Benefit Highlights

IBM

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

	Enhanced plan In-network and out-of-network	**Essential plan** In-network and out-of-network
Annual medical deductible	No 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 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

	Enhanced plan In-network and out-of-network	**Essential plan** In-network and out-of-network
Doctor's office visit Primary care provider (PCP)	$5 copay	$10 copay
Specialist	$30 copay	$40 copay
Virtual visits	$0 copay using Amwell, Doctor on Demand and Teladoc $5 copay using other providers that have the ability and are qualified to offer virtual medical visits	$0 copay using Amwell, Doctor on Demand and Teladoc $10 copay using other providers that have the ability and are qualified to offer virtual medical visits
Preventive services Medicare-covered	$0 copay	$0 copay
Inpatient hospital care	$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

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

Additional benefits and programs not covered by Original Medicare

	Enhanced plan In-network and out-of-network	**Essential plan** In-network and out-of-network
Routine physical	$0 copay, 1 per plan year*	$0 copay, 1 per plan year*
Dental – routine	$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.*
Foot care – routine	$0 copay, 6 visits per plan year*	$0 copay, 6 visits per plan year*

	Enhanced plan In-network and out-of-network	**Essential plan** In-network and out-of-network
UnitedHealthcare Healthy at Home	$0 copay for 28 meals, 12 rides (one-way), and 6 hours of non-medical personal care up to 30 days following all inpatient and SNF discharges. Referral required.	$0 copay for 28 meals, 12 rides (one-way), and 6 hours of non-medical personal care up to 30 days following all inpatient and SNF discharges. Referral required.
UnitedHealthcare Healthy at Home Premium	$0 copay for 28 meals, 24 one-way rides, and 8 hours of non-medical personal care	$0 copay for 28 meals, 24 one-way rides, and 8 hours of non-medical personal care
Over-the-counter (OTC) card Healthy Benefits Plus	$0 copay $40 credit each quarter to purchase approved OTC items from network retail locations or through the OTC catalog or website.	$0 copay $40 credit each quarter to purchase approved OTC items from network retail locations or through the OTC catalog or website.
Hearing – routine exam	$0 copay, 1 exam per plan year*	$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.	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*	$0 copay, 1 exam every 12 months*
Vision – routine eyewear	Plan pays $150 for eyeglasses or, $150 for contact lenses instead of eyeglasses, every 12 months.*	Plan pays $150 for eyeglasses or, $150 for contact lenses instead of eyeglasses, every 12 months.*
Fitness program Renew Active® by UnitedHealthcare	$0 copay for a standard gym membership at participating locations	$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.	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
Annual prescription (Part D) deductible	$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
Initial coverage stage	**Network pharmacy** (30-day retail supply)	
Tier 1: Preferred Generic	$0 copay	$5 copay
Tier 2: Generic	$8 copay	$15 copay
Tier 3: Preferred Brand[1]	$40 copay	$47 copay
Tier 4: Non-preferred Drug[1]	$90 copay	$100 copay
Tier 5: Specialty Tier[1]	30% coinsurance	30% coinsurance
Initial coverage stage	**Mail service pharmacy** (90-day supply)	
Tier 1: Preferred Generic	$0 copay	$5 copay (up to 30-day) $0 copay 31 to 90-day
Tier 2: Generic	$16 copay	$37.50 copay
Tier 3: Preferred Brand[1]	$80 copay	$117.50 copay
Tier 4: Non-preferred Drug[1]	$180 copay	$250 copay
Tier 5: Specialty Tier[1]	30% coinsurance	30% coinsurance
Coverage gap stage	After your total drug costs reach $5,030, you pay 25% of the price (plus the dispensing fee) for brand name drugs and 25% of the price for generic drugs	
Catastrophic coverage stage	During this payment stage, after your total out-of-pocket costs reach $8,000, the plan pays the full cost for your covered drugs. You pay nothing.	

[1]Subject to Medicare guidance, coinsurance may not apply to Part D insulin products. You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven't paid your Part D deductible. 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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