Benefit Highlights

Public School Retirement System of the City of St. Louis Gold Plan 13764
Effective January 1, 2021 to December 31, 2021
This is a short description of your plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan Costs

	In-Network	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 each plan year.	

Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Doctor's office visit	Primary Care Provider: $5 copay	Primary Care Provider: $5 copay
	Specialist: $10 copay	Specialist: $10 copay
	Virtual Doctor Visits: $0 copay	Virtual Doctor Visits: $0 copay
Preventive services	$0 copay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	$200 copay per day: days 1-11 $0 copay per day after that	$200 copay per day: days 1-11 $0 copay per day after that
Skilled nursing facility (SNF)	$20 copay per day: days 1-20 $95 copay per additional day up to 100 days	$20 copay per day: days 1-20 $95 copay per additional day up to 100 days
	Our plan covers up to 100 days in a SNF per benefit period.	
Outpatient surgery	15% coinsurance	15% coinsurance
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	15% coinsurance	15% coinsurance
Mental health (outpatient and virtual)	Group therapy: $10 copay	Group therapy: $10 copay
	Individual therapy: $10 copay	Individual therapy: $10 copay
	Virtual visits: $10 copay	Virtual visits: $10 copay
Diagnostic radiology services (such as MRIs, CT scans)	15% coinsurance	15% coinsurance

Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Lab services	$0 copay	$0 copay
Outpatient x-rays	$10 copay	$10 copay
Therapeutic radiology services (such as radiation treatment for cancer)	15% coinsurance	15% coinsurance
Ambulance	$100 copay	$100 copay
Emergency care	$50 copay (worldwide)	
Urgently needed services	$25 copay (worldwide)	$25 copay (worldwide)

Additional benefits and programs not covered by Original Medicare

	In-Network	Out-of-Network
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Foot care - routine	$10 copay (Up to 6 visits per plan year)*	$10 copay (Up to 6 visits per plan year)*
FirstLine Essentials+	$0 copay; Members receive $60 each quarter ($240 each year) to use on approved health care products as shown in the catalog or website. Dollars may be carried over from month to month.	
Hearing - routine exam	$0 copay (1 exam per plan year)*	$0 copay (1 exam per plan year)*
Hearing aids	Through UnitedHealthcare Hearing, the plan pays up to a $500 allowance for hearing aids every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.	Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.
Vision - routine eye exams	$10 copay (1 exam every 12 months)*	$10 copay (1 exam every 12 months)*
Vision - eyewear	Plan pays up to $130 eyewear allowance every 2 years. Plan pays up to $175 contact lens allowance in lieu of eyewear allowance every 2 years.*	Plan pays up to $130 eyewear allowance every 2 years. Plan pays up to $175 contact lens allowance in lieu of eyewear allowance every 2 years.*
Fitness program through RenewActive™	You have access to Renew Active™ at no additional cost. Renew Active is the gold standard in Medicare fitness programs for body and mind. It includes a gym membership at a fitness location you select from our nationwide network. To get started, log in to your plan website, go to Health & Wellness and look for Renew Active. You can also call the number on the back of your UnitedHealthcare member ID card.	

	In-Network	Out-of-Network
NurseLine	Receive access to nurse consultations and additional clinical resources at no additional cost.	
Routine Transportation	$0 copay; Routine transportation coverage up to 24 one-way trips per year to plan approved medically related appointments (locations) through provider LogistiCare. Restrictions apply.	

*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 (31 to 90-day retail supply)
Tier 1: Preferred Generic	$5 copay	$10 copay
Tier 2: Preferred Brand	$35 copay	$70 copay
Tier 3: Non-preferred Drug	$70 copay	$210 copay
Tier 4: Specialty Tier	$70 copay	$70 copay (limited to a 30-day supply)
Coverage gap stage	After your total drug costs reach $4,130, 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 $6,550, you will pay the greater of $3.70 copay for generic (including brand drugs treated as generic), $9.20 copay for all other drugs, or 5% coinsurance	

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your drug list (formulary). 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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