Benefit Highlights

MoDOT-MSHP 16600
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	Your plan has an annual combined in-network and out-of-network medical deductible of $250 for this plan year.
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 $250 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)	$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

Medical benefits

Medical benefits covered by the plan and Original Medicare

	In-network and out-of-network
Lab services	$0 copay
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*
Chiropractic – routine	$0 copay, 30 visits per plan year*
Foot care – routine	$0 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*
Private duty nursing	$0 copayment for each visit, up to $10,000 per plan year
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.
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.

	In-network and out-of-network

*Benefits are combined in and out-of-network

Prescription drugs

	Your cost	
Initial coverage stage	Network pharmacy (30-day retail supply)	Mail service pharmacy or network pharmacy (90-day supply)
Tier 1: Preferred Generic	$15 copay	$37.50 copay
Tier 2: Preferred Brand [1]	$35 copay	$87.50 copay
Tier 3: Non-Preferred Drug [1]	$40 copay	$100 copay
Tier 4: Specialty Tier [1]	$40 copay	$100 copay
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] 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.

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