

Benefit Highlights

State Employees' Insurance Board 15502

Effective January 1, 2020 to December 31, 2020

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

Benefits covered by Original Medicare and your plan

	Network	Out-of-Network
Doctor's office visit	Primary Care Provider: \$10 copay	Primary Care Provider: \$10 copay
	Specialist: \$15 copay	Specialist: \$15 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 stay	\$0 copay per stay
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$167.50 copay per day: days 21-58 \$0 copay per additional day up to 100 days	\$0 copay per day: days 1-20 \$167.50 copay per day: days 21-58 \$0 copay per additional day up to 100 days
Outpatient surgery	\$150 copay	\$150 copay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	\$15 copay	\$15 copay
Diagnostic radiology services (such as MRIs, CT scans) (when the service is performed at a hospital, outpatient facility or a free-standing facility imaging or diagnostic center)	\$75 copay	\$75 copay
Diagnostic radiology services (such as MRIs, CT scans) performed in a doctor's office (doctor's office visit copay will apply)	\$0 copay	\$0 copay
Diagnostic procedures and testing services (when the service is performed at a hospital, outpatient facility or a freestanding facility imaging or diagnostic center)	\$0 copay	\$0 copay
Diagnostic procedures and testing services received in a doctor's office (doctor's office visit copay will apply)	\$0 copay	\$0 copay

Medical Benefits

Benefits covered by Original Medicare and your plan

	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) (when the service is performed at a hospital, outpatient facility or a free-standing facility imaging or diagnostic center)	\$25 copay	\$25 copay
Therapeutic radiology services (such as radiation treatment for cancer) performed in a doctor's office (doctor's office visit copay will apply)	\$0 copay	\$0 copay
Ambulance	\$50 copay	\$50 copay
Emergency care (waived if admitted within 24 hours)	\$80 copay (worldwide)	
Urgently needed services (waived if admitted within 24 hours)	\$24 copay (worldwide)	\$24 copay (worldwide)
Chiropractic care manual manipulation of the spine to correct subluxation	\$15 copay	\$15 copay
Annual medical out-of-pocket maximum	Your plan has an annual combined network and out-of-network out-of-pocket maximum of \$6,700 each plan year	

Additional benefits and programs not covered by Original Medicare

	Network	Out-of-Network
Routine physical	\$0 copay; 1 per plan year*	\$0 copay; 1 per plan year*
Foot care - routine	\$15 copay (Up to 6 visits per plan year)*	\$15 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	The plan pays up to a \$500 allowance for hearing aids every 3 years*.	The plan pays up to a \$500 allowance for hearing aids every 3 years*.
Vision - routine eye exams	\$15 copay (1 exam every 12 months)*	\$15 copay (1 exam every 12 months)*
Fitness program through SilverSneakers®	Stay active with a basic gym membership at a participating location at no extra cost to you.	

	Network	Out-of-Network
Post-Discharge Meals	\$0 copay; Coverage for up to 84 home-delivered meals immediately following one inpatient hospitalization when referred by a case manager. Benefit is offered one time per year through the provider Mom's Meals NourishCare. Restrictions apply.	
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Behavioral Visits	\$14 copay See and speak to specific mental health professionals using your computer or mobile device. Find participating mental health professionals online at www.UHCRetiree.com/SEIB .	
Virtual Doctor Visits	\$0 copay See and speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com/SEIB .	

*Benefits are combined in and out-of-network

Prescription Drugs

	Your Cost	
Stage 1: Annual prescription (Part D) deductible	\$0 deductible	
Stage 2: Initial Coverage	Network Pharmacy (30-day retail supply)	Network Pharmacy (90-day retail supply)
Tier 1: Generic	\$3 copay	\$8 copay
Tier 2: Preferred brand	\$23 copay	\$23 copay
Tier 3: Non-preferred drug	\$53 copay	\$53 copay
Tier 4: Specialty tier	\$53 copay	\$53 copay
Stage 3: Coverage Gap	After your total drug costs reach \$4,020, you continue to pay the same copay or coinsurance as you did in the initial coverage stage.	
Stage 4: Catastrophic Coverage	After your total out-of-pocket costs reach \$6,350, you will pay a \$3.60 copay for generic drugs (including brand drugs treated as generic), or a \$8.95 copay for all other drugs	

The SEIB 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.

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.

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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