2018 SUMMARY OF BENEFITS

Overview of your plan

UnitedHealthcare® Group Medicare Advantage (PPO)
H2001-817, H2001-820
Group Name (Plan Sponsor): Teachers' Retirement System of the State of Kentucky
Group Number: 13800, 13801

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

Toll-Free **1-844-518-5877**, TTY **711**
8 a.m. – 8 p.m. local time, Monday – Friday

www.UHCRetiree.com/trs

TEACHERS' Retirement System
TRS
KENTUCKY

UnitedHealthcare®

Y0066_160717_022133

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

Summary of Benefits

January 1, 2018 – December 31, 2018

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/trs, or you can call Customer Service with questions you may have.

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, 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).

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.

Use network providers

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.

You can go to www.UHCRetiree.com/trs to search for a network provider using the online directories.

Drug Coverage

We cover Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

UnitedHealthcare® Group Medicare Advantage (PPO)

Premiums and Benefits	In-Network	Out-of-Network
Monthly Plan Premium	Contact your group plan sponsor or benefit administrator to determine your actual premium amount, if applicable.	
Annual Medical Deductible	This plan has deductibles for some medical services. $150 per 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)	
Maximum Out-of-pocket Amount	$1,200 annually for Medicare-covered services you receive from any provider. 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.)	

UnitedHealthcare® Group Medicare Advantage (PPO)

Benefits		In-Network	Out-of-Network
Inpatient Hospital Care		$200 copay per admit	$200 copay per admit
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital Services, including observation		4% coinsurance	4% coinsurance
Doctor Visits	Primary	4% coinsurance	4% coinsurance
	Specialists	4% coinsurance	4% coinsurance

Benefits		In-Network	Out-of-Network
Preventive Care	Medicare-covered	$0 copay	$0 copay
		Abdominal aortic aneurysm screening Annual “Wellness” visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) Cardiovascular disease testing Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screening Diabetes screenings Diabetes self-management training 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) Screening and counseling to reduce alcohol misuse 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. The plan covers preventive care screenings and annual physical exams at 100%.	
	Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*

Benefits		In-Network	Out-of-Network
Emergency Care		$50 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. 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.	
Urgently Needed Services		$35 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 (Costs for services may be different if received in an outpatient surgery setting)	Diagnostic radiology services (e.g., MRI)	4% coinsurance	4% coinsurance
	Lab services	$0 copay	$0 copay
	Diagnostic tests and procedures	4% coinsurance	4% coinsurance
	Therapeutic radiology	4% coinsurance	4% coinsurance
	Outpatient x-rays	4% coinsurance	4% coinsurance
Hearing Services	Exam to diagnose and treat hearing and balance issues	4% coinsurance	4% coinsurance
	Routine hearing exam	$0 copay (1 exam every plan year)*	$0 copay (1 exam every plan year)*
	Hearing aids	Plan pays up to $500 (every 3 plan years)*	Plan pays up to $500 (every 3 plan years)*

Benefits		In-Network	Out-of-Network
Vision Services	Exam to diagnose and treat diseases and conditions of the eye	4% coinsurance	4% coinsurance
	Eyewear after cataract surgery	$0 copay	$0 copay
	Yearly glaucoma screening	$0 copay	$0 copay
	Routine eye exam	$0 copay (1 exam every plan year)*	$0 copay (1 exam every plan year)*
Mental Health	Inpatient visit	$200 copay per admit	$200 copay per admit
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
	Outpatient group therapy visit	4% coinsurance	4% coinsurance
	Outpatient individual therapy visit	4% coinsurance	4% coinsurance
Skilled Nursing Facility (SNF)		$0 copay per day: for days 1–20 $30 copay per day: for days 21–100	$0 copay per day: for days 1–20 $30 copay per day: for days 21–100
		Our plan covers up to 100 days in a SNF.	
Physical Therapy **Speech Therapy**		4% coinsurance	4% coinsurance
Ambulance		4% coinsurance	4% coinsurance
Medicare Part B Drugs	Chemotherapy drugs	4% coinsurance	4% coinsurance
	Other Part B drugs	4% coinsurance	4% coinsurance

Additional Benefits		In-Network	Out-of-Network
Cardiac Rehabilitation		4% coinsurance	4% coinsurance
Chiropractic Care	Manual manipulation of the spine to correct subluxation	4% coinsurance	4% coinsurance
Diabetes Management	Diabetes monitoring supplies	$0 copay	$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.	
	Diabetes Self-management training	$0 copay	$0 copay
	Therapeutic shoes or inserts	4% coinsurance	4% coinsurance
Durable Medical Equipment	Durable Medical Equipment (e.g., wheelchairs, oxygen)	4% coinsurance	4% coinsurance
	Prosthetics (e.g., braces, artificial limbs)	4% coinsurance	4% coinsurance
Fitness program through SilverSneakers		$0 membership fee. Monthly basic membership for SilverSneakers® Fitness Program 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.	

Additional Benefits		In-Network	Out-of-Network
Foot Care (podiatry services)	Foot exams and treatment	4% coinsurance	4% coinsurance
	Routine foot care	$0 copay for each visit (up to 6 visits per plan year)*	$0 copay for each visit (up to 6 visits per plan year)*
Home Health Care		$0 copay Restrictions apply	$0 copay Restrictions apply
Hospice		If you are entitled to Medicare Part A, 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. If you are not entitled to Medicare Part A, all care related to the terminal illness must be provided by a Medicare-certified Hospice, which is billed directly to the plan. Please refer to the Evidence of Coverage.	
NurseLine℠		Speak with a registered nurse (RN) 24 hours a day, 7 days a week.	
Occupational Therapy		4% coinsurance	4% coinsurance
Outpatient Surgery		4% coinsurance	4% coinsurance
Outpatient Substance Abuse	Outpatient group therapy visit	4% coinsurance	4% coinsurance
	Outpatient individual therapy visit	4% coinsurance	4% coinsurance
Renal Dialysis		4% coinsurance	4% coinsurance
Virtual Doctor Visits		Speak to specific doctors using your computer or mobile device with a $0 copay. Find participating doctors online at www.UHCRetiree.com/trs	

*Benefit is combined in and out-of-network.

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
- Occupational Therapy
- Physical Therapy and Speech/Language Therapy
- Cardiac 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)

The deductible does not apply to the following services:

- Chiropractic Services (Medicare-covered)
- 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
- Virtual Doctor Visits

Required Information

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

The 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.

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. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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, TTY 711, 8 a.m. – 8 p.m. local time, Monday – Friday.

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます 。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: گر با شما **فاسی** .که کا شناسایی شما قید شد **(Farsi)** ست، خدما مد بانی به و یگا ختیا شما می باشد. لطفا با شما تلفن یگانی تما بگیرید

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.