Benefit Highlights

Lumen 12273
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)	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, and 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 post-discharge program	$0 copay for 28 meals, 12 rides (one-way), 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 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 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
24/7 Nurse Support	Receive access to nurse consultations and additional clinical resources at no additional cost.
Non-medical personal care CareLinx	$0 copay for 8 hours of non-medical 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 [1]	$40 copay	$80 copay
Tier 4: Non-Preferred Drug [1]	$90 copay	$180 copay
Tier 5: Specialty Tier [1]	30% coinsurance	30% coinsurance
Coverage gap stage	After your total drug costs reach $5,030, 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	During this payment stage, the plan pays the full cost for your covered drugs. You pay nothing.	

[1] Subject to Medicare guidance, coinsurance may not apply to Part D insulin products. You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven't paid your Part D deductible. Most adult Part D vaccines are covered at no cost to you.

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.