinsurance	15% coinsurance
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	15% coinsurance	15% coinsurance
	Prosthetics (e.g., braces, artificial limbs)	15% coinsurance	15% coinsurance
Fitness program through SilverSneakers®		You have access to SilverSneakers®, a Medicare fitness program. SilverSneakers inludes a $0 membership fee for a standard, monthly membership at a participating fitness center. 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	15% coinsurance	15% coinsurance
	Routine foot care	15% coinsurance for each visit (Up to 6 visits per plan year)*	15% coinsurance for each visit (Up to 6 visits per plan year)*
Home Health Care		15% coinsurance	15% coinsurance
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		Receive access to nurse consultations and additional clinical resources at no additional cost.	
Occupational Therapy Visit		15% coinsurance	15% coinsurance
Opioid Treatment Program Services		$0 copay	$0 copay

Additional Benefits

		In-Network	Out-of-Network
Outpatient Substance Abuse	Outpatient group therapy visit	15% coinsurance	15% coinsurance
	Outpatient individual therapy visit	15% coinsurance	15% coinsurance
Renal Dialysis		15% coinsurance	15% coinsurance

[1] 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 and a Medicare-approved Part D sponsor. 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 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.

Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, copay amounts may be higher.

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.

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.

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.