

# Benefit Highlights

## IBM

Effective January 1, 2023 to December 31, 2023

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

	<b>Enhanced plan</b> In-network and out-of-network	<b>Essential plan</b> In-network and out-of-network
<b>Annual medical deductible</b>	No deductible	No deductible
<b>Annual medical out-of-pocket maximum (the most you pay in a plan year for covered medical care)</b>	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$750 for this plan year.	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$5,000 for this plan year.

### Medical benefits

Medical benefits covered by the plan and Original Medicare

	<b>Enhanced plan</b> In-network and out-of-network	<b>Essential plan</b> In-network and out-of-network
<b>Doctor's office visit</b>		
Primary care provider (PCP)	\$5 copay	\$10 copay
Specialist	\$30 copay	\$40 copay
Virtual visits	\$0 using Amwell, Doctor on Demand and Teladoc \$5 using other providers that have the ability and are qualified to offer virtual medical visits	\$0 using Amwell, Doctor on Demand and Teladoc \$10 using other providers that have the ability and are qualified to offer virtual medical visits
<b>Preventive services</b> Medicare-covered	\$0 copay	\$0 copay
<b>Inpatient hospital care</b>	\$250 copay per stay	\$275 copay per day: days 1-5 \$0 copay per day after that

## Medical benefits

Medical benefits covered by the plan and Original Medicare

	<b>Enhanced plan</b> In-network and out-of-network	<b>Essential plan</b> In-network and out-of-network
<b>Skilled nursing facility (SNF)</b>	\$0 copay per day: days 1–20 \$50 copay per day: days 21–35 \$0 copay per day: days 36 and beyond	\$0 copay per day: days 1–20 \$125 copay per day: days 21–61 \$0 copay per day: days 62 and beyond
	Our plan covers unlimited days in a SNF per benefit period.	Our plan covers unlimited days in a SNF per benefit period.
<b>Outpatient surgery</b>	\$100 copay	\$275 copay
<b>Outpatient rehabilitation</b> Physical, occupational, or speech/language therapy	\$20 copay	\$30 copay
<b>Outpatient mental health</b> Group therapy	\$5 copay	\$10 copay
Individual therapy	\$30 copay	\$40 copay
Virtual visits	\$30 copay	\$40 copay
<b>Diagnostic radiology services</b> such as MRIs, CT scans	\$20 copay	\$30 copay
<b>Lab services</b>	\$0 copay	\$0 copay
<b>Outpatient X-rays</b>	\$20 copay	\$35 copay
<b>Therapeutic radiology services</b> such as radiation treatment for cancer	\$20 copay	\$30 copay
<b>Ambulance</b>	\$100 copay	\$250 copay
<b>Emergency care</b>	\$75 copay (worldwide)	\$90 copay (worldwide)
<b>Urgently needed services</b>	\$30 copay (worldwide)	\$40 copay (worldwide)

## Additional benefits and programs not covered by Original Medicare

	<b>Enhanced plan</b> In-network and out-of-network	<b>Essential plan</b> In-network and out-of-network
<b>Routine physical</b>	\$0 copay, 1 per plan year*	\$0 copay, 1 per plan year*
<b>Dental – routine</b>	\$0 copay for preventive dental care including exams, cleanings, X-rays and fluoride, additional fees may apply when using an out-of-network dentist. \$50 yearly deductible and \$1,000 plan year maximum.*	\$0 copay for preventive dental care including exams, cleanings, X-rays and fluoride, additional fees may apply when using an out-of-network dentist. \$50 yearly deductible and \$1,000 plan year maximum.*
<b>Foot care – routine</b>	\$0 copay, 6 visits per plan year*	\$0 copay, 6 visits per plan year*

	<b>Enhanced plan</b> In-network and out-of-network	<b>Essential plan</b> In-network and out-of-network
<b>UnitedHealthcare Healthy at Home</b>	\$0 copay for 28 meals, 12 rides, and 6 hours of in-home personal care up to 30 days following all inpatient and SNF discharges. Referral required.	\$0 copay for 28 meals, 12 rides, and 6 hours of in-home personal care up to 30 days following all inpatient and SNF discharges. Referral required.
<b>UnitedHealthcare Healthy at Home Premium</b>	\$0 copay for 28 meals, 24 one-way rides, and 8 hours of non-medical in-home personal care	\$0 copay for 28 meals, 24 one-way rides, and 8 hours of non-medical in-home personal care
<b>Over-the-counter care</b> FirstLine Medical	\$0 copay; You receive \$40 each quarter to use on approved over-the-counter products as shown in the catalog or website.	\$0 copay; You receive \$40 each quarter to use on approved over-the-counter products as shown in the catalog or website.
<b>Hearing – routine exam</b>	\$0 copay, 1 exam per plan year*	\$0 copay, 1 exam per plan year*
<b>Hearing aids</b> UnitedHealthcare Hearing	Plan pays a \$500 allowance for hearing aids (combined for both ears) every 3 years. Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.	Plan pays a \$500 allowance for hearing aids (combined for both ears) every 3 years. Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.
<b>Vision – routine eye exam</b>	\$0 copay, 1 exam every 12 months*	\$0 copay, 1 exam every 12 months*
<b>Vision – routine eyewear</b>	Plan pays \$150 for eyeglasses every 12 months. Or, \$150 for contact lenses instead of eyeglasses every 12 months.*	Plan pays \$150 for eyeglasses every 12 months. Or, \$150 for contact lenses instead of eyeglasses every 12 months.*
<b>Fitness program</b> Renew Active® by UnitedHealthcare	\$0 copay for a standard gym membership at participating locations	\$0 copay for a standard gym membership at participating locations
<b>Telephonic nurse services</b>	Receive access to nurse consultations and additional clinical resources at no additional cost.	Receive access to nurse consultations and additional clinical resources at no additional cost.

\*Benefits are combined in and out-of-network.

## Prescription drugs

	Enhanced plan	Essential plan
<b>Annual prescription (Part D) deductible</b>	\$0 for Tier 1 and Tier 2 \$50 for Tier 3, Tier 4 and Tier 5	\$0 for Tier 1 and Tier 2 \$395 for Tier 3, Tier 4 and Tier 5
<b>Initial coverage stage</b>	<b>Network pharmacy</b> (30-day retail supply)	
<b>Tier 1: preferred generic</b>	\$0 copay	\$5 copay
<b>Tier 2: generic</b>	\$8 copay	\$15 copay
<b>Tier 3: preferred brand</b>	\$40 copay	\$47 copay
<b>Tier 4: non-preferred drug</b>	\$90 copay	\$100 copay
<b>Tier 5: specialty tier</b>	30% coinsurance	30% coinsurance
<b>Initial coverage stage</b>	<b>Mail service pharmacy</b> (90-day supply)	
<b>Tier 1: preferred generic</b>	\$0 copay	\$5 copay (up to 30-day) \$0 copay 31 to 90-day
<b>Tier 2: generic</b>	\$16 copay	\$37.50 copay
<b>Tier 3: preferred brand</b>	\$80 copay	\$117.50 copay
<b>Tier 4: non-preferred drug</b>	\$180 copay	\$250 copay
<b>Tier 5: specialty tier</b>	30% coinsurance	30% coinsurance
<b>Coverage gap stage</b>	After your total drug costs reach \$4,660, you pay 25% of the price (plus the dispensing fee) for brand name drugs and 25% of the price for generic drugs	
<b>Catastrophic coverage stage</b>	After your total out-of-pocket costs reach \$7,400, you will pay a \$4.15 copay for generic drugs (including brand drugs treated as generic) and \$10.35 copay for all other drugs	

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.