StarTribune

2022 Summary of Benefits

The following is an overview of your medical plan coverage. Where there is a flat dollar amount ($) listed, this is a copayment. Where there is a percentage amount (%), this is coinsurance. For exact terms and conditions, consult your plan materials or call UMR at 1-800-207-3172. For pharmacy, call Optum at 1-877-559-2955.

Medical Plan Highlights	PPO Plan		HSA Plan	
Partial listing of covered services	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible and Out-of-Pocket				
Co. HSA contribution with wellness program			$850 individual/$1,700 family	
Co. HSA contribution without wellness program			$550 individual/ $1,100 family	
Lifetime Maximum	Unlimited	$1,000,000	Unlimited	$1,000,000
Calendar year deductible with wellness program	$400 individual $800 family	$1,200 individual $2,400 family	$2,800 individual $4,600 family	$5,000 individual $10,000 family
Calendar year deductible without wellness program	$800 individual $1,600 family	$1,200 individual $2,400 family	$2,800 individual $4,600 family	$5,000 individual $10,000 family
Calendar year medical out-of-pocket maximum (including deductible)	$5,000 individual $10,000 family	$8,000 individual $16,000 family	$4,000 individual $8,000 family	$8,000 individual $16,000 family
Preventive Health Care				
Routine physical and eye examinations	100% coverage, no deductible	No coverage	100% coverage, no deductible	No coverage
Prenatal, postnatal care and well child care	100% coverage, no deductible	60% coverage after deductible	100% coverage, no deductible	60% coverage after deductible
Immunizations	100% coverage, no deductible	No coverage	100% coverage, no deductible	No coverage
Office Visits				
Illness or injury	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Mental/chemical health care	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Physical, occupational and speech therapy	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Chiropractic care (for neuromusculo-skeletal conditions only)	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Allergy injections	100% coverage, no deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Convenience Care				
Convenience clinics (retail clinics), eVisits	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Teladoc	$15 copay; no deductible	N/A	90% coverage after deductible	N/A
Emergency Care				
Urgently needed care at an urgent care clinic or medical center	80% coverage after deductible	80% coverage after deductible	90% coverage after deductible	90% coverage after deductible
Emergency care at a hospital ER	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Ambulance	80% coverage after deductible	80% coverage after deductible	90% coverage after deductible	90% coverage after deductible
Outpatient Care				
Illness or injury	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Mental/chemical health care	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Outpatient Care				
Scheduled outpatient procedures	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Outpatient MRI and CT scan	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible
Durable Medical Equipment				
Durable Medical Equipment and prosthetic devices	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible

Pharmacy Highlights	PPO Plan		HSA Plan	
Partial listing of covered services	In-Network Pharmacy	Out-of-Network Pharmacy	In-Network Pharmacy	Out-of-Network Pharmacy
Up to a 31-day supply (retail); 32-90 day supply (mail order); up to a 30-day supply (specialty)				
Generic drugs (Tier 1)	$15 Copay per prescription (retail); $30 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	90% coverage after deductible	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.
Preferred brand drugs (Tier 2)	$35 Copay per prescription (retail); $70 Copay per prescription (mail order)		90% coverage after deductible	
Non-preferred brand drugs (Tier 3)	$35 Copay per prescription (retail); $70 Copay per prescription (mail order)		90% coverage after deductible	
Specialty drugs (Tier 4)	80% Copay up to a $200 Maximum per prescription		90% Coverage after deductible up to a $200 Maximum per prescription	