Summary of Benefits 2020

Overview of your plan

UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (Plan Sponsor): CITY OF SACRAMENTO
Group Number: 15882

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 **1-877-714-0178**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.UHCRetiree.com

UnitedHealthcare®

Y0066_SB_H2001_816_000_2020_M

Summary of Benefits

January 1, 2020 - December 31, 2020

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 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 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.	
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 $3,400 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[1]		$0 copay per stay	$0 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital[1] Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC)	$0 copay	$0 copay
	Outpatient hospital, including surgery	$0 copay	$0 copay
	Outpatient hospital observation services	$0 copay	$0 copay
Doctor Visits	Primary	$15 copay	$15 copay
	Specialists[1]	$15 copay	$15 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 Hepatitis C screening HIV screening 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	

Benefits		In-Network	Out-of-Network
		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		$50 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		$20 copay (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.	$20 copay (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.
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)[1]	$0 copay	$0 copay
	Lab services[1]	$0 copay	$0 copay
	Diagnostic tests and procedures[1]	$0 copay	$0 copay
	Therapeutic Radiology[1]	$0 copay	$0 copay
	Outpatient x-rays[1]	$0 copay	$0 copay

Benefits		In-Network	Out-of-Network
Hearing Services	Exam to diagnose and treat hearing and balance issues[1]	$15 copay	$15 copay
	Routine hearing 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 aid(s) every 3 years*.	The plan pays up to a $500 allowance for hearing aid(s) every 3 years*.
Routine Dental Services	Oral exams	$0 copay Limited to once every six months	$0 copay Limited to once every six months
	Routine cleaning	$0 copay Limited to once every six months	$0 copay Limited to once every six months
	Dental bitewing X-rays	$0 copay	$0 copay
		$50 yearly deductible and $1,000 combined in and out-of-network plan year maximum. You may also choose an out-of-network dentist for covered dental services. When you receive your covered dental services from an out-of-network dentist, the plan pays according to a maximum allowable fee schedule. You pay all fees in excess of this amount.	
Vision Services	Exam to diagnose and treat diseases and conditions of the eye[1]	$15 copay	$15 copay
	Eyewear after cataract surgery	$0 copay	$0 copay
	Routine eye exams	$15 copay (1 exam every 12 months)*	$15 copay (1 exam every 12 months)*

Benefits		In-Network	Out-of-Network
	Eye wear	Plan pays up to $365 eyewear allowance every 2 years. Plan pays up to $100 contact lens allowance in lieu of eyewear allowance every 2 years.*	Plan pays up to $365 eyewear allowance every 2 years. Plan pays up to $100 contact lens allowance in lieu of eyewear allowance every 2 years.*
Mental Health	Inpatient visit[1]	$0 copay per stay	$0 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
	Outpatient group therapy visit[1]	$15 copay	$15 copay
	Outpatient individual therapy visit[1]	$15 copay	$15 copay
Skilled Nursing Facility (SNF)[1]		$0 copay per day: days 1-100	$0 copay per day: days 1-100
		Our plan covers up to 100 days in a SNF.	
Physical Therapy and speech and language therapy visit[1]		$0 copay	$0 copay
Ambulance[2]		$0 copay	$0 copay
Routine Transportation		Not covered	
Medicare Part B Drugs	Chemotherapy drugs[1]	$0 copay	$0 copay
	Other Part B drugs[1]	$0 copay	$0 copay

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 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 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	Since you have no deductible, this payment stage doesn't apply.	
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing**	**Mail Order Cost-Sharing**
	One-month supply	**Three-month supply**
Tier 1: Generic	$10 copay	$20 copay
Tier 2: Preferred Brand	$20 copay	$40 copay
Tier 3: Non-Preferred Drugs	$50 copay	$100 copay
Tier 4: Specialty Tier	25% coinsurance	25% coinsurance
Stage 3: Coverage Gap Stage	After your total drug costs reach $4,020, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	
Stage 4: Catastrophic Coverage	After your out-of-pocket costs (what you pay including coverage gap discount program payments) reach the $6,350 limit for the plan year, you move to the Catastrophic Coverage Stage. In this stage, you will continue to pay the same cost share that you paid in the Initial Coverage Stage.	

Additional Benefits		In-Network	Out-of-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation[1]	$15 copay	$15 copay
	Routine chiropractic care	$5 copay (Unlimited visits per plan year)*	$5 copay (Unlimited visits per plan year)*
Diabetes Management	Diabetes monitoring supplies[1]	$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio® Flex, Accu-Chek® Guide Me, Accu-Chek® Guide, and Accu-Chek® Aviva Plus. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, Accu-Chek® SmartView, and Accu-Chek® Compact Plus. 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, Accu-Chek® Guide Me, Accu-Chek® Guide, and Accu-Chek® Aviva Plus. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, Accu-Chek® SmartView, and Accu-Chek® Compact Plus. Other brands are not covered by your plan.
	Medicare covered Therapeutic Continuous Glucose Monitors (CGMs) and supplies[1]	$0 copay	$0 copay
	Diabetes Self-management training[1]	$0 copay	$0 copay
	Therapeutic shoes or inserts[1]	$0 copay	$0 copay
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	$0 copay	$0 copay

Additional Benefits		In-Network	Out-of-Network
	Prosthetics (e.g., braces, artificial limbs)[1]	$0 copay	$0 copay
Fitness program through SilverSneakers®		$0 membership fee. Access to a basic fitness membership offered through SilverSneakers® participating locations. If you live 15 miles or more from a SilverSneakers fitness center you may participate in the SilverSneakers Steps Program and select one of four kits that best fits your lifestyle and fitness level - general fitness, strength, walking or yoga.	
Foot Care (podiatry services)	Foot exams and treatment[1]	$15 copay	$15 copay
	Routine foot care*	$15 copay for each visit (Up to 12 visits per plan year)*	$15 copay for each visit (Up to 12 visits per plan year)*
Home Health Care[1]		$0 copay	$0 copay
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		Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Occupational Therapy Visit[1]		$0 copay	$0 copay
Opioid Treatment Services		$0 copay	$0 copay
Outpatient Substance Abuse	Outpatient group therapy visit[1]	$15 copay	$15 copay
	Outpatient individual therapy visit[1]	$15 copay	$15 copay
Outpatient surgery[1]		$0 copay	$0 copay
Renal Dialysis[1]		$0 copay	$0 copay

Additional Benefits	In-Network	Out-of-Network
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.	
Virtual Doctor Visits	See and speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com.	

[1] Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

[2] 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 benefits 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 https://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 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 the 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.

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The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the member toll-free phone number listed in the front of this booklet.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed in the front of this booklet.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال على رقم الهاتف المجاني للعضو الموجود في مقدمة هذا الكتيب.