Benefit Highlights

State Employees' Insurance Board 15502
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

	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 network and out-of-network out-of-pocket maximum of $6,700 each plan year.	

Medical Benefits

Benefits covered by Original Medicare and your plan

	Network	Out-of-Network
Doctor's office visit	Primary Care Provider: $10 copay	Primary Care Provider: $10 copay
	Virtual Doctor Visits: $0 copay	Virtual Doctor Visits: $0 copay
	Specialist: $15 copay	Specialist: $15 copay
Preventive services	$0 copay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	$0 copay per stay	$0 copay per stay
Skilled nursing facility (SNF)	$0 copay per day: days 1-20 $167.50 copay per day: days 21-58 $0 copay per additional day up to 100 days	$0 copay per day: days 1-20 $167.50 copay per day: days 21-58 $0 copay per additional day up to 100 days
	Our plan covers up to 100 days in a SNF per benefit period.	
Outpatient surgery	$150 copay	$150 copay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	$15 copay	$15 copay
Mental health (outpatient and virtual)	Group therapy: $14 copay	Group therapy: $14 copay
	Individual therapy: $14 copay	Individual therapy: $14 copay
	Virtual visits: $14 copay	Virtual visits: $14 copay

Medical Benefits

Benefits covered by Original Medicare and your plan

	Network	Out-of-Network
Diagnostic radiology services (such as MRIs, CT scans) (when the service is performed at a hospital, outpatient facility or a free-standing facility imaging or diagnostic center)	$75 copay	$75 copay
Diagnostic radiology services (such as MRIs, CT scans) performed in a doctor's office (doctor's office visit copay will apply)	$0 copay	$0 copay
Diagnostic procedures and testing services (when the service is performed at a hospital, outpatient facility or a freestanding facility imaging or diagnostic center)	$0 copay	$0 copay
Diagnostic procedures and testing services received in a doctor's office (doctor's office visit copay will apply)	$0 copay	$0 copay
Lab services	$0 copay	$0 copay
Outpatient x-rays	$0 copay	$0 copay
Therapeutic radiology services (such as radiation treatment for cancer) (when the service is performed at a hospital, outpatient facility or a free- standing facility imaging or diagnostic center)	$25 copay	$25 copay
Therapeutic radiology services (such as radiation treatment for cancer) performed in a doctor's office (doctor's office visit copay will apply)	$0 copay	$0 copay
Ambulance	$50 copay	$50 copay
Emergency care (waived if admitted within 24 hours)	$80 copay (worldwide)	

Medical Benefits

Benefits covered by Original Medicare and your plan

	Network	Out-of-Network
Urgently needed services (waived if admitted within 24 hours)	$24 copay (worldwide)	$24 copay (worldwide)
Chiropractic care manual manipulation of the spine to correct subluxation	$15 copay	$15 copay

Additional benefits and programs not covered by Original Medicare

	Network	Out-of-Network
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Foot care - routine	$15 copay (Up to 6 visits per plan year)*	$15 copay (Up to 6 visits per plan year)*
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 aid(s) 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	$15 copay (1 exam every 12 months)*	$15 copay (1 exam every 12 months)*
Fitness program through SilverSneakers®	You have access to SilverSneakers®, a Medicare fitness program. SilverSneakers includes a $0 membership fee for a standard, monthly membership at a participating fitness center. To get your SilverSneakers ID number or learn more about this benefit, visit SilverSneakers.com or call 1-888-423-4632, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday.	
Post-Discharge Meals	$0 copay; Coverage for up to 84 home-delivered meals immediately following one inpatient hospitalization or skilled nursing facility stay when referred by a UnitedHealthcare Clinical Advocate. Benefit is offered one time per year through the provider Mom's Meals. Restrictions apply.	
NurseLine	Receive access to nurse consultations and additional clinical resources at no additional cost.	

	Network	Out-of-Network
Real Appeal Weight Management Program	$0 copay; Start living a healthier and happier life with help from Real Appeal®, an online weight loss program available at no additional cost. **Real Appeal is available at no additional cost to members with a BMI of 19 and higher. If you are pregnant, please speak with your primary care physician before joining the program.*	

*Benefits are combined in and out-of-network

Prescription Drugs

	Your Cost	
Stage 1: Annual prescription (Part D) deductible	$0 deductible	
Stage 2: Initial Coverage	Network Pharmacy (30-day retail supply)	Network Pharmacy (90-day retail supply)
Tier 1: Preferred Generic	$3 copay	$3 copay (31 to 60-day) $8 copay (61 to 90-day)
Tier 2: Preferred Brand	$23 copay	$23 copay
Tier 3: Non-preferred Drug	$53 copay	$53 copay
Tier 4: Specialty Tier	$53 copay	$53 copay
Stage 3: Coverage Gap	After your total drug costs reach $4,130, you continue to pay the same copay or coinsurance as you did in the initial coverage stage.	
Stage 4: Catastrophic Coverage	After your total out-of-pocket costs reach $6,550, you will pay a $3.70 copay for generic drugs (including brand drugs treated as generic), or a $9.20 copay for all other drugs	

The SEIB 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.