2019 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_4279965_M

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

Summary of Benefits

January 1, 2019 – December 31, 2019

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, be enrolled in Medicare Part B, live in 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. TRS has made arrangements with us to offer a Medicare Advantage plan even though you aren't entitled to Part A based on former employment.

About providers

UnitedHealthcare Group Medicare Advantage (PPO) has a network of doctors, hospitals, and other 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 or been excluded from Medicare.

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

UnitedHealthcare Group Medicare Advantage (PPO)

Premiums and Benefits	In-Network	Out-of-Network
Monthly Plan Premium	Contact your group plan sponsor to determine your actual premium amount, if applicable.	
Annual Medical Deductible	$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	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,200 each 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.)	

UnitedHealthcare Group Medicare Advantage (PPO)

Benefits		In-Network	Out-of-Network
Inpatient Hospital		$200 copay per admit	$200 copay per admit
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital, including Observation		4% coinsurance	4% coinsurance
Doctor Visits	Primary	4% coinsurance	4% coinsurance
	Specialists	4% coinsurance	4% coinsurance
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 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. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.	
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. Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Worldwide coverage is included when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain services.	
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

Benefits		In-Network	Out-of-Network
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)*
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 per benefit period (see the Evidence of Coverage for details on benefit periods).	
Physical Therapy and Speech and Language Therapy Visit		4% coinsurance	4% coinsurance
Ambulance		4% coinsurance	4% coinsurance

Benefits		In-Network	Out-of-Network
Medicare Part B Drugs	Chemotherapy drugs	4% coinsurance	4% coinsurance
	Other Part B drugs	4% coinsurance We cover Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.	4% coinsurance We cover Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

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 ACCU-CHEK® and OneTouch®brands. Covered glucose monitors include: OneTouch Verio®, OneTouch Verio ® IQ, OneTouch Verio®Flex, ACCU-CHEK® Guide, ACCU-CHEK® Aviva, and ACCU-CHEK® Nano Smart View. Test Strips:OneTouch Verio®, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® SmartView, and OneTouch Ultra®. Other brands are not covered by your plan.	
	Diabetes self-management training	$0 copay	$0 copay
	Therapeutic shoes or inserts	4% coinsurance	4% coinsurance
Durable Medical Equipment (DME) and Related Supplies	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 Fitness Program		$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.	
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	$0 copay

Additional Benefits

		In-Network	Out-of-Network
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 Visit		4% coinsurance	4% coinsurance
Outpatient Substance Abuse	Outpatient group therapy visit	4% coinsurance	4% coinsurance
	Outpatient individual therapy visit	4% coinsurance	4% coinsurance
Outpatient Surgery		4% coinsurance	4% coinsurance
Renal Dialysis		4% coinsurance	4% coinsurance
Virtual Behavioral Visits		4% coinsurance See and speak to specific mental health professionals using your computer or mobile device. Find participating mental health professionals online at www.UHCRetiree.com/trs.	
Virtual Doctor Visits		$0 copay See a doctor any time, any day, from wherever you can access a strong internet connection. Experience a live video chat with a doctor using your computer, tablet or smartphone. Ask questions, get a diagnosis, even get medication prescribed and have it sent to your pharmacy. 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

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.

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 plan year.

The 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.

Availability of the SilverSneakers program varies by plan/market. 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.

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 in the front of this booklet.

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 in the front of this booklet.

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 la portada de esta guía.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打本手冊封面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. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: 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 nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال على رقم الهاتف المجاني للعضو الموجود في مقدمة هذا الكتيب.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

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

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre 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。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان اعضا که بر روی جلد این کتابچه قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया इस पुस्तिका के सामने के पृष्ठ पर सूचीबद्ध सदस्य टोल-फ्री फ़ोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខសមាជិកឥតចេញថ្លៃ បានកត់នៅខាងមុខនៃកូនសៀវភៅនេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

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 díí naaltsoos bidáahgi t'áá jiik'eh naaltsoos báha'dít'éhígíí 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 xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.