

## Benefit Highlights

Government of the District of Columbia 13709  
Effective January 1, 2020 to December 31, 2020

This is a short description of your plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

### Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Doctor's office visit	Primary Care Provider: \$5 copay Specialist: \$10 copay	Primary Care Provider: \$5 copay Specialist: \$10 copay
Preventive services	\$0 copay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	\$100 copay per stay	\$100 copay per stay
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$0 copay per additional day up to 100 days	\$0 copay per day: days 1-20 \$0 copay per additional day up to 100 days
Outpatient surgery	\$0 copay	\$0 copay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	\$5 copay	\$5 copay
Diagnostic radiology services (such as MRIs, CT scans)	\$10 copay	\$10 copay
Lab services	\$5 copay	\$5 copay
Outpatient x-rays	\$5 copay	\$5 copay
Therapeutic radiology services (such as radiation treatment for cancer)	\$10 copay	\$10 copay
Ambulance	\$0 copay	\$0 copay
Emergency care	\$65 copay (worldwide)	
Urgently needed services	\$5 copay (worldwide)	\$5 copay (worldwide)
Annual medical out-of-pocket maximum	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$500 each plan year	

### Additional benefits and programs not covered by Original Medicare

	In-Network	Out-of-Network
Routine physical	\$0 copay; 1 per plan year*	\$0 copay; 1 per plan year*
Foot care - routine	\$10 copay (Up to 6 visits per plan year)*	\$10 copay (Up to 6 visits per plan year)*
Hearing - routine exam	\$0 copay (1 exam every 12 months)*	\$0 copay (1 exam every 12 months)*

	In-Network	Out-of-Network
Hearing aids	The plan pays up to a \$500 allowance for hearing aids every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.	Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.
Vision - routine eye exams	\$10 copay (1 exam every 12 months)*	\$10 copay (1 exam every 12 months)*
Fitness program through SilverSneakers®	Stay active with a basic gym membership at a participating location at no extra cost to you.	
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Behavioral Visits	See and speak to specific mental health professionals using your computer or mobile device. Find participating mental health professionals online at <a href="http://www.UHCRetiree.com">www.UHCRetiree.com</a> .	
Virtual Doctor Visits	See and speak to specific doctors using your computer or mobile device. Find participating doctors online at <a href="http://www.UHCRetiree.com">www.UHCRetiree.com</a> .	

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

### Prescription Drugs

	Your Cost	
	Network Pharmacy (30-day retail supply)	Mail Service Pharmacy (90-day supply)
Initial Coverage Stage		
Tier 1: Preferred Generic	\$10 copay	\$20 copay
Tier 2: Preferred Brand	\$30 copay	\$60 copay
Tier 3: Non-preferred Drug	\$40 copay	\$80 copay
Tier 4: Specialty Tier	25% coinsurance	25% coinsurance
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	
Catastrophic coverage stage	After your total out-of-pocket costs reach \$6,350, you will pay the greater of \$3.60 copay for generic (including brand drugs treated as generic), \$8.95 copay for all other drugs, or 5% coinsurance	

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. 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.