2020 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 health services and drug coverages the plan provides.

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®

Y0066_SB_H2001_827_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/ncshp 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.

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 an in-network pharmacy.

You can go to www.UHCRetiree.com/ncshp to search for a network provider or pharmacy using the online directory. 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

	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)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $4,000 each 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.	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $3,300 each 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		Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Inpatient Hospital[1]		$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[1]		$125 copay	$100 copay
Doctor Visits	Primary	$20 copay	$15 copay
	Specialists[1]	$40 copay	$35 copay

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 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 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 year*	$0 copay; 1 per 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" 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" section of this booklet for other costs.
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	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[1]	$40 copay	$35 copay
	Routine hearing exam	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*
	Hearing aids[1]	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[1]	$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[1]	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)[1]		$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[1]		$20 copay	$20 copay
Ambulance[2]		$75 copay	$75 copay
Medicare Part B Drugs[1]	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. You can view the Certificate of Coverage at www.UHCRetiree.com/ncshp 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 Drug List (Formulary). Please see your Additional Drug Coverage list for more information.

	Base Plan	Enhanced Plan
Initial Coverage	**Retail Cost-Sharing** For a one-month (31-day) supply	**Retail Cost-Sharing** For a one-month (31-day) 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
Initial Coverage	**Retail and Mail Order Cost-Sharing** For a three-month (90-day) supply	**Retail and Mail Order Cost-Sharing** For a three-month (90-day) 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 $4,020 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 $4,020 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 $6,350, you will pay $0 copay	After your total out-of-pocket costs reach $6,350, you will pay $0 copay
Annual out-of-pocket maximum	When your maximum out-of-pocket costs (what you personally pay out-of-pocket) reach $2,500, you will not pay any copayments or coinsurance	When your maximum out-of-pocket costs (what you personally pay out-of-pocket) 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[1]	Manual manipulation of the spine to correct subluxation	$20 copay	$20 copay
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	$0 copay	$0 copay
	Therapeutic shoes or inserts[1]	20% coinsurance	20% coinsurance
Durable Medical Equipment (DME) and Related Supplies[1]	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. 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.	$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]	$40 copay	$35 copay
	Routine foot care	$40 copay for each visit (up to 6 visits per year)*	$35 copay for each visit (up to 6 visits per 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.	Speak with a registered nurse (RN) 24 hours a day, 7 days a week.
Occupational Therapy Visit[1]		$20 copay	$20 copay
Opioid Treatment Services		$0 copay	$0 copay
Outpatient Surgery including Surgery[1]		$250 copay	$250 copay
Outpatient Substance Abuse[1]	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	We cover medically necessary 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. The services requested must be ordered by a treating practitioner or specialist after a face-to-face evaluation takes place with a written treatment plan and letter of medical necessity. 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. Services are covered in 15 minute increments. 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.	We cover medically necessary 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. The services requested must be ordered by a treating practitioner or specialist after a face-to-face evaluation takes place with a written treatment plan and letter of medical necessity. 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. Services are covered in 15 minute increments. 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.

Additional Benefits	Base Plan In-Network and Out-of-Network	Enhanced Plan In-Network and Out-of-Network
Private Duty Nursing (continued)	There is a $5,000 limit per year for private duty nursing services. Once the plan has paid $5,000 in a year, you are responsible to pay all charges for the remainder of the year.	There is a $5,000 limit per year for private duty nursing services. Once the plan has paid $5,000 in a year, you are responsible to pay all charges for the remainder of the year.
Renal Dialysis[1]	20% coinsurance	20% coinsurance
Virtual Behavioral Visits	$20 copayment See and speak to specific mental health professionals using your computer or mobile device. Find participating mental health professionals online at **www.UHCRetiree.com/ncshp**	$10 copayment See and speak to specific mental health professionals using your computer or mobile device. Find participating mental health professionals online at **www.UHCRetiree.com/ncshp**
Virtual Doctor Visits	$0 copayment See and speak to specific doctors using your computer or mobile device. Find participating doctors online at **www.UHCRetiree.com/ncshp**	$0 copayment See and speak to specific doctors using your computer or mobile device. Find participating doctors online at **www.UHCRetiree.com/ncshp**

[1]Services with a [1] require your provider to obtain prior authorization from the plan for in-network benefits.

[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.

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 year.

Drugs and prices may vary between pharmacies and are subject to change during the 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.

Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

You are not required to use OptumRx home delivery for a 90- or 100-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.

Solutions for Caregivers assists in coordinating community and in-home resources. The final decision about your care arrangements must be made by you. In addition, the quality of a particular provider must be solely determined and monitored by you. Information provided to you about a particular provider does not imply and is in no way an endorsement of that particular provider by Solutions for Caregivers. The information on and the selection of a particular provider has been supplied by the provider and is subject to change without written consent of Solutions for Caregivers.

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.

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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