

# Summary of Benefits 2021

Medicare Advantage Plan

## UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (Plan Sponsor): Bank of America

Group Numbers: 12322, 12323, 12324, 12325

H2001-817-000

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 **1-866-460-8856**, TTY **711**

8 a.m. – 8 p.m. local time, 7 days a week



[www.UHCRetiree.com/healthplans](http://www.UHCRetiree.com/healthplans)



# Summary of Benefits

## January 1, 2021 – December 31, 2021

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/healthplans](http://www.UHCRetiree.com/healthplans), or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

## 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 below, be a United States citizen or lawfully present in the United States, and meet the eligibility requirements of your former employer (plan sponsor).

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

## About providers

UnitedHealthcare Group Medicare Advantage (PPO) has a network of doctors, hospitals, and other providers. As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Because you are a member of the UnitedHealthcare Group Medicare Advantage (PPO) plan, **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 or precluded from the Medicare Program.**

You can go to [www.UHCRetiree.com/healthplans](http://www.UHCRetiree.com/healthplans) to search for a network provider using the online directory.

# UnitedHealthcare Group Medicare Advantage (PPO)

## Premiums and Benefits

	Medicare Advantage Core In-Network and Out-of-Network†	Medicare Advantage Comprehensive In-Network and Out-of-Network†
<b>Monthly Plan Premium</b>	Contact the Bank of America Global HR Service Center at 1-800-556-6044 to determine your actual premium amount, if applicable.	
<b>Annual Medical Deductible</b>	\$300 per year for some in-network and out-of-network services.	This plan does not have a deductible.
<b>Maximum Out-of-Pocket Amount</b>	<p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$3,000 each plan year.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums.</p>	<p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$600 each plan year.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums.</p>

# UnitedHealthcare Group Medicare Advantage (PPO)

## Benefits

		Medicare Advantage Core In-Network and Out-of-Network†	Medicare Advantage Comprehensive In-Network and Out-of-Network†
<b>Inpatient Hospital<sup>1</sup></b>		<p>\$100 copay per day: days 1–9</p> <p>\$0 copay per day: days 10 and beyond</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p>	<p>\$100 copay per stay</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p>
<b>Outpatient Hospital</b>  Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC) <sup>1</sup>	\$20 copay	\$20 copay
	Outpatient surgery <sup>1</sup>	\$20 copay	\$20 copay
	Outpatient hospital services, including observation <sup>1</sup>	\$20 copay	\$20 copay
<b>Doctor Visits</b>	Primary	\$20 copay	\$5 copay
	Specialists <sup>1</sup>	\$30 copay	\$10 copay
	Virtual Doctor Visits	\$0 copay	\$0 copay

## Benefits

		Medicare Advantage Core	Medicare Advantage Comprehensive
		In-Network and Out-of-Network†	In-Network and Out-of-Network†
<b>Preventive Care</b>	Medicare-covered	\$0 copay	\$0 copay
		<p>Abdominal aortic aneurysm screening</p> <p>Alcohol misuse counseling</p> <p>Annual “Wellness” visit</p> <p>Bone mass measurement</p> <p>Breast cancer screening (mammogram)</p> <p>Cardiovascular disease (behavioral therapy)</p> <p>Cardiovascular screening</p> <p>Cervical and vaginal cancer screening</p> <p>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</p> <p>Depression screening</p> <p>Diabetes screenings and monitoring</p> <p>Diabetes – Self-Management training</p> <p>Dialysis training</p> <p>Glaucoma screening</p> <p>Hepatitis C screening</p> <p>HIV screening</p> <p>Kidney disease education</p> <p>Lung cancer with low dose computed tomography (LDCT) screening</p> <p>Medical nutrition therapy services</p> <p>Medicare Diabetes Prevention Program (MDPP)</p> <p>Obesity screenings and counseling</p> <p>Prostate cancer screenings (PSA)</p> <p>Sexually transmitted infections screenings and counseling</p> <p>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</p> <p>Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</p> <p>“Welcome to Medicare” preventive visit (one-time)</p> <hr/> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>This plan covers preventive care screenings and annual physical exams at 100%.</p>	
	Routine physical	\$0 copay; 1 per plan year*	\$0 copay; 1 per plan year*

## Benefits

		<b>Medicare Advantage Core</b> In-Network and Out-of-Network <sup>†</sup>	<b>Medicare Advantage Comprehensive</b> In-Network and Out-of-Network <sup>†</sup>
<b>Emergency Care</b>		\$75 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” section of this booklet for other costs.	\$65 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” section of this booklet for other costs.
<b>Urgently Needed Services</b>		\$65 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” section of this booklet for other costs.	\$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” section of this booklet for other costs.
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b>	Diagnostic radiology services (e.g., MRI) <sup>1</sup>	\$20 copay	\$20 copay
	Lab services <sup>1</sup>	\$20 copay	\$0 copay
	Diagnostic tests and procedures <sup>1</sup>	\$20 copay	\$20 copay
	Therapeutic radiology <sup>1</sup>	\$20 copay	\$20 copay
	Outpatient x-rays <sup>1</sup>	\$20 copay	\$0 copay
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues <sup>1</sup>	\$30 copay	\$25 copay
	Routine hearing exam	\$0 copay (1 exam per plan year)*	\$0 copay (1 exam per plan year)*
	Hearing Aids	The plan pays up to a \$500 allowance for hearing aid(s) every 3 years.*	The plan pays up to a \$500 allowance for hearing aid(s) every 3 years.*

## Benefits

		<b>Medicare Advantage Core</b> In-Network and Out-of-Network <sup>†</sup>	<b>Medicare Advantage Comprehensive</b> In-Network and Out-of-Network <sup>†</sup>
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye <sup>1</sup>	\$30 copay	\$25 copay
	Eyewear after cataract surgery	\$0 copay	\$0 copay
	Routine eye exam	\$30 copay (1 exam every 12 months)*	\$25 copay (1 exam every 12 months)*
<b>Mental Health</b>	Inpatient visit <sup>1</sup>	\$100 copay per day: days 1–8 \$0 copay per day: days 9–190 Our plan covers 190 days for an inpatient hospital stay.	\$100 copay per stay Our plan covers 190 days for an inpatient hospital stay.
	Outpatient group therapy visit <sup>1</sup>	\$20 copay	\$20 copay
	Outpatient individual therapy visit <sup>1</sup>	\$30 copay	\$25 copay
	Virtual Behavioral Visits	\$30 copay	\$25 copay
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>		\$0 copay per day: days 1–20 \$100 copay per day: days 21–55 \$0 copay per day: days 56–100 The plan covers up to 100 days in a SNF.	\$0 copay per day: days 1–20 \$50 copay per day: days 21–100 The plan covers up to 100 days in a SNF.
<b>Physical Therapy and Speech and Language Therapy Visit<sup>1</sup></b>		\$20 copay	\$20 copay
<b>Ambulance<sup>2</sup></b>		\$100 copay	\$50 copay
<b>Routine Transportation</b>		Not covered.	Not covered.
<b>Medicare Part B Drugs</b>	Chemotherapy drugs <sup>1</sup>	\$20 copay	\$20 copay
	Other Part B drugs <sup>1</sup>	\$20 copay	\$20 copay

## Additional Benefits

		<b>Medicare Advantage Core</b> In-Network and Out-of-Network <sup>†</sup>	<b>Medicare Advantage Comprehensive</b> In-Network and Out-of-Network <sup>†</sup>
<b>Acupuncture</b>	Medicare-covered acupuncture	\$30 copay	\$25 copay
	Routine acupuncture	\$30 copay (Unlimited visits per plan year)*	\$25 copay (Unlimited visits per plan year)*
<b>Chiropractic Care</b>	Manual manipulation of the spine to correct subluxation <sup>1</sup>	\$20 copay	\$20 copay
	Routine chiropractic care	\$30 copay (Up to 20 visits per plan year)*	\$20 copay (Up to 20 visits per plan year)*
<b>Diabetes Management</b>	Diabetes monitoring supplies <sup>1</sup>	<p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p>	<p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, Accu-Chek® Guide Me, and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p>
	Medicare-covered therapeutic contentious glucose monitors (CGMs) and supplies <sup>1</sup>	\$0 copay	\$0 copay
	Diabetes Self-management training	\$0 copay	\$0 copay
	Therapeutic shoes or inserts <sup>1</sup>	\$0 copay	\$0 copay



## Additional Benefits

		<b>Medicare Advantage Core</b> In-Network and Out-of-Network <sup>†</sup>	<b>Medicare Advantage Comprehensive</b> In-Network and Out-of-Network <sup>†</sup>
<b>Durable Medical Equipment (DME) and Related Supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>1</sup>	\$20 copay	\$20 copay
	Prosthetics (e.g., braces, artificial limbs) <sup>1</sup>	\$20 copay	\$20 copay
<b>Fitness program through SilverSneakers®</b>		<p>You have access to SilverSneakers®, a Medicare fitness program. SilverSneakers includes a \$0 membership fee for a standard, monthly membership at a participating fitness center.</p> <p>To get your SilverSneakers ID number or learn more about this benefit, visit <a href="http://SilverSneakers.com">SilverSneakers.com</a> or call 1-888-423-4632, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday.</p>	<p>You have access to SilverSneakers®, a Medicare fitness program. SilverSneakers includes a \$0 membership fee for a standard, monthly membership at a participating fitness center.</p> <p>To get your SilverSneakers ID number or learn more about this benefit, visit <a href="http://SilverSneakers.com">SilverSneakers.com</a> or call 1-888-423-4632, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday.</p>
<b>Foot Care (podiatry services)</b>	Foot exams and treatment <sup>1</sup>	\$30 copay	\$25 copay
	Routine foot care	\$30 copay for each visit (Up to 6 visits per plan year)*	\$25 copay for each visit (Up to 6 visits per plan year)*
<b>Home Health Care<sup>1</sup></b>		<p>\$0 copay</p> <p>See the Evidence of Coverage for the restrictions that apply to this benefit.</p>	<p>\$0 copay</p> <p>See the Evidence of Coverage for the restrictions that apply to this benefit.</p>

## Additional Benefits

		<b>Medicare Advantage Core</b> In-Network and Out-of-Network <sup>†</sup>	<b>Medicare Advantage Comprehensive</b> In-Network and Out-of-Network <sup>†</sup>
<b>Hospice</b>		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.	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.
<b>NurseLine</b>		Receive access to nurse consultations and additional clinical resources at no additional cost.	Receive access to nurse consultations and additional clinical resources at no additional cost.
<b>Occupational Therapy Visit<sup>1</sup></b>		\$20 copay	\$20 copay
<b>Opioid Treatment Program Services<sup>1</sup></b>		\$0 copay	\$0 copay
<b>Outpatient Substance Abuse</b>	Outpatient group therapy visit <sup>1</sup>	\$20 copay	\$20 copay
	Outpatient individual therapy visit <sup>1</sup>	\$30 copay	\$25 copay
<b>Renal Dialysis<sup>1</sup></b>		\$20 copay	\$20 copay

<sup>1</sup>Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

<sup>2</sup>Authorization is required for Non-emergency Medicare-covered ambulance ground and air transportation. Emergency Ambulance does not require authorization.

<sup>†</sup>As a member of plan you can see any provider (in-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 or precluded from the Medicare Program.

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

## 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.

Plans may offer supplemental benefits in addition to Part C benefits.

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 [www.medicare.gov](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.

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

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 our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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 of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2019 All rights reserved.