

Benefit Highlights

Lumen 12273

Effective January 1, 2023 to December 31, 2023

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)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$950 for this plan year.

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)	\$5 copay
Specialist	\$35 copay
Virtual visits	\$0 copay using Amwell, Doctor on Demand and Teladoc \$5 copay using other providers that have the ability and are qualified to offer virtual medical visits
Preventive services Medicare-covered	\$0 copay
Inpatient hospital care	\$250 copay per day: days 1-4 \$0 copay per day after that
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$100 copay per day: days 21-31 \$0 copay per additional day up to 100 days
Outpatient surgery	\$150 copay
Outpatient rehabilitation Physical, occupational, or speech/ language therapy	\$20 copay
Outpatient mental health	
Group therapy	\$35 copay
Individual therapy	\$35 copay
Virtual visits	\$35 copay

Medical benefits

Medical benefits covered by the plan and Original Medicare

	In-network and out-of-network
Diagnostic radiology services such as MRIs, CT scans	\$20 copay
Lab services	\$0 copay
Outpatient X-rays	\$20 copay
Therapeutic radiology services such as radiation treatment for cancer	\$20 copay
Ambulance	\$150 copay
Emergency care	\$90 copay (worldwide)
Urgently needed services	\$35 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	\$35 copay, 12 visits per plan year*
Chiropractic - routine	\$20 copay, 24 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	\$35 copay, 6 visits per plan year*
UnitedHealthcare Healthy at Home	\$0 copay for 28 meals, 12 rides, and 6 hours of in-home 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 UnitedHealthcare Hearing	Plan pays a \$500 allowance for hearing aids (combined for both ears) every 3 years. Hearing aids purchased outside of UnitedHealthcare Hearing's nationwide network are not covered.
Vision - routine eye exam	\$0 copay, 1 exam every 12 months*
Vision - routine eyewear	Plan pays \$100 for eyeglasses every 12 months. Or, \$100 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
Telephonic nurse services	Receive access to nurse consultations and additional clinical resources at no additional cost.
In-home non-medical care CareLinx	\$0 copay for 8 hours of personal care services each month.

	In-network and out-of-network
Personal Emergency Response System (PERS) Lifeline	\$0 copay for a personal emergency response system.

*Benefits are combined in and out-of-network

Prescription drugs

	Your cost	
Annual prescription (Part D) deductible	\$0 for Tier 1 and Tier 2; \$50 for Tier 3, Tier 4 and Tier 5.	
Initial coverage stage	Network pharmacy (30-day retail supply)	Mail service pharmacy (90-day supply)
Tier 1: Preferred Generic	\$0 copay	\$0 copay
Tier 2: Generic	\$8 copay	\$16 copay
Tier 3: Preferred Brand	\$40 copay	\$80 copay
Tier 4: Non-preferred Drug	\$90 copay	\$180 copay
Tier 5: Specialty Tier	30% coinsurance	30% coinsurance
Coverage gap stage	After your total drug costs reach \$4,660, you pay 25% of the price (plus the dispensing fee) for brand name drugs and 25% of the price for generic drugs	
Catastrophic coverage stage	After your total out-of-pocket costs reach \$7,400, you will pay a \$0 copay	

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.

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