Benefit highlights

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

For CalPERS Members
Effective January 1, 2022 to December 31, 2022

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.

Plan costs

	In-network	Out-of-network
Annual medical deductible	No deductible	
Annual medical out-of-pocket maximum (The most you pay in a plan year for covered medical care)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,500 each plan year.	

Medical benefits

Medical benefits covered by the plan and Original Medicare

	In-network	Out-of-network
Doctor's office visit	$10 primary care provider	$10 primary care provider
	$0 virtual doctor visits	$0 virtual doctor visits
	$10 specialist	$10 specialist
Preventive services Medicare-covered	$0 copay	
Inpatient hospital care	$0 copay per stay	$0 copay per stay
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF per benefit period.	
Outpatient surgery	$0 copay	$0 copay
Outpatient rehabilitation Physical, occupational, or speech/language therapy	$10 copay	$10 copay
Mental health Outpatient and virtual	$10 group therapy	$10 group therapy
	$10 individual therapy	$10 individual therapy
	$10 virtual visits	$10 virtual visits
Diagnostic radiology services such as MRIs, CT scans	$0 copay	$0 copay

Medical benefits

Medical benefits covered by the plan and Original Medicare

	In-network	Out-of-network
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	
Emergency care	$50 copay ($50 copay for emergency care outside the United States) per visit	
Urgently needed services	$25 copay ($25 copay for urgently needed services outside the United States) per visit	

Additional benefits and programs not covered by Original Medicare

	In-network	Out-of-network
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Chiropractic and acupuncture – routine	$15 copay, 20 total visits per plan year*	$15 copay, 20 visits per plan year*
Dental – routine	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, 6 visits per plan year*	$10 copay, 6 visits per plan year*
Hearing – routine exam	$0 copay, 1 exam per plan year*	$0 copay, 1 exam per plan year*
Hearing aids	The plan pays up to a $1,000 allowance for hearing aid(s) every 3 years*.	The plan pays up to a $1,000 allowance for hearing aid(s) every 3 years*.
Vision – routine eye exam	$0 copay, 1 exam every 12 months*	$0 copay, 1 exam every 12 months*
Vision – routine eyewear	Plan pays $70 for eyeglasses every 24 months. Or, $105 for contact lenses instead of eyeglasses every 24 months.*	Plan pays $70 for eyeglasses every 24 months. Or, $105 for contact lenses instead of eyeglasses every 24 months.*
Fitness program SilverSneakers®	$0 copay for a standard gym membership at participating locations	
Post-discharge meals	$0 copay for 84 home-delivered meals immediately following one inpatient hospitalization or SNF stay when referred by an advocate	
Telephonic nurse services	Receive access to nurse consultations and additional clinical resources at no additional cost.	

	In-network	Out-of-network
In-home non-medical care CareLinx	$0 copay for 16 hours of personal care services each month	
Post-discharge routine transportation	$0 copay for unlimited rides up to 30 days following a hospital or SNF discharge when referred by an advocate.	
Weight management program Real Appeal	$0 copay online weight loss program.	

*Benefits are combined in and out-of-network

Prescription Drugs

	Your cost	
Initial coverage stage	**Network pharmacy** **30-day retail 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 $4,430, 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 $7,050, you will pay the lesser of $3.95 copay for generic (including brand drugs treated as generic), $9.85 copay for all other drugs or, 5% coinsurance	
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.	

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.

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.

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

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