

Medicare Coverage Summary of Benefits

The following information summarizes your Medicare benefits under the Plan as of January 1, 2025.

Medical Benefits ¹		
Medicare Part B Premium Reimbursement	100% of the standard Part B premium	
Annual Deductible	None	
Coinsurance (unless noted otherwise)	Plan pays 100%	
Hospital Services (including semi-private room and board, surgical, anesthesiology and other medical services)	Plan pays 100%	
Outpatient Surgery	Plan pays 100%	
Office Visits	Plan pays 100%	
Preventive Care/Wellness Services	Plan pays 100%	
Emergency Medical Care	Plan pays 100%	
Annual Out-of-Pocket Maximum	Not Applicable	
Chiropractic Care Initial Care Continuing Care Recurrence of Acute Condition	Up to 10 visits for first 30 days or 20 visits for first 60 days Up to 1 visit per month Up to 8 visits for first 30 days; up to 10 for next 60 days; 1 per month thereafter	
Home Care Services	Limited to 100 visits per calendar year	
Mental Health Benefits Inpatient days Maximum per calendar year Outpatient visits Maximum per calendar year	60 days 25 visits	
Substance Abuse Benefits Inpatient maximum days per confinement Outpatient Services Lifetime limit	28 days for rehabilitation and 5 days for detoxification Not covered 2 Inpatient rehabilitation programs	
Fitness Benefit	\$250 per Participant per year	
Hearing Benefit	Up to \$4,000 per Participant every 3 years	
Health Reimbursement Account	\$750 Single; \$1,500 Family	
Prescription Drug Benefits ^{2,3}		
Maximum Supply	30-day supply (retail or mail)	90-day supply (retail or mail)
Type of Medication Generic Preferred Brand Non-Preferred Brand	For up to a 30-day supply, you pay: \$2 per prescription \$15 per prescription \$24 per prescription	For up to a 90-day supply, you pay: \$4 per prescription \$30 per prescription \$48 per prescription

¹ Covered Services are paid based on Usual and Customary Charges. Participants are responsible for an additional amount if using a Provider that does not accept Medicare assignment.

² See page 48 of the booklet for information about prescription drugs that require prior approval.

³ Any medications eligible for the mail order program may be obtained at retail for the same copayment as at mail order.

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Dental Benefits	
Dental Annual Maximum	\$4,000
Coinsurance – Diagnostic/Preventive	100% for participating dentists
Coinsurance – Basic Services (e.g., fillings, root canals, crowns)	100% for participating dentists
Coinsurance – Major Services (e.g., bridges, implants, dentures)	100% for participating dentists
Vision Benefits	
Annual exam	\$0 copay for network providers
Frames (once/calendar year)	\$0 copay for network providers up to \$300 allowance
Standard lenses (once/calendar year)	\$0 copay for network providers
Contact lenses (once/calendar year)	\$0 copay for network providers up to \$200 allowance
Life Insurance Benefits	
Retiree Life Insurance Benefit <i>Benefit payable to Retiree's Beneficiary</i>	\$20,000
Spouse Life Insurance Benefit <i>Benefit payable to Spouse's Beneficiary</i>	\$12,500