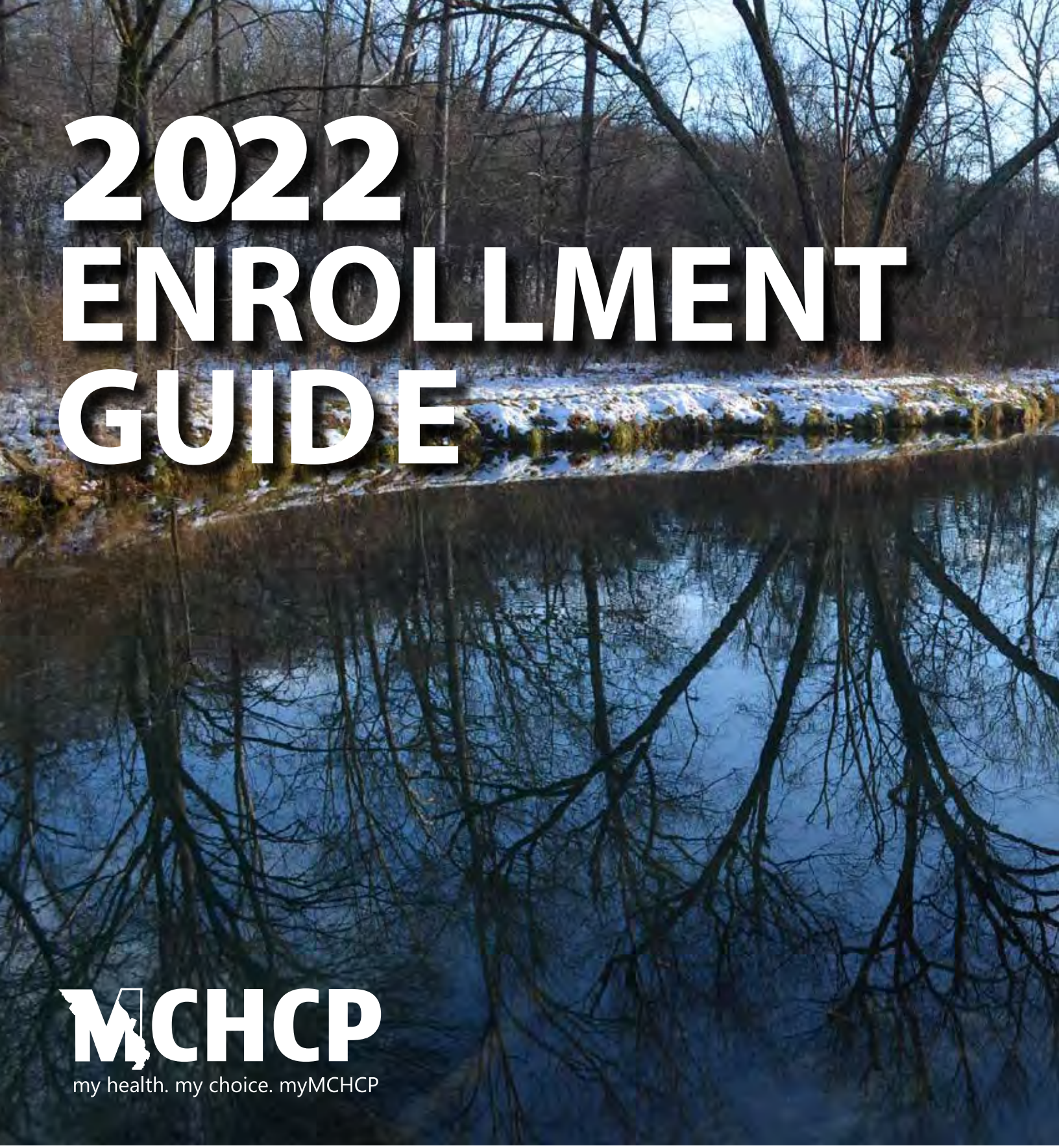

2022 ENROLLMENT GUIDE

MCHCP

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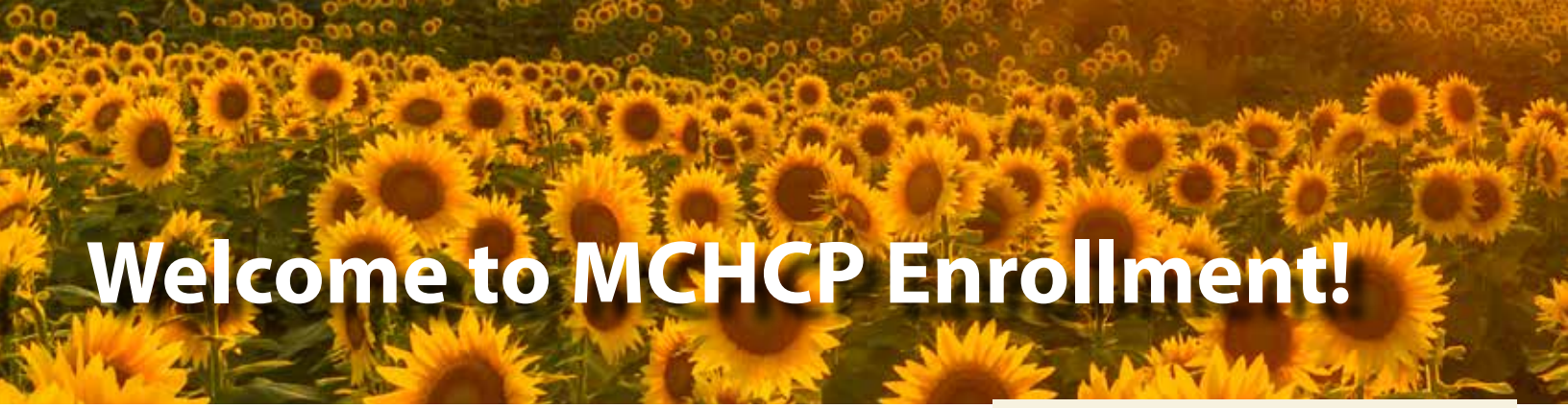
Medicare-Eligible Retired Members
Effective Jan. 1, 2022

October 2021



Welcome to MCHCP Enrollment!

Medicare Advantage Plan for Medicare-Eligible Members

UnitedHealthcare® provides MCHCP's Medicare-eligible members a Group Advantage (PPO) plan for medical coverage. Express Scripts provides a Medicare Prescription Drug Plan for prescription drug coverage to all Medicare-eligible members who are covered by the Medicare Advantage Plan.

You will have a UnitedHealthcare® member ID card for medical coverage and an Express Scripts ID card for prescription drug coverage. You will not need to use your Original Medicare card for your coverage.

Enrolling is Easy

Medicare-eligible members who are not an active state employee or their dependent will be automatically enrolled in the Medicare Advantage Plan and Medicare Prescription Drug Plan.

If you cover non-Medicare-eligible family members, you will have to choose a non-Medicare MCHCP plan for them. You will get a guide book about non-Medicare MCHCP plans to help you choose. For example:

- If you are Medicare-eligible, but your covered spouse and/or covered children are not, you will be automatically enrolled in the Medicare Advantage Plan, and you will choose a non-Medicare MCHCP plan for your spouse and/or covered children.
- If you and/or your covered children are not eligible for Medicare, but your covered spouse is, you will choose a non-Medicare MCHCP plan for you and/or your children, and your spouse will be automatically enrolled in the Medicare Advantage Plan.

About This Guide

MCHCP knows that making health plan choices can be hard to do. We hope this guide helps you understand your MCHCP health plan options and benefits. There is much more information on MCHCP's website. Be sure to check it out.

Questions?

MCHCP Member Services:
573-751-0771
Toll-free: 800-487-0771
Relay Missouri: 711 or 800 735-2966 (TTY)

MCHCP Website:

www.mchcp.org

Use your smartphone camera to scan this QR code.

If you are Medicare-eligible and do not want the Medicare Advantage Plan

If you do not want to be enrolled in the Medicare Advantage Plan, you must cancel your coverage with MCHCP, unless you qualify for an exception. If you do not cancel, you will be automatically enrolled in the Medicare Advantage Plan. Please review your options carefully before choosing to cancel.

If you decide not to enroll in the Medicare Advantage Plan:

- You will lose your medical and prescription drug coverage through MCHCP, and you and your dependents will not be able to enroll at a later time.
- If your Medicare-covered dependent decides not to enroll, s/he will lose medical and prescription drug coverage through MCHCP, and will not be able to enroll at a later time.
- If you are a long-term disability subscriber, you will lose your medical and prescription drug coverage through MCHCP, and you will not be able to enroll until your retirement date, if applicable.

Enrollment in a non-MCHCP Medicare Advantage Plan or Medicare Part D Prescription Plan will disenroll you from MCHCP Medicare Plans, and may result in you losing MCHCP coverage.

Table of Contents

UnitedHealthCare® Group Medicare-Advantage (PPO)

MCHCP has chosen the UnitedHealthcare® Group Medicare Advantage (PPO) plan for your medical coverage.

The word "Group" means that UnitedHealthcare® designed this plan just for MCHCP. Only Medicare eligible MCHCP members can enroll in this plan.

"Medicare Advantage" is also known as Medicare Part C. These plans have 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).

The UnitedHealthcare® Group Medicare Advantage (PPO) plan is a PPO plan with a Medicare contract. You will have access to the UnitedHealthcare® provider network with nationwide coverage. You can see any provider (network or non-network) at the same cost share, as long as they accept the plan and have not opted out of Medicare.

Once you are enrolled, you will receive an information packet about services covered by this plan, as well as a member ID card from UnitedHealthcare®. Each member of your family that is eligible to enroll in the UnitedHealthcare® Group Medicare Advantage (PPO) plan is enrolled separately, and will get their own packet of information.

In addition to the medical services, UnitedHealthcare® offers special programs, like SilverSneakers®. SilverSneakers® includes access to exercise equipment, classes and more at 14,000+ fitness locations.

Preventive services are covered with no cost sharing. Most other services have copayments. That means you have a set fee, and the plan will pay the rest. You do not have to meet a deductible beforethe plan starts paying for these services – you just owe the copayment. For services with coinsurance, you must first meet the $400 deductible before the plan will pay. Once the deductible is met, you will have to pay a 20% coinsurance. Your plan has an annual out-of-pocket maximum of $2,500. Refer to your information packet or contact UnitedHealthCare® for additional information.

This is a short description of some of the Medicare Advantage Plan benefits. Refer to your information packet or contact UnitedHealthCare® for additional benefit information.

Service Type	You will owe
Doctor's office	Primary Care Provider - $15 copayment Specialist - $30 copayment
Medicare-covered preventive services	$0 copayment
Inpatient hospital care	$350 copayment
Skilled nursing facility	$0 copayment per day: days 1-20 $100 copayment per day: day 21 up to 100 days
Physical, occupational, or speech therapy	$30 copayment
Diagnostic and therapeutic radiology (such as MRIs, CT scans, radiation for cancer)	$30 copayment
Lab	$0 copayment
X-rays (outpatient)	$25 copayment
Ambulance	$100 copayment
Emergency care (worldwide)	$100 copayment
Urgent care (worldwide)	$50 copayment

Additional benefits not covered by Original Medicare

Routine annual physical	$0 copayment
Routine podiatry	$30 copayment; 6 visits per year
Chiropractic care	$30 copayment
Hearing and vision annual routine exam	$30 copayment
Hearing aids - only through UnitedHealthcare® Hearing	Up to $5,000 allowance every 2 years (Network only)
Virtual doctor and behavioral visits	See and speak to a specific doctor or mental health professionals using your computer or mobile device. Find participating providers online at www.UHCRetiree.com/mchcp.

Express Scripts Medicare Prescription Drug Plan

The Medicare Prescription Drug Plan is a Medicare Part D Plan with expanded prescription coverage. Express Scripts Medicare Prescription Drug Plan (PDP) administers the benefits. Eligible members will automatically be enrolled in the Express Scripts Medicare PDP when they enroll in a medical plan. Non-Medicare eligible dependents will remain in the non-Medicare prescription drug plan. Subscribers will receive a separate prescription ID card upon enrollment.

Network and Coverage

Express Scripts Medicare PDP maintains a nationwide pharmacy network. Members must use the network pharmacies to fill prescriptions. Covered Medicare Part D drugs are available at non-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. Members may have to pay additional costs for drugs received at non-network pharmacies.

This plan maintains a broad choice of covered drugs through the Medicare PDP formulary. The drug formulary is a list of FDA-approved generic and brand-name prescription drugs and supplies covered by your health insurance plan. ESI places covered drugs into three levels: preferred generic, preferred brand or non-preferred.

Preferred drugs are covered at a lower cost to you. Non-preferred drugs are covered, but you will pay more than if you choose preferred brand or preferred generic drugs. If your health care provider prescribes a non-preferred drug, discuss preferred alternative options with your provider.

Medicare Part B drugs will be covered by the UnitedHealthcare® Group Medicare Advantage (PPO) plan rather than by Express Scripts. Generally, drugs covered under Medicare Part B are drugs you wouldn't usually give to yourself. These include drugs you get at a doctor's office or hospital outpatient setting. A few examples of Part B drugs include vaccinations like flu shots (covered at 100%), drugs used with a DME item, injectable and infused drugs, transplant drugs and certain oral cancer drugs and anti-nausea drugs. For Medicare-covered Part B drugs not covered as a preventive service, you will pay a 20% coinsurance.

There are some drugs that are not covered. These drugs have a covered alternative option that can be discussed with your provider. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price. Your provider may request a clinical exception to cover the drug by calling Express Scripts' Prior Authorization Line. Approved exceptions are covered as a non-preferred drug.

The formulary list is available on the MCHCP website or by contacting ESI, and can change throughout the year.

Members can fill a prescription from any prescriber at a network pharmacy or through home delivery, and may receive up to a 90-day supply of certain maintenance drugs. The home delivery benefit covers up to a 90-day supply for 2 1/2 copayments.

Members will receive additional plan information directly from Express Scripts Medicare, including a benefit overview, formulary, pharmacy directory and monthly explanations of benefits.

Description	Tier	Home delivery three-month (90-day) supply	Retail one-month (31-day) supply	Retail two-month (60-day) supply	Retail three-month (90-day) supply
Initial Coverage Stage	Tier 1 Preferred Generic drugs	$25 copayment	$10 copayment	$20 copayment	$30 copayment
	Tier 2 Preferred Brand drugs	$100 copayment	$40 copayment	$80 copayment	$120 copayment
	Tier 3 Non-preferred drugs	$250 copayment	$100 copayment	$200 copayment	$300 copayment
Coverage Gap Stage (Donut Hole)	After annual drug costs reach $4,430, members will continue to pay the same cost-sharing amount as in the Initial Coverage stage until annual out-of-pocket drug costs reach $7,050.				
Catastrophic Coverage Stage	After annual out-of-pocket drug costs reach $7,050,members will pay the greater of 5% coinsurance or: • A $3.95 copayment for covered preferred generic drugs(including preferred drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage Stage. • An $9.85 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage Stage.				

Dental

Service Type	Brief Description	You will owe
Preventive (Type A)	Teeth Cleaning, Oral Exam, Bitewing x-rays.	Network – You owe nothing. There is no deductible. Non-Network – You pay the difference between network allowable and the bill.
Basic Restorative (Type B)	Fillings, simple extractions, x-rays	Network – You owe 20% coinsurance after deductible is met. Non-Network - You owe 20% coinsurance after deductible is met and the difference between network allowable and the bill.
Major Restorative (Type C) **12-month waiting period required, waived with proof of prior 12-month dental coverage**	Oral surgery, implants, bridges and dentures, root canal.	Network – You owe 50% coinsurance after deductible is met Non-Network - You owe 50% coinsurance after deductible is met and the difference between network allowable and the bill.

MetLife offers dental benefits through their nationwide network, Preferred Dentist Program (PDP) Plus. These benefits include preventive services, basic restorative services and major restorative services.

You select a dentist of your choice. It is recommended you choose a MetLife network provider for best use of the dental plan. However, if you decide to go to a non-network provider, you can, but your out-of-pocket costs will likely be much higher. When receiving services from a network provider, MetLife pays the provider directly. When receiving services from a non-network provider, members may need to pay the provider and file the claim. The non-network dentist hasn't agreed to accept MetLife network fees, so they may bill you the difference between MetLife's allowable and the full cost of the service.

The maximum benefit, per individual is $2,000 (preventive services do not count toward the maximum). The annual deductible, per individual is $50. The table above is a summary of benefits. More information is available at www.mchcp.org.

Vision

Service Type	Brief Description	You will owe	Premium Plan - Network	Non-Network
Exams	One per year; 2 per year up to age 18	$10 Copayment	$10 Copayment	NVA pays up to $45
Lenses	Single-vision, bifocal, trifocal, lenticular (see website for other types of lens coverage)	$25 copayment	$25 Copayment	Maximum amount NVA pays varies based on type of lenses.
Frames	Once every 2 years; once every year up to age 18	Up to $125 retail allowance and 20% discount off remaining balance	Up to $175 Retail allowance and 20% discount off remaining balance	NVA pays up to $70.
Contact Lenses– Elective (you prefer contacts to glasses)	Once every calendar year in place of eyeglass lenses	Up to $125 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance	Up to $175 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance	NVA pays up to $105.
Contact Fitting and Evaluations	For daily contact lenses; extended contact lenses and specialty contact lenses	$20 to $50 copayment depending on type of lenses	$20 to $50 copayment depending on type of lenses	NVA pays up to $20 to $30 depending on type of lenses.

National Vision Administrators, L.L.C. (NVA) offers vision benefits through a nationwide network. Basic and premium plans are offered with specific copayments for services from network providers. Both plans offer allowances for services from non-network providers. The vision plan does not replace medical coverage for eye disease or injury.

You select a provider of your choice. It is recommended you choose an NVA network provider for best use of the vision plan. However, if you decide to go to a non-network provider, you can, but your out-of-pocket costs will likely be much higher. When receiving services from a network provider, NVA pays the provider directly. When receiving services from a non-network provider, members pay the provider and file the claim. Reimbursement checks for non-network claims may take up to 30 days to process. The table on the previous page is a summary of benefits, and more benefit information is available at www.mchcp.org.

Contacts

Medicare Advantage Plan
UnitedHealthcare®
Group Medicare Advantage (PPO) plan
www.uhcretiree.com/MCHCP
1-844-884-1848
8 a.m. to 8 p.m. M-F

Claims Address
PO Box 30995
Salt Lake City, UT 84130-0995

Appeals Address
P.O. Box 6103
Cypress, CA 90630-0023

Prescription Drug Plan for Medicare Members
Express Scripts Medicare
www.express-scripts.com
866-544-6963
TTY: 800-716-3231
24 hours a day

Medicare Home Delivery Pharmacy Service
PO Box 66577
St. Louis, MO 63166-9843

Appeals Address
Express Scripts
Attn: Medicare Clinical Appeals
PO Box 66588
St. Louis, MO 63166-6588
800-935-6103

Dental Plan
Metlife
www.metlife.com/mybenefits
1-800-942-0854
844-222-9106 dedicated to MCHCP
7 a.m. to 10 p.m. M-F

Claims Address
MetLife Dental Claims
PO Box 14588
Lexington, KY 40512

Appeals Address
MetLife Group Claims Review
PO Box 14589
Lexington, KY 40512

Vision Plan
National Vision Administrators, L.L.C. (NVA)
www.e-nva.com
User Name: mchcp
Password: vision1
877-300-6641
24 hours a day

Claims Address
Attn: Claims
PO Box 2187
Clifton, NJ 07015

Appeals Address
Attn: Complaints, Grievances & Appeals
PO Box 2187
Clifton, NJ 07015

MCHCP
www.mchcp.org
573-751-8881
Member Services: 573-751-0771
Toll-free: 800-487-0771
Relay Missouri: 711 or 800-735-2966 (TTY)
Fax: 866-346-8785

PO Box 104355
Jefferson City, MO 65110-4355

Who to Contact
Your plan for:
- Claim questions
- ID Cards
- Specific benefit questions
- Appeal information

MCHCP for:
- Eligibility questions
- Enrollment questions
- MCHCPid requests
- General benefit questions
- Address changes or forms
- HIPAA forms and questions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