



# 2025 Plan Guide

**The Episcopal Church Medical Trust**

UnitedHealthcare® Group Medicare Advantage (PPO)

**Group Number:** 16241, 16242

**Effective:** January 1, 2025 through December 31, 2025

United  
Healthcare®  
Group Medicare Advantage



# With the UnitedHealthcare® Group Medicare Advantage (PPO) plan, you get more

The Episcopal Church Medical Trust (Medical Trust) has chosen a UnitedHealthcare® Group Medicare Advantage (PPO) plan that offers both medical and prescription drug coverage for you and your eligible dependents. With this plan, you'll enjoy an easier than ever Medicare experience. You've earned it.



## Read through this Plan Guide to get to know your new plan

The guide includes:

- A description of the plan and its 2 options
  - GMA Premium (PPO) 16242 – annual medical out-of-pocket maximum\* of \$1,500 per member
  - GMA Comprehensive (PPO) 16241 – annual medical out-of-pocket maximum\* of \$2,000 per member
- Information about benefits, programs and services, and how much they cost
- Information about covered drugs and how much they cost
- What you can expect after your enrollment

Please keep this Plan Guide. It has information that will be helpful once you become a member. You can also get plan information at the website below. Use the Group Number on the front cover of this book to access plan materials online. To learn about the other benefits, including dental, available to you as a retiree of the Medical Trust, visit [cpg.org/otherbenefits](https://cpg.org/otherbenefits).



## How to enroll

Please review your options and choose a medical plan that best meets your healthcare needs.

### To enroll:

1. **Read your UnitedHealthcare Plan Guide.** The guide will include details on the GMA Premium (PPO) and GMA Comprehensive (PPO) plan options.

 [retiree.uhc.com/ECMT](https://retiree.uhc.com/ECMT)



Call toll-free **1-866-519-5401**, TTY **711**  
8 a.m.-8 p.m. local time, Monday-Friday

## **2. Complete the enrollment form to make your benefits elections.**

You can find the form in the retirement information sent to you from the Church Pension Group. You can also access the enrollment form at [cpg.org/gmaenrollmentform](http://cpg.org/gmaenrollmentform).

## **3. Please sign the enrollment form** and return it to us in the enclosed self-addressed envelope. To prevent a delay in processing, please return it to us 60 days prior to your effective date.

### **Need help enrolling?**

Please contact The Medical Trust at **1-800-480-9967**, 8:30 a.m.–8 p.m. ET, Monday–Friday. To secure your Medical Trust dental coverage for 2025, you must enroll in a Delta Dental plan during Annual Enrollment. Cigna Dental will no longer be offered.



### **Take control of your health**

- Learn about this new plan and the many benefits it offers, such as UnitedHealthcare Hearing, UnitedHealthcare Global Travel and fitness benefits
- Get tools and resources to help you be in more control of your health
- Find ways to save money on healthcare so you can focus more on what matters to you
- Get access to care when you need it










To speak with someone about plan choices and benefits, contact UnitedHealthcare at the toll-free number below.

\*An out-of-pocket maximum places a limit on how much money you pay out of pocket for your medical expenses in a calendar year. This does not include prescription drug costs or plan premiums.

# More than health insurance

With this GMA Comprehensive (PPO) plan you get medical and prescription drug coverage and so much more. More benefits. More savings. More experience. More choices. More convenience.

## Here's just some of what this plan offers

-  **No deductible**
-  **Earn rewards** to spend on eligible items like gifts, clothing, groceries and more
-  **Free delivery with Optum® Home Delivery Pharmacy** for prescriptions you take regularly
-  **Free standard gym membership** at participating locations
-  **Free UnitedHealthcare® HouseCalls visit** from one of our licensed health care practitioners
-  **Free hearing exam** and \$3,000 with GMA Comprehensive plan or \$4,000 with the GMA Premium plan to spend on a broad selection of hearing aids
-  **Virtual doctor and behavioral health visits** using your computer, tablet or smartphone – anytime, day or night
-  **Medicare Advantage's largest national provider network**
-  **Special programs to help you** if you are living with a chronic disease, like diabetes or heart disease, or other complex health needs
-  **Free diabetic supplies** like continuous glucose monitors, needles and test strips

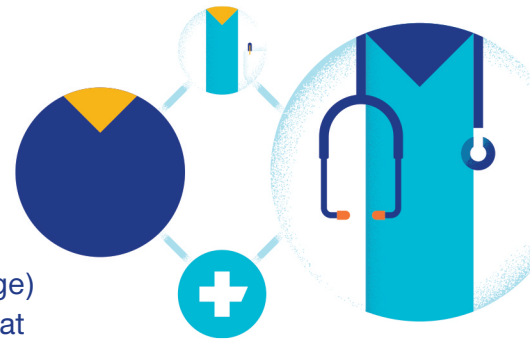


**Review the Summary of Benefits in this guide for more details**

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# + More from your health plan



Your PPO plan is a Medicare Advantage plan, also known as Medicare Part C. This plan has all the benefits of Medicare Part A (hospital coverage) and Medicare Part B (doctor and outpatient care) plus extra programs that go beyond Original Medicare (Medicare Parts A and B). Medicare has rules about what types of coverage you can add or combine with a group-sponsored Medicare Advantage plan.

## Here's how this PPO plan works



**Get care from providers in or out-of-network as long as they accept Medicare and the plan**



**No referral is needed to see a specialist or other provider**



**Select a primary care provider (PCP) to oversee and help manage your care**

It's not required by the plan, but it's very beneficial for your long-term health and well-being.



**You pay a standard copay or coinsurance to see a network or out-of-network provider**

We work closely with our network (contracted) providers to make sure they have access to resources and tools to help them work with you for better health outcomes.



**This plan has separate maximum annual out-of-pocket amounts for medical and prescription drugs**

If you reach your plan's medical limit, the plan will pay 100% of your Medicare-covered services for the rest of the plan year. After you and others on your behalf have paid a combined total of \$2,000 for your prescription drugs, you won't pay anything for your Medicare-covered Part D drugs for the rest of the calendar year.



**Emergency and urgently needed services are covered anywhere in the world**



**This plan includes prescription drug coverage for thousands of brand name and generic drugs**

Always use network pharmacies for your plan's lowest cost on prescription drugs.

To search for a network provider or pharmacy, visit [retiree.uhc.com/ECMT](https://retiree.uhc.com/ECMT). You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

**Scan this code to view the Drug List**



# Get to know your plan

It's important that you understand your plan and what benefits are covered. You can find the Drug List, Provider and Pharmacy directories and more at [retiree.uhc.com/ECMT](http://retiree.uhc.com/ECMT).



## Review the online Drug List to see what prescription drugs are covered

And what drug tier they are in. Generally, the lower the drug tier, the less you'll pay.



## Review the online Provider Directory to see if your providers are in the network

It's okay if they're not. This plan allows you to see out-of-network providers at the same cost share as long as they accept Medicare and the plan.



## Review the online Pharmacy Directory to see what pharmacies are in our network

If your pharmacy is not in the network, you will need to select a new network pharmacy to pay your plan's lowest cost for prescription drugs.



## Review the Summary of Benefits in this guide to see how much you'll pay for medical services and prescription drugs

You can also review the Summary of Benefits online.

If you're not sure if you are enrolled in Medicare Part B, check with Social Security at [ssa.gov/locator](http://ssa.gov/locator) or call 1-800-772-1213, TTY 1-800-325-0778, 8 a.m.–7 p.m., Monday–Friday, or call your local office.

You may be disenrolled from this plan if you stop paying your Medicare Part B premium.

## You're eligible to enroll in this Medicare Advantage plan if you:



Are entitled to Medicare Part A and enrolled in Medicare Part B.



Continue to pay your Part B premium (unless it's paid for you).



**Remember:** If you drop or are disenrolled from your group-sponsored retiree coverage, you may not be able to re-enroll. Limitations and restrictions vary by former employer or plan sponsor.



# Summary of Benefits 2025

## **GMA Comprehensive (PPO)**

Group Name (Plan Sponsor): The Episcopal Church Medical Trust

Group Number: 16241

H2001-847-000

Look inside to learn more about the plan and the health and drug services it covers.  
Contact us for more information about the plan.



**[retiree.uhc.com/ECMT](https://retiree.uhc.com/ECMT)**



**Toll-free 1-866-519-5401, TTY 711**

8 a.m.-8 p.m. local time, Monday-Friday

**United  
Healthcare**  
Group Medicare Advantage

Y0066\_SB\_H2001\_847\_000\_2025\_M

# Summary of Benefits

**January 1, 2025 - December 31, 2025**

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can call Customer Service if you want a copy of the EOC or need help. When you enroll in the plan, you will get more information on how to view your plan details online.

## GMA Comprehensive (PPO)

| Medical premium and limits   |                                  |  |
|--|----------------------------------|--|
|  |                                  | In-network and out-of-network  |
| <b>Monthly plan premium</b>  |                                  | Contact your group plan benefit administrator to determine your actual premium amount, if applicable.  |
| <b>Maximum out-of-pocket amount</b><br>(does not include prescription drugs) |                                  | <p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$2,000 for this plan year.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered for hospital and medical services and we will pay the full cost for the rest of the plan year.</p> <p>Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.</p> |
| Medical benefits   |                                  |  |
|  |                                  | In-network and out-of-network  |
| <b>Inpatient hospital care</b> <sup>1</sup>                                  |                                  | <p>\$0 copay per stay</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p>   |
| <b>Outpatient hospital</b> <sup>1</sup>                                      | Ambulatory surgical center (ASC) | \$0 copay  |
| Cost sharing for additional plan   | Outpatient surgery               | \$0 copay  |



## Medical benefits

|  |  | In-network and out-of-network  |
|--|--|--|
| covered services will apply.   | Outpatient hospital services, including observation  | \$0 copay  |
|  <b>Doctor visits</b> | Primary care provider (PCP)  | \$5 copay  |
|  | Virtual visit  | \$0 copay for designated providers<br>\$5 copay for other providers  |
|  | Specialist <sup>1</sup>  | \$10 copay   |
| <b>Preventive services</b>   | Routine physical   | \$0 copay; 1 per plan year*  |
|  | Medicare-covered   | \$0 copay  |
|  | <ul style="list-style-type: none"> <li>□ Abdominal aortic aneurysm screening</li> <li>□ Alcohol misuse counseling</li> <li>□ Annual wellness visit</li> <li>□ Bone mass measurement</li> <li>□ Breast cancer screening (mammogram)</li> <li>□ Cardiovascular disease (behavioral therapy)</li> <li>□ Cardiovascular screening</li> <li>□ Cervical and vaginal cancer screening</li> <li>□ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>□ Depression screening</li> <li>□ Diabetes screenings and monitoring</li> <li>□ Diabetes – Self-Management training</li> <li>□ Dialysis training</li> <li>□ Glaucoma screening</li> <li>□ Hepatitis C screening</li> <li>□ HIV screening</li> </ul> | <ul style="list-style-type: none"> <li>□ Kidney disease education</li> <li>□ Lung cancer with low dose computed tomography (LDCT) screening</li> <li>□ Medical nutrition therapy services</li> <li>□ Medicare Diabetes Prevention Program (MDPP)</li> <li>□ Obesity screenings and counseling</li> <li>□ Prostate cancer screenings (PSA)</li> <li>□ Sexually transmitted infections screenings and counseling</li> <li>□ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>□ Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</li> <li>□ “Welcome to Medicare” preventive visit (one-time)</li> </ul> |

## Medical benefits

### In-network and out-of-network

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%.

#### Emergency care

\$100 copay (worldwide)

If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.

#### Urgently needed services

\$10 copay (worldwide)

If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing 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

Diagnostic radiology services (e.g. MRI, CT scan)<sup>1</sup>

\$0 copay

Lab services<sup>1</sup>

\$0 copay

Diagnostic tests and procedures<sup>1</sup>

\$0 copay

Therapeutic radiology<sup>1</sup>

\$0 copay

Outpatient X-rays<sup>1</sup>

\$0 copay


#### Hearing services

Exam to diagnose and treat hearing and balance issues<sup>1</sup>

\$10 copay

Routine hearing exam<sup>^</sup>

\$0 copay, 1 exam per plan year\*

| Medical benefits   |  |   |
|--|--|---|
|  |  | In-network and out-of-network   |
|  | Hearing Aids^<br>UnitedHealthcare<br>Hearing                               | Through UnitedHealthcare Hearing, the plan pays a \$3,000 allowance for hearing aids (combined for both ears) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing. |
|  <b>Vision services</b> | Exam to diagnose and treat diseases and conditions of the eye <sup>1</sup> | \$10 copay  |
|  | Eyewear after cataract surgery   | \$0 copay   |
| <b>Mental health</b>   | Inpatient visit <sup>1</sup>   | \$0 copay per stay<br><br>Our plan covers an unlimited number of days for an inpatient hospital stay.   |
|  | Outpatient group therapy visit <sup>1</sup>                                | \$10 copay  |
|  | Outpatient individual therapy visit <sup>1</sup>                           | \$10 copay  |
|  | Outpatient therapy or office visit with a psychiatrist <sup>1</sup>        | \$10 copay  |
|  | Virtual behavioral visits  | \$10 copay  |
| <b>Skilled nursing facility (SNF)<sup>1</sup></b>  |  | \$0 copay per day: days 1-100<br><br>Our plan covers up to 100 days in a SNF per benefit period.  |
| <b>Outpatient Rehabilitation (physical, occupational, or speech/language therapy)<sup>1</sup></b>        |  | \$0 copay   |
| <b>Ambulance<sup>2</sup></b>   |  | \$25 copay  |
| <b>Medicare Part B Drugs</b>   | Chemotherapy drugs <sup>1</sup>  | 20% coinsurance   |

## Medical benefits

|   |                                 | In-network and out-of-network |
|---|---------------------------------|-------------------------------|
| Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | Other Part B drugs <sup>1</sup> | 20% coinsurance               |

## Good news for 2025

The Coverage Gap, or “donut hole”, has been eliminated and your out-of-pocket limit (the amount you and others on your behalf pay) is \$2,000. That means you're more protected from high drug costs in 2025.

## Prescription drugs

|   |  |                                |
|---|--|--------------------------------|
| <b>Deductible</b>   | The plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.   |                                |
| <b>Initial coverage</b>   | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of \$2,000 you move to the Catastrophic Coverage stage. |                                |
| <b>Tier drug coverage</b><br>(After you pay your deductible, if applicable) | <b>Retail Cost-Sharing</b>   | <b>Mail Order Cost-Sharing</b> |
|   | <b>31-day supply</b>   | <b>90-day supply</b>           |
| <b>Tier 1:</b><br>Preferred Generic   | \$10 copay   | \$25 copay                     |
| <b>Tier 2:</b><br>Preferred Brand ~   | \$30 copay   | \$70 copay                     |
| <b>Tier 3:</b><br>Non-preferred Drug ~                                      | \$50 copay   | \$120 copay                    |
| <b>Tier 4:</b><br>Specialty Tier ~  | \$50 copay   | \$120 copay                    |

## Prescription drugs

### Catastrophic coverage

Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year.

If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information.

<sup>~</sup> You will pay a maximum of \$35 for a 1-month supply of each Part D insulin product covered by our plan. Most adult Part D vaccines are covered at no cost to you.

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor offers drug coverage in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D benefit and your additional drug coverage. For more information, see your Additional Drug Coverage list. You can also view the Certificate of Coverage at [retiree.uhc.com/ECMT](http://retiree.uhc.com/ECMT) or call Customer Service to have a hard copy sent to you.

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 31-day supply at a retail pharmacy.

\$0

### You may qualify for Extra Help from Medicare

Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. There's no penalty for applying, and you can re-apply every year. To see if you qualify for Extra Help, call:


- The Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778
- Your state Medicaid office




### The UnitedHealthcare Savings Promise


UnitedHealthcare is committed to keeping your prescription drug costs down. As a UnitedHealthcare member, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan copay, the pharmacy's retail price or our contracted price with the pharmacy.

## Additional benefits

|  |   | In-network and out-of-network   |
|--|---|---|
| <b>Acupuncture services</b>  | Medicare-covered acupuncture (for chronic low back pain)  | \$10 copay  |
|  | Routine acupuncture services <sup>^</sup>   | \$10 copay, up to 12 visits per plan year*  |
| <b>Chiropractic services</b>   | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>1</sup> | \$10 copay  |
|  | Routine chiropractic services <sup>^</sup>  | \$10 copay, for each visit per plan year*   |
|  <b>Diabetes management</b> | Diabetes monitoring supplies <sup>1</sup>   | \$0 copay<br><br>We only cover Accu-Chek® and OneTouch® brands.<br><br>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide.<br><br>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView.<br><br>Other brands are not covered by your plan. |
|  | Medicare covered Continuous Glucose Monitors (CGMs) and supplies <sup>1</sup>                             | \$0 copay   |
|  | Diabetes self-management training   | \$0 copay   |
|  | Therapeutic shoes or inserts <sup>1</sup>   | 20% coinsurance   |

## Additional benefits

|   |  | In-network and out-of-network  |
|---|--|--|
| <b>Durable medical equipment (DME) and related supplies</b>   | Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>1</sup> | 20% coinsurance  |
|   | Prosthetics (e.g., braces, artificial limbs) <sup>1</sup>          | 20% coinsurance  |
|  <b>Fitness program</b><br>Renew Active® by UnitedHealthcare         |  | <p>\$0 copay for Renew Active® by UnitedHealthcare®, the gold standard in Medicare fitness programs. It includes a free gym membership at a fitness location you select from a large nationwide network, plus online classes and fun social activities.</p> <p>Call or go online to learn more and to get your confirmation code. Sign in to your member site, look for My Coverage and select Access gym code or call the number on your UnitedHealthcare member ID card to obtain your code.</p>   |
| <b>Foot care (podiatry services)</b>  | Foot exams and treatment <sup>1</sup>                              | \$10 copay   |
|   | Routine foot care <sup>^</sup>                                     | \$10 copay, 6 visits per plan year*  |
| <b>Global travel assistance</b><br>UnitedHealthcare Global  |  | <p>\$0 copay for 24-hour travel and medical assistance while you're traveling outside your country or over 100 miles away from your home.</p> <p>You'll get a separate ID card for the UnitedHealthcare Global services including contact information for the Emergency Response Center (ERC).</p>   |
|  <b>UnitedHealthcare Healthy at Home</b><br>Post-discharge program |  | <p>\$0 copay for the following benefits for up to 30 days following each inpatient hospital and SNF stay:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 28 home-delivered meals, referral required</li> <li><input type="checkbox"/> 12 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip, referral required</li> <li><input type="checkbox"/> 6 hours of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver, no referral required</li> </ul> |

| Additional benefits   |  | In-network and out-of-network   |
|---|--|---|
|   |  | Services must be provided by approved vendors. Call Customer Service for more information, to request a referral after each discharge and to use your benefits.   |
|  Home health care <sup>1</sup> |  | \$0 copay   |
| <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.  |
| <b>In-home non-medical care</b>   |  | \$0 copayment for 8 hours per month of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver. Unused hours do not roll over. Some restrictions and limitations apply. |
| <b>Opioid treatment program services<sup>1</sup></b>  |  | \$0 copay   |
| <b>Outpatient substance use disorder services</b>   | Outpatient group therapy visit <sup>1</sup>      | \$10 copay  |
|   | Outpatient individual therapy visit <sup>1</sup> | \$10 copay  |
| <b>Renal dialysis<sup>1</sup></b>   |  | \$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 air transportation. Authorization is not required for non-emergency Medicare-covered ambulance ground transportation. Emergency ambulance (ground or air) does not require authorization.

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

^Covered services that do not count toward your maximum out-of-pocket amount.



## About this plan

GMA Comprehensive (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, union group or trust administrator (plan sponsor).

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

## About providers and network pharmacies

GMA Comprehensive (PPO) has a network of doctors, hospitals, pharmacies 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 or precluded from the Medicare program. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to [retiree.uhc.com/ECMT](https://retiree.uhc.com/ECMT) to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

## Required Information

GMA Comprehensive (PPO) is 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 and Part D 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.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunice con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

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

Benefits, features and/or devices vary by plan/area. Limitations and exclusions may apply.

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. There may be other pharmacies in our network.

The Formulary, pharmacy network, and/or 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.

Participation in the fitness program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. The fitness program includes standard fitness membership and other offerings. Fitness membership equipment, classes, activities and events may vary by location. Certain services, discounts, classes, activities, events and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. Gym network may vary in local market and plan.



# Summary of Benefits 2025

## **GMA Premium (PPO)**

Group Name (Plan Sponsor): The Episcopal Church Medical Trust

Group Number: 16242

H2001-847-000

Look inside to learn more about the plan and the health and drug services it covers.  
Contact us for more information about the plan.



**[retiree.uhc.com/ECMT](https://retiree.uhc.com/ECMT)**



**Toll-free 1-866-519-5401, TTY 711**

8 a.m.-8 p.m. local time, Monday-Friday

**United  
Healthcare®**  
Group Medicare Advantage

Y0066\_SB\_H2001\_847\_000\_2025\_M

# Summary of Benefits

**January 1, 2025 - December 31, 2025**

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can call Customer Service if you want a copy of the EOC or need help. When you enroll in the plan, you will get more information on how to view your plan details online.

## GMA Premium (PPO)

| Medical premium and limits   |  |
|--|--|
|  | In-network and out-of-network  |
| <b>Monthly plan premium</b>  | Contact your group plan benefit administrator to determine your actual premium amount, if applicable.  |
| <b>Maximum out-of-pocket amount</b><br>(does not include prescription drugs) | <p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$1,500 for this plan year.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered for hospital and medical services and we will pay the full cost for the rest of the plan year.</p> <p>Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.</p> |

| Medical benefits                           |                                  |   |
|--|----------------------------------|---|
|  |                                  | In-network and out-of-network   |
| <b>Inpatient hospital care<sup>1</sup></b> |                                  | \$0 copay per stay  |
|  |                                  | Our plan covers an unlimited number of days for an inpatient hospital stay. |
| <b>Outpatient hospital<sup>1</sup></b>     | Ambulatory surgical center (ASC) | \$0 copay   |
| Cost sharing for additional plan           | Outpatient surgery               | \$0 copay   |

## Medical benefits

|  |  | In-network and out-of-network  |
|--|--|--|
| covered services will apply.   | Outpatient hospital services, including observation  | \$0 copay  |
|  <b>Doctor visits</b> | Primary care provider (PCP)  | \$5 copay  |
|  | Virtual visit  | \$0 copay for designated providers<br>\$5 copay for other providers  |
|  | Specialist <sup>1</sup>  | \$10 copay   |
| <b>Preventive services</b>   | Routine physical   | \$0 copay; 1 per plan year*  |
|  | Medicare-covered   | \$0 copay  |
|  | <ul style="list-style-type: none"> <li><input type="checkbox"/> Abdominal aortic aneurysm screening</li> <li><input type="checkbox"/> Alcohol misuse counseling</li> <li><input type="checkbox"/> Annual wellness visit</li> <li><input type="checkbox"/> Bone mass measurement</li> <li><input type="checkbox"/> Breast cancer screening (mammogram)</li> <li><input type="checkbox"/> Cardiovascular disease (behavioral therapy)</li> <li><input type="checkbox"/> Cardiovascular screening</li> <li><input type="checkbox"/> Cervical and vaginal cancer screening</li> <li><input type="checkbox"/> Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li><input type="checkbox"/> Depression screening</li> <li><input type="checkbox"/> Diabetes screenings and monitoring</li> <li><input type="checkbox"/> Diabetes – Self-Management training</li> <li><input type="checkbox"/> Dialysis training</li> <li><input type="checkbox"/> Glaucoma screening</li> <li><input type="checkbox"/> Hepatitis C screening</li> <li><input type="checkbox"/> HIV screening</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Kidney disease education</li> <li><input type="checkbox"/> Lung cancer with low dose computed tomography (LDCT) screening</li> <li><input type="checkbox"/> Medical nutrition therapy services</li> <li><input type="checkbox"/> Medicare Diabetes Prevention Program (MDPP)</li> <li><input type="checkbox"/> Obesity screenings and counseling</li> <li><input type="checkbox"/> Prostate cancer screenings (PSA)</li> <li><input type="checkbox"/> Sexually transmitted infections screenings and counseling</li> <li><input type="checkbox"/> Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li><input type="checkbox"/> Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</li> <li><input type="checkbox"/> “Welcome to Medicare” preventive visit (one-time)</li> </ul> |

## Medical benefits

### In-network and out-of-network

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%.

#### Emergency care

\$50 copay (worldwide)

If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.

#### Urgently needed services

\$10 copay (worldwide)

If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing 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

Diagnostic radiology services (e.g. MRI, CT scan)<sup>1</sup>

\$0 copay

Lab services<sup>1</sup>

\$0 copay

Diagnostic tests and procedures<sup>1</sup>

\$0 copay

Therapeutic radiology<sup>1</sup>

\$0 copay

Outpatient X-rays<sup>1</sup>

\$0 copay


#### Hearing services

Exam to diagnose and treat hearing and balance issues<sup>1</sup>

\$10 copay

Routine hearing exam<sup>^</sup>

\$0 copay, 1 exam per plan year\*

| Medical benefits   |  |   |
|--|--|---|
|  |  | In-network and out-of-network   |
|  | Hearing Aids^<br>UnitedHealthcare<br>Hearing                               | Through UnitedHealthcare Hearing, the plan pays a \$4,000 allowance for hearing aids (combined for both ears) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing. |
|  <b>Vision services</b> | Exam to diagnose and treat diseases and conditions of the eye <sup>1</sup> | \$10 copay  |
|  | Eyewear after cataract surgery   | \$0 copay   |
| <b>Mental health</b>   | Inpatient visit <sup>1</sup>   | \$0 copay per stay<br><br>Our plan covers an unlimited number of days for an inpatient hospital stay.   |
|  | Outpatient group therapy visit <sup>1</sup>                                | \$10 copay  |
|  | Outpatient individual therapy visit <sup>1</sup>                           | \$10 copay  |
|  | Outpatient therapy or office visit with a psychiatrist <sup>1</sup>        | \$10 copay  |
|  | Virtual behavioral visits  | \$10 copay  |
| <b>Skilled nursing facility (SNF)<sup>1</sup></b>  |  | \$0 copay per day: days 1-100<br><br>Our plan covers up to 100 days in a SNF per benefit period.  |
| <b>Outpatient Rehabilitation (physical, occupational, or speech/language therapy)<sup>1</sup></b>        |  | \$0 copay   |
| <b>Ambulance<sup>2</sup></b>   |  | \$25 copay  |
| <b>Medicare Part B Drugs</b>   | Chemotherapy drugs <sup>1</sup>  | 10% coinsurance   |

## Medical benefits

|   |                                 | In-network and out-of-network |
|---|---------------------------------|-------------------------------|
| Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | Other Part B drugs <sup>1</sup> | 10% coinsurance               |

## Good news for 2025

The Coverage Gap, or “donut hole”, has been eliminated and your out-of-pocket limit (the amount you and others on your behalf pay) is \$2,000. That means you're more protected from high drug costs in 2025.

## Prescription drugs

|   |  |                                |
|---|--|--------------------------------|
| <b>Deductible</b>   | The plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.   |                                |
| <b>Initial coverage</b>   | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of \$2,000 you move to the Catastrophic Coverage stage. |                                |
| <b>Tier drug coverage</b><br>(After you pay your deductible, if applicable) | <b>Retail Cost-Sharing</b>   | <b>Mail Order Cost-Sharing</b> |
|   | <b>31-day supply</b>   | <b>90-day supply</b>           |
| <b>Tier 1:</b><br>Preferred Generic   | \$5 copay  | \$12 copay                     |
| <b>Tier 2:</b><br>Preferred Brand ~   | \$25 copay   | \$60 copay                     |
| <b>Tier 3:</b><br>Non-preferred Drug ~                                      | \$40 copay   | \$100 copay                    |
| <b>Tier 4:</b><br>Specialty Tier ~  | \$40 copay   | \$100 copay                    |



## Prescription drugs

### Catastrophic coverage

Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year.

If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information.

<sup>~</sup> You will pay a maximum of \$35 for a 1-month supply of each Part D insulin product covered by our plan. Most adult Part D vaccines are covered at no cost to you.

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor offers drug coverage in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D benefit and your additional drug coverage. For more information, see your Additional Drug Coverage list. You can also view the Certificate of Coverage at [retiree.uhc.com/ECMT](http://retiree.uhc.com/ECMT) or call Customer Service to have a hard copy sent to you.

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 31-day supply at a retail pharmacy.

\$0

### You may qualify for Extra Help from Medicare

Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. There's no penalty for applying, and you can re-apply every year. To see if you qualify for Extra Help, call:


- The Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778
- Your state Medicaid office





### The UnitedHealthcare Savings Promise


UnitedHealthcare is committed to keeping your prescription drug costs down. As a UnitedHealthcare member, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan copay, the pharmacy's retail price or our contracted price with the pharmacy.

## Additional benefits

|  |   | In-network and out-of-network   |
|--|---|---|
| <b>Acupuncture services</b>  | Medicare-covered acupuncture (for chronic low back pain)  | \$10 copay  |
|  | Routine acupuncture services <sup>^</sup>   | \$10 copay, up to 12 visits per plan year*  |
| <b>Chiropractic services</b>   | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>1</sup> | \$10 copay  |
|  | Routine chiropractic services <sup>^</sup>  | \$10 copay, for each visit per plan year*   |
|  <b>Diabetes management</b> | Diabetes monitoring supplies <sup>1</sup>   | \$0 copay<br><br>We only cover Accu-Chek® and OneTouch® brands.<br><br>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide.<br><br>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView.<br><br>Other brands are not covered by your plan. |
|  | Medicare covered Continuous Glucose Monitors (CGMs) and supplies <sup>1</sup>                             | \$0 copay   |
|  | Diabetes self-management training   | \$0 copay   |
|  | Therapeutic shoes or inserts <sup>1</sup>   | 10% coinsurance   |

## Additional benefits

|   |  | In-network and out-of-network  |
|---|--|--|
| <b>Durable medical equipment (DME) and related supplies</b>   | Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>1</sup> | 10% coinsurance  |
|   | Prosthetics (e.g., braces, artificial limbs) <sup>1</sup>          | 10% coinsurance  |
|  <b>Fitness program</b><br>Renew Active® by UnitedHealthcare         |  | <p>\$0 copay for Renew Active® by UnitedHealthcare®, the gold standard in Medicare fitness programs. It includes a free gym membership at a fitness location you select from a large nationwide network, plus online classes and fun social activities.</p> <p>Call or go online to learn more and to get your confirmation code. Sign in to your member site, look for My Coverage and select Access gym code or call the number on your UnitedHealthcare member ID card to obtain your code.</p>   |
| <b>Foot care (podiatry services)</b>  | Foot exams and treatment <sup>1</sup>                              | \$10 copay   |
|   | Routine foot care <sup>^</sup>                                     | \$10 copay, 6 visits per plan year*  |
| <b>Global travel assistance</b><br>UnitedHealthcare Global  |  | <p>\$0 copay for 24-hour travel and medical assistance while you're traveling outside your country or over 100 miles away from your home.</p> <p>You'll get a separate ID card for the UnitedHealthcare Global services including contact information for the Emergency Response Center (ERC).</p>   |
|  <b>UnitedHealthcare Healthy at Home</b><br>Post-discharge program |  | <p>\$0 copay for the following benefits for up to 30 days following each inpatient hospital and SNF stay:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 28 home-delivered meals, referral required</li> <li><input type="checkbox"/> 12 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip, referral required</li> <li><input type="checkbox"/> 6 hours of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver, no referral required</li> </ul> |

| Additional benefits   |  | In-network and out-of-network   |
|---|--|---|
|   |  | Services must be provided by approved vendors. Call Customer Service for more information, to request a referral after each discharge and to use your benefits.   |
|  Home health care <sup>1</sup> |  | \$0 copay   |
| <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.  |
| <b>In-home non-medical care</b>   |  | \$0 copayment for 8 hours per month of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver. Unused hours do not roll over. Some restrictions and limitations apply. |
| <b>Opioid treatment program services<sup>1</sup></b>  |  | \$0 copay   |
| <b>Outpatient substance use disorder services</b>   | Outpatient group therapy visit <sup>1</sup>      | \$10 copay  |
|   | Outpatient individual therapy visit <sup>1</sup> | \$10 copay  |
| <b>Renal dialysis<sup>1</sup></b>   |  | \$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 air transportation. Authorization is not required for non-emergency Medicare-covered ambulance ground transportation. Emergency ambulance (ground or air) does not require authorization.

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

^Covered services that do not count toward your maximum out-of-pocket amount.

## About this plan

GMA Premium (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, union group or trust administrator (plan sponsor).

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

## About providers and network pharmacies

GMA Premium (PPO) has a network of doctors, hospitals, pharmacies 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 or precluded from the Medicare program. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to [retiree.uhc.com/ECMT](https://retiree.uhc.com/ECMT) to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

## Required Information

GMA Premium (PPO) is 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 and Part D 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.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunice con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

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

Benefits, features and/or devices vary by plan/area. Limitations and exclusions may apply.

Optum<sup>®</sup> Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. There may be other pharmacies in our network.

The Formulary, pharmacy network, and/or 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.

Participation in the fitness program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. The fitness program includes standard fitness membership and other offerings. Fitness membership equipment, classes, activities and events may vary by location. Certain services, discounts, classes, activities, events and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. Gym network may vary in local market and plan.

# Additional Drug Coverage

This is not a complete list of prescription drugs and supplies available to you. The prescription drugs and supplies on this list are covered in addition to the plan's Drug List (Formulary). You can find the plan's Drug List on your member site or scan the QR code at the end of this Additional Drug Coverage section.

## Bonus drug list

| Drug name   | Drug tier | Coverage rules or limits on use          |
|---|-----------|--|
| <b>Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions</b>  |           |  |
| <b>Inflammation</b>   |           |  |
| Salsalate   | 1         |  |
| <b>Urinary Tract Pain</b>   |           |  |
| Phenazopyridine   | 1         |  |
| <b>Anorexiant - drugs to promote weight loss</b>  |           |  |
| Phentermine   | 1         | QL (maximum of 1 capsule/tablet per day) |
| <b>Anticoagulants - drugs to prevent clotting</b>                                       |           |  |
| Heparin Lock Flush  | 1         |  |
| <b>Dermatological agents - drugs to treat skin conditions</b>                           |           |  |
| <b>Dry, Itchy Skin</b>  |           |  |
| Sulfacetamide Sodium Liquid Wash 10%  | 1         |  |
| Sulfacetamide Sodium w/Sulfur (Cream 10-5%)   | 1         |  |
| <b>Itching or Pain</b>  |           |  |
| Pramoxine/Hydrocortisone (Cream 1-2.5%)   | 1         |  |
| <b>Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions</b> |           |  |
| <b>Hemorrhoids</b>  |           |  |
| Hydrocortisone Acetate (Suppository 25 mg)  | 1         |  |
| Lidocaine/Hydrocortisone (Perianal Cream 3%-0.5%)                                       | 1         |  |
| <b>Irritable Bowel or Ulcers</b>  |           |  |
| Hyoscyamine Sulfate   | 1         |  |
| <b>Levbid</b>   | 3         |  |

**Bold type = Brand name drug** Plain type = Generic drug

| Drug name   | Drug tier | Coverage rules or limits on use          |
|---|-----------|--|
| <b>Genitourinary agents - drugs to treat bladder, genital and kidney conditions</b> |           |  |
| <b>Erectile Dysfunction</b>   |           |  |
| <b>Edex</b>   | 3         | QL (maximum of 6 cartridges per month)   |
| Sildenafil (25 mg, 50 mg, 100 mg)   | 1         | QL (maximum of 6 tablets per month)      |
| Tadalafil   | 1         | QL (maximum of 6 tablets per month)      |
| Vardenafil  | 1         | QL (maximum of 6 tablets per month)      |
| <b>Sexual Desire Disorder</b>   |           |  |
| <b>Addyi</b>  | 3         | QL (maximum of 1 tablet per day)         |
| <b>Vyleesi</b>  | 3         | QL (maximum of 8 injections per 30 days) |
| <b>Urinary Tract Infection</b>  |           |  |
| <b>Uro-MP (118 mg)</b>  | 3         |  |
| <b>Urinary Tract Spasm and Pain</b>   |           |  |
| Belladonna Alkaloids & Opium (Suppositories)  | 1         | MME, 7D, DL                              |
| <b>Hormonal agents - hormone replacement/modifying drugs</b>                        |           |  |
| <b>Thyroid Supplement</b>   |           |  |
| <b>Armour Thyroid</b>   | 3         |  |
| NP Thyroid  | 1         |  |
| <b>Nutritional supplements - drugs to treat vitamin &amp; mineral deficiencies</b>  |           |  |
| <b>Potassium Supplement</b>   |           |  |
| <b>K-Phos (Tab)</b>   | 3         |  |
| Potassium Bicarbonate Effervescent Tab 25 mEq                                       | 1         |  |
| <b>Vitamins and Minerals</b>  |           |  |
| Cyanocobalamin (Injection) (Vitamin B12) (1000 mcg)                                 | 1         |  |
| Folic Acid (1 mg) (Rx only)   | 1         |  |
| Folic Acid-Vitamin B6-Vitamin B12 (Tablet 2.5-25-1 mg)                              | 1         |  |
| Phytonadione Tab  | 1         |  |

**Bold type = Brand name drug** Plain type = Generic drug



| Drug name   | Drug tier | Coverage rules or limits on use |
|---|-----------|---------------------------------|
| Reno Cap  | 1         |                                 |
| Vitamin D (50,000 unit) (Rx only)   | 1         |                                 |
| <b>Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions</b> |           |                                 |
| <b>Cough and Cold</b>   |           |                                 |
| Benzonatate (100 mg, 200 mg)  | 1         |                                 |
| Brompheniramine/Pseudoephedrine/<br>Dextromethorphan (Syrup)                                | 1         |                                 |
| Guaifenesin/Codeine (Syrup)   | 1         | DL                              |
| Hydrocodone Polst/Chlorpheniramine (ER<br>Susp) (generic for Tussionex)                     | 1         | DL                              |
| Hydrocodone/Homatropine   | 1         | DL                              |
| Promethazine/Codeine (Syrup)  | 1         | DL                              |
| Promethazine/Dextromethorphan (Syrup)   | 1         |                                 |

**Bold type = Brand name drug** Plain type = Generic drug

Covered drugs are placed in tiers. Each tier may have a different cost. See the Summary of Benefits to find out what you'll pay for these drugs.

Although you pay the same copay for these drugs as shown in the Summary of Benefits and Evidence of Coverage, the amount you pay for these additional prescription drugs **does not apply to your Medicare Part D out-of-pocket costs**. Payments for these additional prescription drugs (made by you or the plan) are treated differently from payments made for other prescription drugs.

Coverage for the prescription drugs on the bonus drug list is in addition to your Medicare prescription drug coverage under the plan. Unlike your Medicare prescription drug coverage under the plan, you are unable to file a Medicare appeal or grievance for drugs on the bonus drug list.

If you get Extra Help from Medicare to pay for your prescription drugs, it will not apply to the drugs on this bonus drug list.

If your drug has any coverage rules or limits, there will be code(s) in the "Coverage rules or limits on use" column of the chart. The codes and what they mean are shown below.

#### **QL - Quantity limits**

The plan will only cover a certain amount of this drug for one copay or over a certain number of days. These limits can help ensure safe and effective use of the drug.

#### **MME - Morphine Milligram Equivalent**

Additional quantity limits may apply to all opioid drugs used to treat pain. This additional limit is called a cumulative Morphine Milligram Equivalent (MME). It's designed to monitor safe dosing levels of opioids for people who may be taking more than one opioid drug for pain management. If your doctor or prescriber prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor or prescriber can ask the plan to cover the additional quantity.

**7D - 7-day limit**

An opioid drug used to treat pain may be limited to a 7-day supply if you don't have a recent history of using opioids. This limit helps minimize long-term opioid use. If you are new to the plan and have a recent history of using opioids, the pharmacy may override the limit when appropriate.

**DL - Dispensing limit**

Dispensing limits apply to this drug. This drug is limited to a one-month supply per prescription.

**Scan this  
code to view  
the Drug List**



This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copay, and restrictions may apply.

Benefits and/or copay/coinsurance may change each plan/benefit year.

The Drug List may change at any time. You will receive notice when necessary.

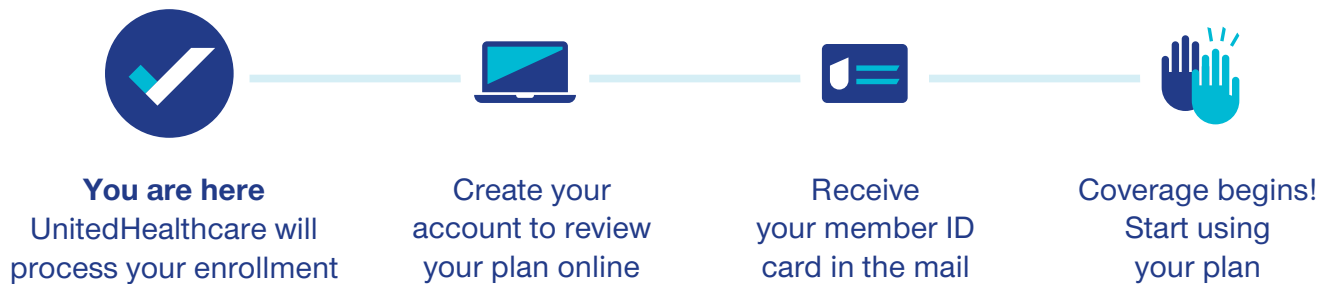
This information is available for free in other languages. Please call our Customer Service number on the cover.

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# Here's what you can expect next

Once you're a member, the UnitedHealthcare Customer Service team and your online account make it easier to get the care you need, when and how you need it.



## Manage your plan online

Use your Medicare number or member ID number to create an account at [retiree.uhc.com/ECMT](https://retiree.uhc.com/ECMT). Online you can:

- Look up your latest claim information and complete your health assessment
- Find network providers, pharmacies, your Drug List (Formulary) and other benefit information and plan materials
- Learn more about health and wellness topics
- Sign up to get plan information and your Explanation of Benefits online

## Once your coverage begins

- Schedule your annual wellness visit
- Get a yearly in-home visit with UnitedHealthcare® HouseCalls. Visit [uhhousecalls.com](https://uhhousecalls.com) to learn more
- Get the medications you take regularly through Optum® Home Delivery Pharmacy

## Benefits and costs may change at the end of your plan year

We'll send you an Annual Notice of Changes before your plan year ends that will tell you about any changes to your plan for the next plan year.

### Thank you for trusting UnitedHealthcare with your health care coverage

If you have any questions, please call the toll-free number on the back of this Plan Guide. This number will also be on your member ID card when you get it.

Scan this code to access the member site



# Statements of understanding

By enrolling in this plan, I agree to the following:

- ✓ **This is a Medicare Advantage Plan contracted with the federal government. This is not a Medicare Supplement Plan.**  
I need to keep my Medicare Part A and/or Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party. To be eligible for this plan, I must live in the plan's service area and be a United States citizen or be lawfully present in the U.S.
- ✓ **The service area includes the 50 United States, the District of Columbia and all U.S. territories.**  
I may not be covered while out of the country, except for limited coverage near the U.S. border. However, under this plan, when I am outside of the U.S. I am covered for emergency or urgently needed care.
- ✓ **I can only have one Medicare Advantage or Prescription Drug Plan at a time.**
  - Enrolling in this plan will automatically disenroll me from any other Medicare health plan.
  - If I enroll in a different Medicare Advantage Plan or Medicare Part D Prescription Drug Plan, I will be automatically disenrolled from this plan.
  - If I disenroll from this plan, I will be automatically transferred to Original Medicare.
  - Enrollment in this plan is for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.
- ✓ **My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations.**  
Medicare may also release my information for research and other purposes that follow all applicable federal statutes and regulations.
- ✓ **For members of the Group Medicare Advantage Plan.**  
I understand that when my coverage begins, I must get all of my medical and prescription drug benefits from the plan. Benefits and services provided by the plan and contained in the Evidence of Coverage (EOC) document will be covered. Neither Medicare nor the plan will pay for benefits or services that are not covered.

## Nondiscrimination notice

**Discrimination is against the law.** The company complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes.

If you believe you were treated unfairly because of your race, color, national origin, age, disability, or sex, you can send a grievance to our Civil Rights Coordinator.

- **Email:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)
- **Mail:** Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608, Salt Lake City, UT 84130

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- **Online:** <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>
- **Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)
- **Mail:** U.S. Department of Health and Human Services  
200 Independence Ave SW, HHH Building, Room 509F  
Washington, D.C. 20201

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free phone number on your member identification card or listed on the cover of the booklet (TTY **711**).

This notice is available at

<https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notice>.

## 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, please call us using the toll-free number on your member identification card or listed on the cover of the booklet. Someone who speaks your language can help you. This is a free service.

**Spanish:** Contamos con servicios gratuitos de intérprete para responder cualquier pregunta que pudiera tener sobre nuestro plan de salud o de medicamentos. Para obtener los servicios de un intérprete, llámenos al número de teléfono gratuito que figura en su tarjeta de identificación de miembro o en la portada del folleto. Una persona que habla su idioma podrá ayudarle. Es un servicio gratuito.

**Chinese Mandarin:** 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打您的會員識別卡或手冊封面列出的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

**Chinese Cantonese:** 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打您的會員識別卡或手冊封面列出的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo ng interpreter para sagutin anumang tanong na maaaring mayroon ka tungkol sa kalusugan o plano ng gamot. Para makakuha ng interpreter, pakitawagan kami gamit ang libreng numero na nasa iyong kard ng pagkakakilanlan ng kasapi o nakalista sa pabalat ng booklet. Sinumang nagsasalita ng wika mo ay puwedeng makatulong sa iyo. Ang serbisyonang ito ay libre.

**French:** Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser sur notre régime d'assurance maladie ou d'assurance-médicaments. Pour recevoir l'aide d'un interprète, veuillez nous appeler en composant le numéro gratuit figurant sur votre carte d'identification de membre ou sur la première de couverture de la brochure. Quelqu'un parlant votre langue peut vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi mà bạn có về chương trình bảo hiểm sức khỏe hay thuốc của chúng tôi. Để gặp thông dịch viên, vui lòng gọi cho chúng tôi theo số điện thoại miễn phí trên thẻ nhận dạng hội viên của bạn hoặc ghi trên bìa của quyển sách nhỏ. Người nói cùng ngôn ngữ với bạn có thể giúp bạn. Đây là dịch vụ miễn phí.

**German:** Wir verfügen über kostenlose Dolmetscherdienste, um alle Fragen zu beantworten, die Sie über unseren Gesundheits- oder Medikamentenplan haben mögen. Um einen Dolmetscher zu erhalten, rufen Sie uns bitte unter der kostenfreien Nummer an, die auf Ihrem Mitgliedsausweis oder auf dem Umschlag der Broschüre aufgeführt ist. Jemand, der Ihre Sprache spricht, kann Ihnen helfen. Dies ist eine kostenlose Dienstleistung.

**Korean:** 건강 또는 의약품 플랜에 관한 질문에 답변해드리기 위해 무료 통역 서비스를 제공합니다. 통역 서비스를 이용하려면, 가입자 ID 카드 또는 이 소책자 표지에 나와 있는 수신자 부담 전화번호로 전화해 주십시오. 한국어를 사용하는 통역사가 도움을 드릴 수 있습니다. 이 서비스는 무료입니다.

**Russian:** Если у Вас возникнут какие-либо вопросы о нашем плане медицинского страхования или плане по приобретению препаратов, мы предоставим Вам бесплатные услуги устного перевода. Для того чтобы воспользоваться услугами устного перевода, пожалуйста, свяжитесь с нами по бесплатному номеру телефона, указанному на Вашей идентификационной карте участника плана или спереди на буклете. Сотрудник, который говорит на Вашем языке, сможет Вам помочь. Данная услуга предоставляется бесплатно.

**Arabic:** لدينا خدمات ترجمة فورية للرد على أي أسئلة قد تكون لديك حول الخطة الصحية أو خطة الأدوية الخاصة بنا. للحصول على مترجم، اتصل بنا باستخدام رقم الهاتف المجاني على بطاقة تعريف عضويتك أو على غلاف الكتيب. سيساعدك شخص ما يتحدث لغتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा प्लान के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं मौजूद हैं। दुभाषिया पाने के लिए, कृपया अपने सदस्य पहचान पत्र पर या पुस्तिका के अग्रभाग पर सूचीबद्ध टोल-फ्री नंबर का उपयोग करके हमें कॉल करें। आपकी भाषा बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

**Italian:** Mettiamo a disposizione un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per avvalersi di un interprete, si prega di chiamare il numero verde riportato sulla tessera identificativa o indicato sulla copertina dell'opuscolo. Una persona che parla italiano potrà fornire l'assistenza richiesta. Il servizio è gratuito.

**Portuguese:** Dispomos de serviços de intérprete gratuitos para esclarecer quaisquer dúvidas que tenha sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número gratuito no seu cartão de identificação de membro ou indicado na parte da frente do folheto. Alguém que fala a sua língua pode ajudá-lo(a). Este é um serviço gratuito.

**French Creole:** Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou gendwa genyen konsènan plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, tanpri rele nou apati nimewo apèl gratis ki sou kat idantifikasyon manm ou an oswa ki endike sou kouvèti ti liv la. Yon moun ki pale lang ou ka ede ou. Sa se yon sèvis gratis.

**Polish:** Oferujemy bezpłatne usługi tłumaczeniowe, aby odpowiedzieć na wszelkie pytania dotyczące naszego planu ubezpieczenia zdrowotnego lub planu refundacji leków. Aby skorzystać z pomocy tłumacza, proszę zadzwonić pod bezpłatny numer telefonu podany na Pana/Pani karcie identyfikacyjnej lub na okładce broszury. Osoba posługująca się Pana/Pani językiem Panu/Pani pomoże. Usługa ta jest bezpłatna.

**Japanese:** 当社の医療または処方薬プランに関する質問にお答えするために、無料の通訳サービスをご利用いただけます。通訳が必要な場合には、会員 ID カードまたは本冊子の表紙に記載されているフリーダイヤル番号を使用して、当社までお問い合わせください。お客様の言語を話す通訳者がお手伝いいたします。これは無料のサービスです。









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