2016 Summary of BENEFITS

UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (plan sponsor): Kentucky Teachers' Retirement System
Group Number: 13800, 13801

H2001-817, H2001-820

Y0066_150827_212133

SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

This booklet gives you 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. To get a complete list of services we cover, see your "Evidence of Coverage."

Your Health Care Coverage

This plan is offered through your plan sponsor.

You may be able to join or leave a plan only at certain times designated by your plan sponsor. If you choose to enroll in a Medicare health plan or Medicare Prescription Drug plan that is not offered by your plan sponsor, you may lose the option to enroll in a plan offered by your plan sponsor in the future. You could also lose coverage for other plan sponsor retirement benefits you may currently have. Once enrolled in our plan, if you choose to end your membership outside of your plan sponsor's open enrollment period, re-enrollment in any plan your plan sponsor offers may not be permitted, or you may have to wait until their next open enrollment period.

It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other benefits before submitting a request to enroll in a plan not offered by your plan sponsor, or a request to end your membership in our plan.

If you want information 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.

Sections in this booklet

- Things to Know About UnitedHealthcare Group Medicare Advantage (PPO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at **1-844-518-5877**.

THINGS TO KNOW ABOUT UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (PPO)

Hours of Operation

You can call us 8 a.m. to 8 p.m. local time, Monday through Friday.

UnitedHealthcare Group Medicare Advantage (PPO) Phone Numbers and Website

- Call toll-free at **1-844-518-5877**.
- Our website: www.UHCRetiree.com/ktrs

Who can join?

To join UnitedHealthcare Group Medicare Advantage (PPO) you must be entitled to Medicare Part A, enrolled in Medicare Part B, live in our service area and you meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

If you are not entitled to Medicare Part A, please refer to your plan sponsor's enrollment materials, or contact your plan sponsor directly to determine if you are eligible to enroll in our plan. Some plan sponsors have made arrangements with us to offer a Medicare Advantage plan even though you aren't entitled to Part A based on former employment.

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

Which doctors and hospitals can I use?

UnitedHealthcare Group Medicare Advantage (PPO) has a network of doctors, hospitals and other providers. You can see any provider (in-network or out-of-network) that participates in Medicare and accepts the plan at the same cost share. Your copays or coinsurance will be the same.

You can see our plan's provider directory at our website www.UHCRetiree.com/ktrs. Or, call us and we will send you a copy of the provider directory.

What do we cover?

Like all Medicare Advantage health plans, we cover everything that Original Medicare covers — and more.

- **Our plan members get all of the benefits covered by Original Medicare.**
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

UnitedHealthcare Group Medicare Advantage (PPO) covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

<table>
<tr><th colspan="2">MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES</th></tr>
<tr><td>How much is the monthly premium?</td><td>Contact your plan sponsor to determine your actual premium amount, if applicable.</td></tr>
<tr><td>How much is the deductible?</td><td>This plan has deductibles for some medical services.
$150 per plan year for some in-network and out-of-network services.
(See Additional Information About UnitedHealthcare Group Medicare Advantage (PPO) for more information on your plan year deductible)</td></tr>
<tr><td>Is there any limit on how much I will pay for my covered services?</td><td>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.
Your yearly limit(s) in this plan:
• $1,200 combined in-network and out-of-network out-of-pocket limit.
If you reach $1,200 in 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.
(The amounts you pay for deductibles, copays and coinsurance for covered services count toward this combined maximum in-network and out-of-network out-of-pocket limit. Expenses for non-emergency care while in a foreign country do not apply toward this limit.)</td></tr>
<tr><td>Is there a limit on how much the plan will pay?</td><td>No. There are no limits on how much our plan will pay.</td></tr>
<tr><th colspan="2">COVERED MEDICAL AND HOSPITAL BENEFITS</th></tr>
<tr><th colspan="2">OUTPATIENT CARE AND SERVICES</th></tr>
<tr><td>Ambulance</td><td>• In-network: 4% of the cost
• Out-of-network: 4% of the cost</td></tr>
<tr><td>Chiropractic Care</td><td>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):
• In-network: 4% of the cost
• Out-of-network: 4% of the cost</td></tr>
</table>

Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: 4% of the cost • Out-of-network: 4% of the cost
Diabetes Supplies and Services	Diabetes monitoring supplies: • In-network: $0 copay • Out-of-network: $0 copay Diabetes self-management training: • In-network: $0 copay • Out-of-network: $0 copay Therapeutic shoes or inserts: • In-network: 4% of the cost • Out-of-network: 4% of the cost For Diabetes monitoring supplies, we only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra® 2 System, OneTouch Ultra Mini®, OneTouch Verio® Sync, OneTouch Verio IQ, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Plus.
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for services may differ if received as a result of outpatient surgery)	Diagnostic radiology services (such as MRIs, CT scans): • In-network: 4% of the cost • Out-of-network: 4% of the cost Diagnostic tests and procedures: • In-network: 4% of the cost • Out-of-network: 4% of the cost Lab services: • In-network: $0 copay • Out-of-network: $0 copay Outpatient x-rays: • In-network: 4% of the cost • Out-of-network: 4% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 4% of the cost • Out-of-network: 4% of the cost

<table>
<tr><td>Doctor’s Office Visits</td><td>Primary care physician visit:
• In-network: 4% of the cost
• Out-of-network: 4% of the cost

Specialist visit:
• In-network: 4% of the cost
• Out-of-network: 4% of the cost</td></tr>
<tr><td>Durable Medical Equipment (wheelchairs, oxygen, etc.)</td><td>• In-network: 4% of the cost
• Out-of-network: 4% of the cost</td></tr>
<tr><td>Emergency Care</td><td>• $50 copay

If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.

Your benefit includes Non-emergency world-wide care for 20% coinsurance up to a maximum benefit of $5,000 per year.

Non-emergency world-wide care does not apply to your out-of-pocket maximum.</td></tr>
<tr><td>Foot Care (podiatry services)</td><td>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:
• In-network: 4% of the cost
• Out-of-network: 4% of the cost

Additional benefit not covered by Original Medicare

Routine foot care (for up to 6 visits every plan year):
• In-network: $0 copay for each visit
• Out-of-network: $0 copay for each visit

Benefit is combined in and out-of-network.</td></tr>
</table>

Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: 4% of the cost • Out-of-network: 4% of the cost **Additional benefit not covered by Original Medicare** Routine hearing exam (for up to 1 every plan year): • In-network: $0 copay for each visit • Out-of-network: $0 copay for each visit Benefit is combined in and out-of-network. Hearing aids: • In-network: Our plan pays up to a $500 allowance for hearing aids every 3 years • Out-of-network: Our plan pays up to a $500 allowance for hearing aids every 3 years Benefit is combined in and out-of-network.
Home Health Care	• In-network: You pay nothing • Out-of-network: You pay nothing
Mental Health Care	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $200 copay per stay • Out-of-network: $200 copay per stay Outpatient group therapy visit: • In-network: 4% of the cost • Out-of-network: 4% of the cost Outpatient individual therapy visit: • In-network: 4% of the cost • Out-of-network: 4% of the cost
Outpatient Rehabilitation	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: 4% of the cost • Out-of-network: 4% of the cost Occupational therapy visit: • In-network: 4% of the cost • Out-of-network: 4% of the cost Physical therapy and speech and language therapy visit: • In-network: 4% of the cost • Out-of-network: 4% of the cost

Outpatient Substance Abuse	Group therapy visit: • In-network: 4% of the cost • Out-of-network: 4% of the cost Individual therapy visit: • In-network: 4% of the cost • Out-of-network: 4% of the cost
Outpatient Surgery	Ambulatory surgical center: • In-network: 4% of the cost • Out-of-network: 4% of the cost Outpatient hospital: • In-network: 4% of the cost • Out-of-network: 4% of the cost
Prosthetic Devices (braces, artificial limbs, etc.)	Prosthetic devices: • In-network: 4% of the cost • Out-of-network: 4% of the cost Related medical supplies: • In-network: 4% of the cost • Out-of-network: 4% of the cost
Renal Dialysis	• In-network: 4% of the cost • Out-of-network: 4% of the cost
Urgently Needed Services	• $35 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services. See the “Inpatient Hospital Care” section of this booklet for other costs.

Vision Services	Exam to diagnose and treat diseases and conditions of the eye: • In-network: 4% of the cost • Out-of-network: 4% of the cost Yearly glaucoma screening: • In-network: $0 copay • Out-of-network: $0 copay Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: You pay nothing **Additional benefit not covered by Original Medicare** Routine eye exam (for up to 1 every plan year): • In-network: $0 copay • Out-of-network: $0 copay Benefit is combined in and out-of-network.

Preventive Care	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including but not limited to: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening 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) • Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.

Preventive Care (continued)	**Additional benefit not covered by Original Medicare** Annual routine physical exam: • In-network: $0 copay • Out-of-network: $0 copay Fitness program: • $0 membership fee. • SilverSneakers® Fitness Program through network fitness centers. There is no visit or use fee for basic membership when you use network service providers. • SilverSneakers® Steps at Home program is available for members living 15 miles away or more from a SilverSneakers® fitness center. Member may select one of four kits that best fit their lifestyle and fitness level - general fitness, strength, walking or yoga. NurseLine℠: • You may call the NurseLine℠, 24 hours a day, 7 days a week and speak to a registered nurse (RN) about your medical concerns and questions.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
INPATIENT CARE	
Inpatient Hospital Care	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $200 copay per stay • Out-of-network: $200 copay per stay
Inpatient Mental Health Care	For inpatient mental health care, see the “Mental Health Care” section of this booklet.

Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF.
	• In-network:
	  • $0 copay per day for days 1 through 20
	  • $30 copay per day for days 21 through 100
	• Out-of-network:
	  • $0 copay per day for days 1 through 20
	  • $30 copay per day for days 21 through 100

PRESCRIPTION DRUG BENEFITS	
How much do I pay?	For Part B drugs such as chemotherapy drugs: • In-network: 4% of the cost • Out-of-network: 4% of the cost Other Part B drugs: • In-network: 4% of the cost • Out-of-network: 4% of the cost Our plan does not cover Part D prescription drugs.

ADDITIONAL INFORMATION ABOUT UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (PPO)

Your Plan Year Deductible

Your combined in-network and out-of-network deductible is $150. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services.

Until you have paid the deductible amount, you must pay the full cost for most of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the plan year.

The deductible applies to the following services:

- Outpatient Surgery
- Outpatient Hospital Services
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Occupational Therapy
- Physical Therapy and Speech/Language Therapy
- Cardiac/Pulmonary Rehabilitation Services
- Kidney Dialysis
- Ambulance Services
- Part B Drugs
- Durable Medical Equipment
- Orthotics and Prosthetics
- Medical Supplies
- Diagnostic Procedure/Test
- Outpatient X-ray Services
- Diagnostic Radiology Services
- Therapeutic Radiology Service
- Primary Care Physician Office Visit
- Specialist Office Visit
- Outpatient Mental Health/Substance Abuse
- Podiatry Visit (Medicare-covered)
- Eye Exam (Medicare-covered)
- Hearing Exam (Medicare-covered)
- Dental Services (Medicare-covered)

The deductible does not apply to the following services:

- Chiropractic Services (Medicare-covered)
- Blood
- Diabetes Monitoring Supplies
- Diabetes Self-Management Training
- Clinical Lab Services
- Emergency Care
- Home Health Care
- Urgently Needed Services
- Medicare-covered eye wear after cataract surgery
- All Medicare Preventive Services
- Hospice Services
- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Routine Eye Exam
- Routine Foot Care
- Routine Hearing Exam

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-518-5877 . Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-518-5877 . Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-844-518-5877 。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-844-518-5877 。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-518-5877 . Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-518-5877 . Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-518-5877 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-518-5877 . Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-518-5877 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-518-5877. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه . سيقوم شخص ما يتحدث العربية 1-844-518-5877 ترجم فوري، ليس عليك سوى الاتصال بنا على خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-518-5877 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-518-5877. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

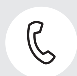
Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-518-5877. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal wa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-518-5877. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-518-5877. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-518-5877 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

For more information, please contact Customer Service at:



Toll-Free **1-844-518-5877**, TTY **711**

8 a.m. to 8 p.m. local time, Monday – Friday

A UnitedHealthcare® Medicare Solution

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.

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