# Summary of Benefits Public Employee Benefits Cooperative (PEBC)

**Effective: Jan. 1, 2023, through Dec. 31, 2023**

| Overview of your plans | | UnitedHealthcare Group Medicare Advantage PPO (MPO) | UnitedHealthcare Group Medicare Advantage HMO (PMA) |
|---|---|---|---|
| **Monthly plan premium** | | Contact your group plan benefit administrator to determine your actual premium amount, if applicable | |
| **Plan eligibility** | **General requirements** | You must be entitled to Medicare Part A, be enrolled in Medicare Part B, 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. | |
| | **Area of residence** | Includes the 50 United States, the District of Columbia and all U.S. territories | You must reside in these counties in Texas: Angelina, Aransas, Atascosa, Bandera, Bee, Bexar, Collin, Comal, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Gregg, Guadalupe, Henderson, Hood, Houston, Hunt, Jim Wells, Johnson, Kaufman, Kendall, Kerr, Kleberg, Medina, Nacogdoches, Navarro, Nueces, Panola, Parker, Polk, Rockwall, Rusk, San Augustine, San Jacinto, San Patricio, Shelby, Smith, Tarrant, Trinity, Tyler, Van Zandt, Victoria, Walker, Wilson and Wise |
| | **Network** | 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. You are not required to select a primary care provider (PCP) from the network. | You must use network providers. This health plan requires you to select a primary care provider (PCP) from the network. If you need to see a network specialist or other network provider, you may need to get a referral from your PCP. |

## Summary of Benefits Public Employee Benefits Cooperative (PEBC) (continued)

| Overview of your plans | | UnitedHealthcare Group Medicare Advantage PPO (MPO) | UnitedHealthcare Group Medicare Advantage HMO (PMA) |
|---|---|---|---|
| **Benefits and coverage** | | **Network and out of network** | **Network only** |
| **Annual medical deductible** | | None | None |
| **Annual medical out-of-pocket maximum (does not include prescription drugs)** | | None | $6,700 |
| **Inpatient hospital stay*** | Per admission. Covers an unlimited number of days for an inpatient hospital stay. | $0 | $250 |
| **Outpatient hospital*** | Ambulatory Surgical Center (ASC) | $0 | $125 |
| | Outpatient surgery | $0 | $125 |
| | Outpatient hospital services, including observation | $0 | $125 |
| **Doctor visits** | PCP office visit (includes non-MD office visits) | $0 | $20 |
| **Preventive care (Medicare-covered)** | Specialist office visit* | $0 | $40 |
| | Cardiovascular screenings | $0 | $0 |
| | Immunizations (flu, pneumococcal, hepatitis B vaccines) | $0 | $0 |
| | Pap smears and pelvic exams | $0 | $0 |
| | Prostate cancer screening | $0 | $0 |
| | Colorectal cancer screenings | $0 | $0 |
| | Bone mass measurement (bone density) | $0 | $0 |
| | Mammography | $0 | $0 |
| | Diabetes – self-management training | $0 | $0 |
| | Medical nutrition therapy and counseling | $0 | $0 |
| | Annual wellness exam and one-time welcome-to-Medicare exam | $0 | $0 |

*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.

## Summary of Benefits Public Employee Benefits Cooperative (PEBC) (continued)

| Overview of your plans | | UnitedHealthcare Group Medicare Advantage PPO (MPO) | UnitedHealthcare Group Medicare Advantage HMO (PMA) |
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| **Benefits and coverage** | | **Network and out of network** | **Network only** |
| **Urgent care (includes worldwide coverage)** | If you are admitted to the hospital within 24 hours, you pay the Inpatient Hospital copay instead of the Urgently Needed Services copay | $0 | $20 |
| **Diagnostic tests, lab and radiology services, and X-rays** | Diagnostic radiology services (e.g., MRI)* | $0 | $0 |
| | Lab services* | $0 | $0 |
| | Diagnostic tests and procedures* | $0 | $0 |
| | Therapeutic radiology* | $0 | $0 |
| | Outpatient X-rays* | $0 | $0 |
| **Hearing services** | Exam to diagnose and treat hearing and balance issues* | $0 | $40 |
| | Routine hearing exam (1 exam every 12 months) | $0 | $0 |
| | Hearing aid allowance | $500 | $500 |
| | Hearing aid period in years | 3 | 3 |
| **Vision services** | Exam to diagnose and treat diseases and conditions of the eye* | $0 | $40 |
| | Eyewear after cataract surgery | $0 | $0 |
| | Routine eye exam (1 exam every 12 months) | $0 | $40 |

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| **Mental health** | Inpatient Visit, up to 190 days* | $0 | $250 copay per stay |
| | Outpatient Group Therapy Visit* | $0 | $40 |
| | Outpatient Individual Therapy Visit* | $0 | $40 |
| **Skilled Nursing Facility (SNF)*** | | $0 | $0 days 1–20; $50 days 21–100 |
| **Physical therapy and speech and language therapy visit*** | | $0 | $40 |
| **Ambulance services**** | | $0 | $50 |
| **Meal delivery program** | Includes post-discharge meal delivery of 2 meals per day for a 2-week period immediately following all inpatient or skilled nursing facility discharges when referred by a UnitedHealthcare Advocate | Included | Included |
| **Post-discharge routine transportation** | Includes 12 rides to and from medically related appointments and pharmacies up to 30 days following inpatient or skilled nursing facility discharges | Included | Included |
| **In-home personal care** | Includes up to 6 hours of personal care post-discharge, provided by a CareLinx professional caregiver; this may include grocery shopping, meal preparation, light housekeeping, personal care, medication reminders and more | Included | Included |
| **Medicare Part B drugs** | Chemotherapy drugs* | $0 | $0 |
| | Other Part B drugs* | $0 | $0 |
| **Chiropractic visit** | Manual manipulation of the spine to correct subluxation* | $0 | 50% |
| **Podiatry visit** | Foot exams and treatment* | $0 | $40 |

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| **Benefits and coverage** | **Network and out of network** | **Network only** |
| **Outpatient prescription drug coverage** | | |
| **Stage 1: Annual prescription deductible** | Since you have no deductible, this payment stage doesn't apply | |
| **Stage 2: Initial coverage** | Part D Retail Copay up to 30-day supply | |
| **Tier 1: Preferred Generic (most generic drugs)** | $10 | $10 |
| **Tier 2: Preferred Brand (many common brand-name drugs, called preferred brands, and some higher-cost generic drugs)** | $20 | $20 |
| **Tier 3: Non-Preferred Brand (non-preferred generic and non-preferred brand-name drugs)** | $35 | $40 |
| **Tier 4: Specialty Tier (unique and/or very-high-cost drugs)** | $35 | $40 |
| **Stage 2: Initial coverage** | Part D Preferred Mail-Order Copay (up to a 90-day supply) | |
| **Tier 1: Preferred Generic (most generic drugs)** | $20 | $20 |
| **Tier 2: Preferred Brand (many common brand-name drugs, called preferred brands, and some higher-cost generic drugs)** | $40 | $40 |
| **Tier 3: Non-Preferred Brand (non-preferred generic and non-preferred brand-name drugs)** | $70 | $80 |
| **Tier 4: Specialty Tier (unique and/or very-high-cost drugs)** | $70 | $80 |
| **Stage 3: Coverage gap stage** | After your total drug costs reach $4,660, 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 yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay a $4.15 copay for generic drugs (including brand-name drugs treated as generic), and a $10.35 copay for all other drugs | |
| **Evidence of Coverage (EOC)** | 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 EOC provides a complete list of services we cover. You can see it online at **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 EOC. | |
| **UnitedHealthcare Customer Service (Medicare-eligible retirees)** | Toll-free **1-866-519-3813**, TTY 711, 8 a.m. – 8 p.m. local time, 7 days a week | Toll-free **1-877-714-0178**, TTY 711, 8 a.m. – 8 p.m. local time, 7 days a week |