Benefit Highlights

Arkansas State Employee (ASE) and Public School Employee (PSE) 13582,13583
Effective January 1, 2024 to December 31, 2024

This is a short summary of your plan benefits and costs. See your Summary of Benefits for more information. Or review the Evidence of Coverage for a complete description of benefits, limitations, exclusions and restrictions. Benefit limits and restrictions are combined in- and out-of-network.

Plan costs

	In-network and out-of-network
Annual medical deductible	No deductible
Annual medical out-of-pocket maximum (the most you pay in a plan year for covered medical care)	You pay nothing for Medicare-covered services from any provider

Medical benefits

Medical benefits covered by the plan and Original Medicare

	In-network and out-of-network
Doctor's office visit	
Primary care provider (PCP)	$0 copay
Specialist	$0 copay
Virtual visits	$0 copay
Preventive services Medicare-covered	$0 copay
Inpatient hospital care	$0 copay per stay
Skilled nursing facility (SNF)	$0 copay per day up to 100 days
Outpatient surgery	$0 copay
Outpatient rehabilitation Physical, occupational, or speech/ language therapy	$0 copay
Outpatient mental health	
Group therapy	$0 copay
Individual therapy	$0 copay
Virtual visits	$0 copay
Diagnostic radiology services such as MRIs, CT scans	$0 copay
Lab services	$0 copay

Medical benefits

Medical benefits covered by the plan and Original Medicare

	In-network and out-of-network
Outpatient X-rays	$0 copay
Therapeutic radiology services such as radiation treatment for cancer	$0 copay
Ambulance	$0 copay
Emergency care	$0 copay (worldwide)
Urgently needed services	$0 copay (worldwide)

Additional benefits and programs not covered by Original Medicare

	In-network and out-of-network
Routine physical	$0 copay; 1 per plan year*
Acupuncture – routine	$0 copay, and 12 visits per plan year*
Chiropractic – routine	$0 copay, 15 visits per plan year*
Dental - routine	$0 copay for preventive dental care including exams, cleanings, X-rays and fluoride. Additional fees may apply*
Foot care – routine	$0 copay, 6 visits per plan year*
Over-the-counter (OTC) card Healthy Benefits Plus	$0 copay $40 credit each quarter to purchase approved OTC items from network retail locations or through the OTC catalog.
UnitedHealthcare Healthy at Home post-discharge program	$0 copay for 28 meals, 12 rides, and 6 hours of non-medical personal care up to 30 days following all inpatient and SNF discharges. Referral required.
Hearing – routine exam	$0 copay, 1 exam per plan year*
Hearing aids	Plan pays a $2,800 allowance for hearing aids (combined for both ears) every 3 years*.
Vision – routine eye exam	$0 copay, 1 exam every 12 months*
Vision – routine eyewear	Plan pays up to $150 for eyeglasses, or $150 for contact lenses instead of eyeglasses, every 12 months.*
Fitness program Renew Active® by UnitedHealthcare	$0 copay for a standard gym membership at participating locations
24/7 Nurse Support	Receive access to nurse consultations and additional clinical resources at no additional cost.
Personal emergency response system (PERS) Lifeline	$0 copay for a personal emergency response system.

	In-network and out-of-network
Rally Coach™ programs	$0 copay for the Rally Coach™ Programs: Real Appeal® Weight Management, Real Appeal Diabetes Prevention, Wellness Coaching and a tobacco cessation program. *Refer to your Evidence of Coverage for eligibility requirements.

*Benefits are combined in and out-of-network

Prescription Drugs

	Your cost		
Initial Coverage Stage	Network Retail Pharmacy (31-day retail supply)	Network Retail Pharmacy (93-day retail supply)	Mail Service Pharmacy (93-day supply)
Tier 1: Preferred Generic	$15 copay	$45 copay	$30 copay
Tier 2: Preferred Brand [1]	$40 copay	$120 copay	$80 copay
Tier 3: Non-Preferred Drug [1]	$80 copay	$240 copay	$160 copay
Tier 4: Specialty Tier [1]	$100 copay	$300 copay	$200 copay
Coverage gap stage	After your total drug costs reach $5,030, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost		
Catastrophic coverage stage	During this payment stage, the plan pays the full cost for your covered drugs. You pay nothing.		
Pharmacy Out-of-Pocket Maximum	When your total Out-of-Pocket costs (what you pay) reach $3,100 you will not pay any copay or coinsurance		

[1] 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.

Your plan sponsor offers additional prescription drug coverage. Please see your Additional Drug Coverage list for more information.
Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. 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 Drug List (Formulary), pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Y0066_GRMABH_2024_M UHEX24PP0103532_000