

**January 1, 2024**  
**Summary of Benefits - Advantage Plan**

<b>Plan Costs</b>	<b>In-network and out-of-network</b>
<b>Annual medical deductible</b>	No deductible
<b>Annual medical out-of-pocket maximum (the most you pay in a plan year for covered medical care)</b>	You pay nothing for Medicare-covered services from any provider

**Medical benefits**

Medical benefits covered by the plan and Original Medicare

For plan details go to: [retiree.uhc.com/SchoolCare](http://retiree.uhc.com/SchoolCare) or call 1-866-207-2262

	<b>In-network and out-of-network</b>
<b>Doctor's office visit</b>	
Primary care provider (PCP)	\$0 copay
Specialist	\$0 copay
Virtual visits	\$0 copay
<b>Preventive services</b> Medicare-covered	\$0 copay
<b>Inpatient hospital care</b>	\$0 copay per stay
<b>Skilled nursing facility (SNF)</b>	\$0 copay per day: days 1-20 \$0 copay per additional day up to 100 days
<b>Outpatient surgery</b>	\$0 copay
<b>Outpatient rehabilitation</b> PT, OT, ST	\$0 copay
<b>Outpatient mental health</b>	
Group therapy	\$0 copay
Individual therapy	\$0 copay
Virtual visits	\$0 copay
<b>Diagnostic radiology services</b> such as MRIs, CT scans	\$0 copay
<b>Lab services</b>	\$0 copay
<b>Outpatient X-rays</b>	\$0 copay
<b>Therapeutic radiology services</b> such as radiation treatment for cancer	\$0 copay
<b>Ambulance</b>	\$0 copay
<b>Emergency care</b>	\$0 copay (worldwide)
<b>Urgently needed services</b>	\$0 copay (worldwide)

## Additional benefits and programs not covered by Original Medicare

	In-network and out-of-network
<b>Routine physical</b>	\$0 copay; 1 per plan year*
<b>Foot care - routine</b>	\$0 copay, 6 visits per plan year*
<b>UnitedHealthcare Healthy at Home</b>	\$0 copay for 28 meals, 12 rides, and 6 hours of in-home personal care up to 30 days following all inpatient and SNF discharges. Referral required.
<b>Hearing - routine exam</b>	\$0 copay, 1 exam per plan year*
<b>Hearing aids</b> UnitedHealthcare Hearing	Plan pays a \$500 allowance for hearing aids (combined for both ears) every 3 years. Hearing aids purchased outside of UnitedHealthcare Hearing's nationwide network are not covered.
<b>Vision - routine eye exam</b>	\$0 copay, 1 exam every 12 months*
<b>Vision - routine eyewear</b>	Plan pays \$100 for eyeglasses every 12 months. Or, \$100 for contact lenses instead of eyeglasses every 12 months.*
<b>Fitness program</b> Renew Active® by UnitedHealthcare	\$0 copay for a standard gym membership at participating locations
<b>Telephonic nurse services</b>	Receive access to nurse consultations and additional clinical resources at no additional cost.
<b>Personal Emergency Response System (PERS) Lifeline</b>	\$0 copay for a personal emergency response system.
<b>Rally Coach™ Programs</b>	\$0 copay for the Rally Coach™ Programs: Real Appeal® Weight Loss and Real Appeal Diabetes Prevention, Wellness Coaching and the Quit for Life® Tobacco Cessation Program.

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

## Prescription drugs

	Your cost	
<b>Initial coverage stage</b>	Network pharmacy (31-day retail supply)	Mail service pharmacy (90-day supply)
<b>Tier 1: Preferred Generic</b>	\$10 copay	\$15 copay
<b>Tier 2: Preferred Brand</b>	\$30 copay	\$45 copay
<b>Tier 3: Non-preferred Drug</b>	\$40 copay	\$60 copay
<b>Tier 4: Specialty Tier</b>	12% coinsurance	12% coinsurance
<b>Coverage gap stage</b>	After your total drug costs reach \$5,030, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	
<b>Catastrophic coverage stage</b>	After your out-of-pocket costs (what you pay including coverage gap discount program payments) reach the \$8,000 limit for the plan year, you move to the catastrophic coverage stage. After your out-of-pocket costs reach \$8,000, you pay \$0 for the remainder of the plan year.	

Your plan sponsor offers additional prescription drug coverage. Please see your Additional Drug Coverage list for more information. 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.