

# Benefit Highlights

## IBM

Effective January 1, 2025 to December 31, 2025

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
<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		
	Enhanced plan In-network and out-of-network	Essential plan In-network and out-of-network
<b>Doctor visits</b>		
Primary care provider (PCP)	\$5 copay	\$10 copay
Specialist	\$30 copay	\$40 copay
Virtual visit	\$0 copay for designated providers \$5 copay for other providers	\$0 copay for designated providers \$10 copay for other providers
<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
<b>Skilled nursing facility (SNF)</b>	\$0 copay per day: days 1–20 \$50 copay per day: days 21–35 \$0 copay per additional day: days 36 and beyond	\$0 copay per day: days 1–20 \$125 copay per day: days 21–61 \$0 copay per additional day: days 62 and beyond
<b>Outpatient surgery</b>	\$100 copay	\$275 copay

**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>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
Therapy or office visit with a psychiatrist	\$30 copay	\$40 copay
Virtual visit	\$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*

## 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>Over-the-counter (OTC) credit</b>	\$40 credit each quarter to buy covered OTC products from network retail locations	\$40 credit each quarter to buy covered OTC products from network retail locations
<b>UnitedHealthcare Healthy at Home</b> post-discharge program	\$0 copay for 28 meals, 12 one-way trips and 6 hours of non-medical personal care up to 30 days following all inpatient hospital and SNF stays. Referral required.	\$0 copay for 28 meals, 12 one-way trips and 6 hours of non-medical personal care up to 30 days following all inpatient hospital and SNF stays. Referral required.
<b>UnitedHealthcare Healthy at Home Premium</b>	\$0 copay for 28 meals, 24 one-way trips, and 8 hours of non-medical personal care	\$0 copay for 28 meals, 24 one-way trips, and 8 hours of non-medical personal care
<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 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.
<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 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*
<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>Rewards</b>	Earn rewards to spend on eligible items like gifts, clothing, groceries and more.	Earn rewards to spend on eligible items like gifts, clothing, groceries and more.

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

## Good news for 2025

The Coverage Gap, or “donut hole”, has been eliminated and your out-of-pocket maximum cost (the amount paid by you and others pay on your behalf) is \$2,000. That means you’re more protected from high drug costs in 2025.

Prescription drugs		
	Enhanced plan	Essential plan
<b>Deductible</b>	\$0 for Tier 1 and Tier 2 Part D prescription drugs \$50 for Tier 3, Tier 4 and Tier 5 drugs	\$0 for Tier 1 and Tier 2 Part D prescription drugs \$395 for Tier 3, Tier 4 and Tier 5 drugs
<b>Initial Coverage</b>	<b>Network pharmacy (30-day retail supply)</b>	
<b>Tier 1: Preferred Generic</b>	\$0 copay	\$5 copay
<b>Tier 2: Generic</b>	\$8 copay	\$15 copay
<b>Tier 3: Preferred Brand<sup>1</sup></b>	\$40 copay	\$47 copay
<b>Tier 4: Non-Preferred Drug<sup>1</sup></b>	\$90 copay	\$100 copay
<b>Tier 5: Specialty Tier<sup>1</sup></b>	30% coinsurance	28% coinsurance
<b>Initial Coverage</b>	<b>Mail service pharmacy (90-day supply)</b>	
<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<sup>1</sup></b>	\$80 copay	\$117.50 copay
<b>Tier 4: Non-Preferred Drug<sup>1</sup></b>	\$180 copay	\$250 copay
<b>Tier 5: Specialty Tier<sup>1</sup></b>	30% coinsurance	28% coinsurance
<b>Catastrophic Coverage</b>	After you, and others on your behalf, have paid a combined total of \$2,000, you won’t pay anything for your Medicare-covered Part D drugs for the rest of the plan year. If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information.	

<sup>1</sup>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.

## Required Information

UnitedHealthcare® Group Medicare Advantage is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunice con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

Benefits, features and/or devices vary by plan/area. Limitations and exclusions may apply.

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. There may be other pharmacies in our network.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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.

Medicare Advantage reward offerings may vary by plan and are not available in all plans. By participating in the program or accessing rewards funds, you agree to the Rewards Program Terms of Service located on the right side of the page at [myuhcmedicare.com/retiree/rewards](http://myuhcmedicare.com/retiree/rewards). Rewards can only be used by members of UnitedHealthcare Group Medicare Advantage plans for eligible items at participating merchants and in accordance with applicable Medicare laws. Rewards funds are not redeemable for cash except as required by law. No ATM access. Fees may apply. Rewards cannot be used to purchase Medicare-covered items or services, including medical or prescription drug out-of-pocket costs, or alcohol, tobacco or firearms. The Reloadable Visa® Reward Card may be used for qualified purchases in the U.S. and District of Columbia. Please contact your program sponsor directly for a full list of qualified purchases.