Benefit Highlights

For CalPERS Members
Effective January 1, 2019 to December 31, 2019

UnitedHealthcare® Group Medicare Advantage (PPO) Plan with Dental and Vision

This is a short description of your plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions and restrictions may apply.

Medical Benefits

	In-Network	Out-of-Network
Doctor's office visit	Primary Care Provider: $10 copay Specialist: $10 copay	Primary Care Provider: $10 copay Specialist: $10 copay
Preventive Services	$0 copay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	$0 copay per admission	$0 copay per admission
Skilled nursing facility (SNF)	$0 copay per day up to 100 days	$0 copay per day up to 100 days
Outpatient surgery	$0 copay	$0 copay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	$10 copay	$10 copay
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay	$0 copay
Lab services	$0 copay	$0 copay
Outpatient X-rays	$0 copay	$0 copay
Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay	$0 copay
Ambulance	$0 copay	$0 copay
Emergency care	$50 copay (worldwide)	$50 copay (worldwide)
Urgently needed services	$25 copay (worldwide)	$25 copay (worldwide)
Annual out-of-pocket maximum	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,500 each plan year	

Extra programs beyond Original Medicare

	In-Network	Out-of-Network
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Chiropractic care and Acupuncture	$15 copay Combination of 20 chiropractic and acupuncture visits per plan year*	$15 copay Combination of 20 chiropractic and acupuncture visits per plan year*
Dental	Preventive and comprehensive dental services, with $100 yearly deductible and $1,500 Annual Calendar Maximum.*	Preventive and comprehensive dental services, with $100 yearly deductible and $1,500 Annual Calendar Maximum.*
Foot care – routine	$10 copay (up to 6 visits per plan year)*	$10 copay (up to 6 visits per plan year)*
Hearing – routine exam	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*
Hearing aids	Plan pays up to $1,000 (every 3 years)*	Plan pays up to $1,000 (every 3 years)*
Vision – routine eye exams	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*
Vision – eyewear	Plan pays up to $70 eyewear allowance every 24 months. Plan pays up to $105 contact lens allowance in lieu of eyewear allowance every 24 months.*	Plan pays up to $70 eyewear allowance every 24 months. Plan pays up to $105 contact lens allowance in lieu of eyewear allowance every 24 months.*
Fitness program through SilverSneakers® Fitness program	Stay active with a basic membership at a participating location at no extra cost to you	
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Behavioral Visits	See and speak to specific mental health professionals using your computer or mobile device. Find participating mental health professionals online at www.UHCRetiree.com/calpers.	
Virtual Doctor Visits	See and speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com/calpers.	

*Benefits are combined in and out-of-network.

Prescription Drugs

	Your Cost	
Initial Coverage Stage	**Network Pharmacy (30-day supply)**	**Mail Service Pharmacy (90-day supply)**
Tier 1 – Preferred Generic	$5 copay	$10 copay
Tier 2 – Preferred Brand	$20 copay	$40 copay
Tier 3 – Non-preferred Drug	$50 copay	$100 copay
Tier 4 – Specialty Tier	$20 copay	$40 copay
Coverage Gap Stage	After your total drug costs reach $3,820, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost	
Catastrophic Coverage Stage	After your total out-of-pocket costs reach $5,100, you will pay the lesser of $3.40 copay for generic (including brand drugs treated as generic), $8.50 copay for all other drugs or, 5% of the cost	
Annual Out-of-Pocket Maximum (for mail order drugs)	Once you've paid $1,000 in a plan year for Tier 1, Tier 2, and Tier 4 formulary drugs through the plan's mail service pharmacy, you will pay $0 for Tier 1, Tier 2, and Tier 4 formulary mail order drugs. Once your yearly out-of-pocket drug costs for retail and mail order drugs reach $5,100, you pay the copays listed under the Catastrophic coverage stage above until the end of the calendar year	

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.

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.

Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. 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.

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