2019 SUMMARY OF BENEFITS

Overview of your plan

UnitedHealthcare® Group Medicare Advantage (PPO)
H2001-827
Group Name (Plan Sponsor): North Carolina State Health Plan for Teachers and State Employees
Group Numbers: 12326, 12327, 12328, 12329, 12330, 12331, 12332, 12333

Look inside to learn more about the plan and the health and drug services it covers.
Call Customer Service or go online for more information about the plan.

Toll-Free **1-866-747-1014**, TTY **711**
8 a.m. – 8 p.m. ET, Monday – Friday

www.UHCRetiree.com/ncshp

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Dale R. Folwell, CPA
State Treasurer of North Carolina

UnitedHealthcare®

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Our service area includes the 50 United States, the District of Columbia and all US territories.

Summary of Benefits

January 1, 2019 – December 31, 2019

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/ncshp, or you can call Customer Service with questions you may have. You get an EOC when you enroll in the plan.

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 within our service area as listed inside the cover, 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).

About providers and network pharmacies.

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 Medicare. 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 an in-network pharmacy.

You can go to www.UHCRetiree.com/ncshp to search for a network provider or pharmacy using the online directories. You can also view the plan formulary (drug list) to see what drugs are covered, and if there are any restrictions.

UnitedHealthcare® Group Medicare Advantage (PPO)

Premiums and Benefits

	Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and 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)	$4,000 annually for Medicare-covered services you receive from any provider. 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 plan year. Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.	$3,300 annually for Medicare-covered services you receive from any provider 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 plan 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		Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Inpatient Hospital Care		$160 copay per day: for days 1–10 $0 copay per day: for days 11 and beyond Our plan covers an unlimited number of days for an inpatient hospital stay.	$150 copay per day: for days 1–10 $0 copay per day: for days 11 and beyond Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital, including observation		$125	$100
Doctor Visits	Primary	$20 copay	$15 copay
	Specialists	$40 copay	$35 copay

Benefits

Benefits		Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
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 screenings Medical nutrition therapy services Medicare diabetes prevention program (MDPP) Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling 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 cover 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		$65 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 Care” section of this booklet for other costs.	$65 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 Care” section of this booklet for other costs.

Benefits		Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Urgently Needed Services		$50 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 Care" section of this booklet for other costs.	$40 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 Care" section of this booklet for other costs.
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g., MRI)	$100 copay	$100 copay
	Lab services	$40 copay If a lab test is performed and **processed in a doctor's office**: $0 copay	$20 copay If a lab test is performed and **processed in a doctor's office**: $0 copay
	Diagnostic tests and procedures	$40 copay If a diagnostic test is performed and **processed in a doctor's office**: $0 copay	$10 copay If a diagnostic test is performed and **processed in a doctor's office**: $0 copay
	Therapeutic radiology	$40 copay	$10 copay
	Outpatient x-rays	$40 copay If an outpatient x-ray is performed and **processed in a doctor's office**: $0 copay	$25 copay If an outpatient x-ray is performed and **processed in a doctor's office**: $0 copay
Hearing Services	Exam to diagnose and treat hearing and balance issues	$40 copay	$35 copay
	Routine hearing exam	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*
	Hearing aids	Plan pays up to $500 (every 3 years)*	Plan pays up to $500 (every 3 years)*

Benefits		Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Vision Services	Exam to diagnose and treat diseases and conditions of the eye	$40 copay	$35 copay
	Eyewear after cataract surgery	$0 copay	$0 copay
	Routine eye exam	$40 copay (1 exam every 12 months)*	$35 copay (1 exam every 12 months)*
Mental Health	Inpatient visit	$140 copay per day: for days 1–10 $0 copay per day: for days 11–190 Our plan covers 190 days for an inpatient hospital stay.	$150 copay per day: for days 1–10 $0 copay per day: for days 11–190 Our plan covers 190 days for an inpatient hospital stay.
	Outpatient group therapy visit	$20 copay	$10 copay
	Outpatient individual therapy visit	$20 copay	$10 copay
Skilled Nursing Facility (SNF)		$0 copay per day: for days 1–20 $50 copay per day: for days 21–100 Our plan covers up to 100 days in a SNF.	$0 copay per day: for days 1–20 $50 copay per day: for days 21–100 Our plan covers up to 100 days in a SNF.
Physical Therapy and Speech and Language Therapy Visit		$20 copay	$20 copay
Ambulance		$75 copay	$75 copay
Medicare Part B Drugs	Chemotherapy drugs	$50 copay	$50 copay
	Other Part B drugs	$50 copay	$50 copay
	Allergy shots and injections	$0 copay, if administered in a physician's office	$0 copay, if administered in a physician's office

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. Once you are enrolled in this plan, you will receive a separate document called the "Certificate of Coverage" with more information about this supplemental drug coverage.

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.

	Base Plan	Enhanced Plan
Stage 1: Initial Coverage	**Retail Cost-Sharing** For a one-month supply	**Retail Cost-Sharing** For a one-month supply
Tier 1: Preferred Generic	$10 copay	$10 copay
Tier 2: Preferred Brand	$40 copay	$35 copay
Tier 3: Non-preferred Drug	$64 copay	$50 copay
Tier 4: Specialty Tier	25% coinsurance or a $100 copay maximum	25% coinsurance or a $100 copay maximum
Stage 1: Initial Coverage	**Retail and Mail Order Cost-Sharing** For a three-month supply	**Retail and Mail Order Cost-Sharing** For a three-month supply
Tier 1: Preferred Generic	$24 copay	$20 copay
Tier 2: Preferred Brand	$80 copay	$70 copay
Tier 3: Non-preferred Drug	$128 copay	$100 copay
Tier 4: Specialty Tier	25% coinsurance or a $300 copay maximum	25% coinsurance or a $200 copay maximum
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	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 $0 copay	After your total out-of-pocket costs reach $5,100, you will pay $0 copay
Annual out-of-pocket maximum	When your maximum out-of-pocket costs reach $2,500, you will not pay any copayments or coinsurance	When your maximum out-of-pocket costs reach $2,500, you will not pay any copayments or coinsurance

Additional Benefits

		Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation	$20 copay	$20 copay
Diabetes Management	Diabetes monitoring supplies	$0 copay We only cover blood glucose monitors and test strips from the following brands: OneTouch® Ultra® 2, OneTouch® UltraMini®, OneTouch® Verio®, OneTouch® Verio® IQ, OneTouch® Verio® Flex™, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Connect. Other brands are not covered by our plan.	$0 copay We only cover blood glucose monitors and test strips from the following brands: OneTouch® Ultra® 2, OneTouch® UltraMini®, OneTouch® Verio®, OneTouch® Verio® IQ, OneTouch® Verio® Flex™, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Connect. Other brands are not covered by our plan.
	Diabetes Self-management training	$0 copay	$0 copay
	Therapeutic shoes or inserts	20% coinsurance	20% coinsurance
Durable Medical Equipment	Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% coinsurance	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs)	20% coinsurance	20% coinsurance

Additional Benefits

		Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Fitness program through SilverSneakers®		$0 membership fee. Monthly basic membership for SilverSneakers through network fitness centers. 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.	$0 membership fee. Monthly basic membership for SilverSneakers through network fitness centers. 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	$40 copay	$35 copay
	Routine foot care	$40 copay for each visit (up to 6 visits per plan year)*	$35 copay for each visit (up to 6 visits per plan year)*
Home Health Care		$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.	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.
Occupational therapy visit		$20 copay	$20 copay
Outpatient Surgery		$250 copay	$250 copay
Outpatient Substance Abuse	Outpatient group therapy visit	$20 copay	$10 copay
	Outpatient individual therapy visit	$20 copay	$10 copay

Additional Benefits

	Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Private duty nursing	Nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state where services are received. Covered services include nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) delivered to a covered individual who is confined in the home due to a medical condition. Note: Custodial and domestic services are not covered. If covered private duty nursing services are received before you reach the out-of-pocket maximum, you pay a 20% coinsurance for each visit. The amounts you pay do not apply to the out-of-pocket maximum. There is a $5,000 limit per plan year for private duty nursing services. Once the plan has paid $5,000 in a plan year, you are responsible to pay all charges for the remainder of the plan year.	Nursing services provided in the home by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state where services are received. Covered services include nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) delivered to a covered individual who is confined in the home due to a medical condition. Note: Custodial and domestic services are not covered. If covered private duty nursing services are received before you reach the out-of-pocket maximum, you pay a 20% coinsurance for each visit. The amounts you pay do not apply to the out-of-pocket maximum. There is a $5,000 limit per plan year for private duty nursing services. Once the plan has paid $5,000 in a plan year, you are responsible to pay all charges for the remainder of the plan year.
Renal Dialysis	20% coinsurance	20% coinsurance
Virtual Doctor Visits	Speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com/ncshp	Speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com/ncshp

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

Required Information

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

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

Benefits, premium and/or copayments/coinsurance may change at the beginning of each plan year.

You must continue to pay your Medicare Part B premium.

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 http://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.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90-day supply of your maintenance medication.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage 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.