

Benefit Highlights

City of Saint Paul 13487

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 \$3,000 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)	\$10 copay
Specialist	\$10 copay
Virtual visits	\$0 copay using Amwell, Doctor on Demand and Teladoc \$10 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	\$100 copay per stay
Skilled nursing facility (SNF)	\$0 copay per day up to 100 days
Outpatient surgery	\$50 copay
Outpatient rehabilitation Physical, occupational, or speech/ language therapy	\$10 copay
Outpatient mental health	
Group therapy	\$5 copay
Individual therapy	\$10 copay
Virtual visits	\$10 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	\$50 copay (worldwide)
Urgently needed services	Urgent care center: \$50 copay (worldwide) Retail walk-in clinic: \$10 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	\$10 copay for each visit per plan year*
Foot care – routine	\$10 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 \$1,000 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 \$150 combined allowance for eyeglasses and contact lenses 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.

*Benefits are combined in and out-of-network

Prescription drugs

	Your cost	
Initial coverage stage	Network pharmacy (30-day retail supply)	Mail service pharmacy (90-day supply)

Prescription drugs

	Your cost	
Tier 1: Preferred Generic	\$10 copay at a Preferred pharmacy \$15 copay at a Standard pharmacy	\$20 copay
Tier 2: Preferred Brand ¹	\$25 copay at a Preferred pharmacy \$30 copay at a Standard pharmacy	\$50 copay
Tier 3: Non-Preferred Drug ¹	\$30 copay at a Preferred pharmacy \$30 copay at a Standard pharmacy	\$60 copay
Tier 4: Specialty Tier ¹	\$60 copay (limited to a 30-day supply) at a Preferred pharmacy \$60 copay (limited to a 30-day supply) at a Standard pharmacy	\$60 copay (limited to a 30-day supply)
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.	

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.

UnitedHealthcare® Group Medicare Advantage (PPO) pharmacy network includes limited lower-cost pharmacies in urban ND; suburban HI, ND, PA, and rural AK, AR, HI, IA, ID, KS, MN, MT, NE, OK, PA, SD, and WY. There are an extremely limited number of preferred cost share pharmacies in suburban MT and rural ND. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call us or consult the online pharmacy directory using the contact information that appears on the booklet cover.