Public School Retirement System of the City of St. Louis (PSRSSTL) Medical Benefits Comparison
Plan Year 2021

Medicare Plans

	SLPS-Sponsored UnitedHealthcare® Commercial Group Health PPO Plans				UnitedHealthcare® Group Medicare Advantage PPO Plans*		
	Nationwide Network						
	Base Plan		Buy-Up Plan		Gold Plan	Low Plan	High Plan
	Network Providers	Non-Network Providers	Network Providers	Non-Network Providers	Network OR Non-Network Providers		
Annual Deductible	Medicare-eligible members also pay $300 annual deductible for prescriptions in the Base and Buy-Up plans (see below)				N/A		
(Amount Member pays toward Eligible Expenses before Plan benefits start; Does not apply to Copay services)							
Individual	$500	$1,000	$200	$400			
Family	$1,000	$2,000	$400	$800			
Coinsurance Percentage (Percentage Member pays for most Eligible Expenses after Annual Deductible has been met or Copay satisfied; Coinsurance does not apply to Copay services)	20%	30%	10%	30%	N/A		
Member Annual Out-of-Pocket Maximum							
Individual (65+ with Medicare)	$3,800	$7,300	$1,700	$3,100	$3,000 per member All Medicare-covered services apply towards the Annual Out-Of-Pocket Maximum		$1,500 per member All Medicare-covered services apply towards the Annual Out-Of-Pocket Maximum
Family (65+ with Medicare)	$7,600	$14,600	$3,400	$6,200			
Member Lifetime Maximum Benefit	Unlimited for all medical plans						
Office Visit Copay	$25 Copay per visit Primary $35 Copay per visit Specialist	Subject to Deductible and Coinsurance	$15 Copay per visit Primary $30 Copay per visit Specialist	Subject to Deductible and Coinsurance	$5 Copay per visit Primary $10 Copay per visit Specialist		$10 Copay per visit Primary $20 Copay per visit Specialist
Preventive Care (In accordance with the National Health Care Reform guidelines. See Preventative Guidelines at cdc.gov)	100%	Subject to Deductible and Coinsurance	100%	Subject to Deductible and Coinsurance	$0 Copay for Preventive Care services; however, additional cost-share may apply if bundled with non-preventive services or procedures.		$0 Copay for Preventive Care services; however, additional cost-share may apply if bundled with non-preventive services or procedures.
Prescription Drug Benefit	The City of St. Louis Board of Education Managed Pharmacy Benefit Program administered by Express Scripts includes an Over-the-Counter (OTC) Program. Medicare-Eligible Retirees pay a $300 annual individual prescription drug deductible and must participate in a Mandatory Generic Prescription Drug Program. Please refer to the SLPS Board of Education managed Pharmacy Benefit Program Sheet for detailed information regarding this benefit.				Standard (CMS minimum) Coverage Gap applies. There is NO additional coverage through the Coverage Gap. Medicare Part B Drugs: 20% Coinsurance; Chemotherapy Drugs: 15% Coinsurance	Tier 1 (Generics) Only Coverage Gap Applies. Coverage Gap does not apply to generic drugs covered by the Plan; Medicare Part B Drugs: 20% Coinsurance; Chemotherapy Drugs: 15% Coinsurance	Full Gap Coverage (Tiers 1-3) applies. Plan Copay/Coinsurance structure continues through the Coverage Gap. Medicare Part B Drugs: 20% Coinsurance; Chemotherapy Drugs: 20% Coinsurance
Retail (Up to a 30-day supply)	$10 Copay if drug cost to plan is $10-$40; $25 Copay if drug cost to plan is $40.01-$80; $40 Copay if drug cost to plan is $80.01 & over	Not covered out of network	$10 Copay if drug cost to plan is $10-$40; $20 Copay if drug cost to plan is $40.01-$80; $40 Copay if drug cost to plan is $80.01 & over	Not covered out of network	Tier 1 - $5 Tier 2 - $35 Tier 3 - $70 Tier 4 - $70 Part B Drugs: 20% Coinsurance Formulary - Yes NO Gap Coverage	Tier 1 - $4 Tier 2 - $28 Tier 3 - $55 Tier 4 - $55 Part B Drugs: 20% Coinsurance Formulary - Yes Gap Coverage - Tier 1 Only	Tier 1 - $10 Tier 2 - $20 Tier 3 - $50 Tier 4 - 25% Part B Drugs: 20% Coinsurance Formulary - Yes Full Gap Coverage (Tiers 1-3)
Retail or Mail Order (Up to 90-day supply)	$20 Copay if drug cost to plan is $20-$80; $50 Copay if drug cost to plan is $80.01-$160; $80 Copay if drug cost to plan is $160.01 & over		$20 Copay if drug cost to plan is $20-$80; $40 Copay if drug cost to plan is $80.01-$160; $80 Copay if drug cost to plan is $160.01 & over		Tier 1 - $10 Tier 2 - $70 Tier 3 - $210 Tier 4 (limited to 30-day supply)- $70 Formulary - Yes NO Gap Coverage	Tier 1 - $8 Tier 2 - $74 Tier 3 - $165 Tier 4 (limited to 30-day supply)- $55 Formulary - Yes Gap Coverage - Tier 1 Only	Tier 1 - $20 Tier 2 - $40 Tier 3 - $100 Tier 4 (limited to 30-day supply)- 25% Formulary - Yes Full Gap Coverage (Tiers 1-3)
Ambulance Service	20% of Eligible Expenses after Deductible		10% of Eligible Expenses after Deductible		$100 Copay per trip		
Chiropractic Services	$20 Copay	Subject to Deductible and Copay	$20 Copay	Subject to Deductible and Copay	$10 Copay for each Medicare-covered visit		$20 Copay for each Medicare-covered visit
Durable Medical Equipment	20% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	10% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	$0 Copay for diabetes monitoring supplies; 20% Coinsurance for all other Medicare-covered benefits		

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Emergency Room	$250 Copay at Hospital Emergency Room (If admitted, Deductible and Coinsurance apply; emergency Copay waived)		$150 Copay at Hospital Emergency Room (If admitted, Deductible and Coinsurance apply; emergency Copay waived)		$50 Copay per visit (Waived if admitted to Hospital for the same condition within 24 hours)		
Home Health Care	20% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	10% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	100% coverage (unlimited, medically necessary visits)		
Hospital Care (Inpatient care including physician services)	20% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	10% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	$200 per day (days 1-11); $0 per day thereafter		$300 per day (days 1-5); $0 per day thereafter
Immunization and Influenza or Pneumonia Vaccine (any age)	100%	Subject to Deductible and Coinsurance	100%	Subject to Deductible and Coinsurance	$0 Copay		
Maternity Care	$0 Copay applies to Office Visit only. Hospital care subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	$0 Copay applies to Office Visit only. Hospital care subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	$5 Copay per visit Primary; $10 Copay per visit Specialist; Inpatient Care - see Hospital Care		$10 Copay per visit Primary; $20 Copay per visit Specialist; Inpatient Care - see Hospital Care
Mental Health Services and Substance Abuse	Member must receive prior authorization through the Mental Health/Substance Abuse Designee				**Inpatient Services:** $175 Copay per day (days 1-11), $0 Copay per day (days 12-190); **Partial Hospitalization:** $10 Copay per day; **Outpatient Services:** $10 Copay for group session; $10 Copay for individual session		**Inpatient Services:** $300 Copay per day (days 1-5), $0 Copay per day (days 6-190); **Partial Hospitalization:** $20 Copay per day; **Outpatient Services:** $20 Copay for group session; $20 Copay for individual session
	$35 Copay for office visits; Inpatient care subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance	$30 Copay for office visits; Inpatient care subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance			
Outpatient Diagnostic Services (Lab, X-ray and Mammography Testing)	Covered at 100% of Eligible Expenses	Subject to Deductible and Coinsurance	Covered at 100% of Eligible Expenses	Subject to Deductible and Coinsurance	$0 Copay for each Medicare-covered clinical/diagnostic lab service. $10 for each Medicare-covered X-ray visit. 15% coinsurance for any other diagnostic radiology services or therapeutic lab.	$0 Copay for each Medicare-covered clinical/diagnostic lab service. $0 for each Medicare-covered X-ray visit. 15% coinsurance for any other diagnostic radiology services or therapeutic lab.	$0 Copay for each Medicare-covered clinical/diagnostic lab service. $15 for each Medicare-covered X-ray visit. 20% coinsurance for any other diagnostic radiology services or therapeutic lab.
Outpatient Diagnostic/Therapeutic Services (CT Scans, Pet Scans, MRIs and Nuclear Medicine)	20% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	10% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	15% Coinsurance for Medicare-covered diagnostic procedures and tests, diagnostic radiology services, or therapeutic radiology service.		20% Coinsurance for Medicare-covered diagnostic procedures and tests, diagnostic radiology services, or therapeutic radiology service.
Outpatient Therapeutic Treatment (Chemotherapy; Radiation Therapy; Respiratory Therapy; Dialysis Treatment)	20% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	10% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	Renal Dialysis: Member pays 20% Coinsurance each visit; 15% Coinsurance each visit for all other services		20% of the cost for Medicare-covered benefits
Podiatry Services	$35 Copay	Subject to Deductible and Coinsurance	$30 Copay	Subject to Deductible and Coinsurance	$10 Copay for each Medicare-covered visit. $10 Copay for up to six (6) supplemental routine visits per year.		$20 Copay for each Medicare-covered visit. $20 Copay for up to six (6) supplemental routine visits per year.
Prosthetic Devices	20% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	10% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	20% Coinsurance for all Medicare-covered benefits		
Rehabilitation Services - Outpatient Therapy (Physical, Occupational, or Speech/Language Therapy)	**Limited to 60 visits per plan year**				15% Coinsurance for each Medicare-covered visit		20% Coinsurance for each Medicare-covered visit
	$25 Copay per visit	Subject to Deductible and Coinsurance	$15 Copay per visit	Subject to Deductible and Coinsurance			

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Skilled Nursing Facility Care (SNF)/ Inpatient Rehabilitation Facility Services (Non-custodial care)	Nursing is limited to 45 days per calendar year. Inpatient rehabilitation services are limited to 60 days per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.				**SNF**: $20 Copay per day for days 1-20; $95 Copay per day for days 21-100; **Inpatient Rehabilitation:** Included in Inpatient Hospital Copay of $200 per day for days 1-11, $0 per day thereafter		**SNF**: $0 Copay per day for days 1-5; $20 Copay per day for days 6-35; $0 Copay per day for days 36-100; **Inpatient Rehabilitation:** Included in Inpatient Hospital Copay of $300 per day for days 1-5, $0 per day thereafter
	20% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	10% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance			
Surgery and Related Services (Physician's office for Medicare Advantage Plans; outpatient hospital for all plans)	20% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	10% of Eligible Expenses after Deductible	Subject to Deductible and Coinsurance	$5 Copay per visit Primary; $10 Copay per visit Specialist; Outpatient Surgery - 15% Coinsurance each visit		$10 Copay per visit Primary; $20 Copay per visit Specialist; Outpatient Surgery: $250 per visit for outpatient surgery, 20% Coinsurance for other outpatient services
Urgent Care	$40 Copay	Subject to Deductible and Coinsurance	$40 Copay	Subject to Deductible and Coinsurance	$25 Copay each visit (Waived if admitted to the Hospital for the same condition within 24 hours)		$50 Copay each visit (Waived if admitted to the Hospital for the same condition within 24 hours)
Vision Services	$25 Copay; One eye exam every 12 mos. Spectera Eyecare Network Vision Care Providers can be found at myuhcvision.com	Subject to Deductible and Coinsurance	$15 Copay; One eye exam every 12 mos. Spectera Eyecare Network Vision Care Providers can be found at myuhcvision.com	Subject to Deductible and Coinsurance	$10 Copay for Medicare-covered eye exam; $10 Copay annual routine eye exam; $130 Eyeglasses Allowance, $175 Contact Lenses Allowance, Eyewear period: 24 months		$20 Copay for Medicare-covered eye exam; $20 Copay annual routine eye exam; $130 Eyeglasses Allowance, $175 Contact Lenses Allowance, Eyewear period: 24 months
Notification/Precertification Required for: **- Inpatient Care** **- Home Health Care** **- Emergency Dental Services** **- Durable Medical Equipment** **- Skilled Nursing Facility** **- Hospice** **- Outpatient Surgery (Medicare Advantage Plans)** **- Reconstructive Procedures** **- Inpatient Rehabilitation Facility** **Also, see footnotes below**	Network providers handle all notifications and managed care requirements for Members.	Members are responsible for obtaining notifications. If the required certification is not obtained, Benefits will be reduced to 50% of the eligible expenses or may result in no benefits payable.	Network providers handle all notifications and managed care requirements for Members.	Members are responsible for obtaining notifications. If the required certification is not obtained, Benefits will be reduced to 50% of the eligible expenses or may result in no benefits payable.	UnitedHealthcare wants to make access to health care as easy as possible for its members. Therefore, it is the responsibility of the contracted provider for notification of acute hospital and/or skilled nursing and not the member. Contracted providers are required to notify UnitedHealthcare of an acute inpatient hospitalization or skilled nursing facility admission within 24 hours. The member is not held responsible if a provider does not notify UnitedHealthcare. In addition, UnitedHealthcare has greatly reduced the number of covered benefits that require prior authorization thereby reducing the hassle for doctors and members alike. Non-contracted (or out-of-network) providers are not required to notify UnitedHealthcare regarding hospital or Skilled Nursing Facility admissions and prior authorizations do not apply.		
Customer Service:	**SLPS-Sponsored UnitedHealthcare® Commercial Group Health Plans (medical coverage): 1-844-298-8930** **Express Scripts (Pharmacy Benefit Manager--prescription drug services): 1-877-850-3348**				**UnitedHealthcare® Group Medicare Advantage PPO Plans: 1-844-876-6160** **Optum RX (Pharmacy Benefit Manager): 1-888-279-1828, TTY 711** **24-Hour Nurse Line: 1-877-365-7949** **RenewActive Fitness Program: 1-877-651-2848 OR www.uhcrenewactive.com** **OTC Health Products Benefit (First Line Medical): 1-800-933-2914, TTY 711 Monday through Friday 7 a.m. to 7 p.m. CT Saturday 7 a.m. to 4 p.m. CT** **Logisticare (Transportation): 1-833-219-1182 / TTY: 1-844-488-9724 Monday-Friday** **UnitedHealthcare® Hearing : 1-855-523-9355**		

Please note: If there are any discrepancies between the benefits outlined in this spreadsheet and the benefits outlined in the policy, the policy will dictate the benefits.

To enroll in a Medicare Advantage plan, you must be enrolled in Medicare Parts A & B

***Medicare Advantage plans are contracted with Medicare to provide Medicare benefits to Medicare-eligible members. In addition, Medicare Advantage plans provide value-added services, e.g., prescription drug coverage, routine eye care and eyeglass benefit, fitness benefit (Renew Active), Transportation (Logisticare) for medically-related appointments, mail order over-the-counter allowance for specific items, and a 24-hour Nurseline.**

This summary should be used for benefit comparisons only. It should not be relied upon to fully determine coverage. See the Certificate of Coverage for each Insurance Carrier for more detailed information. If differences occur between an Insurance Carrier's Certificate of Coverage and this summary, the Insurance Carrier's Certificate governs. PSRSSTL reserves the right to discontinue its health care insurance programs at any time and for any reason.

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