Benefit Highlights

HP PPO Core Plan 15648
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 $325 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 $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)	$30 copay
Specialist	$40 copay
Virtual visits	$0 copay using Amwell, Doctor on Demand and Teladoc $30 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	$230 copay per day: days 1-7 $0 copay per day after that
Skilled nursing facility (SNF)	$0 copay per day: days 1-20 $178 copay per additional day up to 100 days
Outpatient surgery	20% coinsurance
Outpatient rehabilitation Physical, occupational, or speech/ language therapy	20% coinsurance
Outpatient mental health	
Group therapy	$30 copay
Individual therapy	$40 copay
Virtual visits	$40 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% coinsurance
Lab services	$30 copay
Outpatient X-rays	$30 copay
Therapeutic radiology services such as radiation treatment for cancer	20% coinsurance
Ambulance	$175 copay
Emergency care	$100 copay (worldwide)
Urgently needed services	$30 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	$0 copay for each visit up to $500 per plan year*
Foot care – routine	$40 copay, 6 visits per plan year*
UnitedHealthcare Healthy at Home Premium	$0 copay for 28 meals, 24 one-way rides, and 8 hours of non-medical personal care
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 $5,000 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.

*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	$10 copay	$20 copay
Tier 2: Preferred Brand [1]	$40 copay	$100 copay
Tier 3: Non-Preferred Drug [1]	$60 copay	$150 copay
Tier 4: Specialty Tier [1]	$60 copay	$150 copay
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.

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