

Pre-Medicare Coverage Summary of Benefits

The following information summarizes your Pre-Medicare benefits under the Plan as of January 1, 2026.

Medical Benefits	Network	Non-Network ¹
Pre-Certification Penalty (required for Non-Network benefits only)	If you do not call for pre-certification of Non-Network benefits when required, you are responsible for paying the entire cost of those services. See page 14 of the SPD for a description of the benefits that must be pre-certified.	
Annual Deductible	None	\$700 per person, up to a family maximum of \$2,100
Office Visits (including specialist visits)	Plan pays 100%	After deductible, Plan pays 70%
Coinsurance (unless noted otherwise)	Plan pays 100%	After deductible, Plan pays 70%
Emergency Medical Care	Plan pays 100%, no deductible required	
Hospital Services (including semi-private room and board, surgical, anesthesiology and other medical services)	Plan pays 100%	After deductible, Plan pays 70%
Preventive Care/Wellness	Plan pays 100%, with no deductible	
Annual Out-of-Pocket Maximum (including deductible)	Not Applicable	\$2,000 per person, up to a family maximum of \$6,000
Lifetime Maximum	None	\$500,000 per person (with up to \$10,000 yearly restoration)
Chiropractic Care	Plan pays 100%	After deductible, Plan pays 70%
Initial Care	No visit limit	Up to 10 visits for first 30 days or 20 visits for first 60 days
Continuing Care	No visit limit	Up to 1 visit per month
Recurrence of Acute Conditions	No visit limit	Up to 8 visits for first 30 days; up to 10 for next 60 days; 1 per month thereafter
Acupuncture	Plan pays 100%, up to 20 visits per year; visits above 20 require prior authorization	After deductible, plan pays 70%, up to 20 visits per year; visits above 20 require prior authorization
Home Care Services	Limited to 100 visits per calendar year, combined Network and Non-Network	Limited to 100 visits per calendar year, combined Network and Non-Network
Mental Health Benefits	28 days, Network and Non-Network combined	28 days, Network and Non-Network combined
Inpatient days	55 days, Network and Non-Network combined	55 days, Network and Non-Network combined
Maximum per calendar year	Plan pays 100%	After deductible, Plan pays 70%
Maximum per lifetime	118 visits, Network and Non-Network combined	118 visits, Network and Non-Network combined
Outpatient visits		
Maximum per lifetime		
Substance Abuse Benefits	Plan pays 100%	After deductible, Plan pays 70%
Inpatient	30 days, Network and Non-Network and Mental Health and Substance Abuse combined	30 days, Network and Non-Network and Mental Health and Substance Abuse combined
Maximum per calendar year	Plan pays 100%, up to 50 visits, Network and Non-Network combined	After deductible, Plan pays 70%, up to 50 visits, Network and Non-Network combined
Outpatient	2 rehabilitation programs, Inpatient and Outpatient, Network and Non-Network combined, up to \$25,000	2 rehabilitation programs, Inpatient and Outpatient, Network and Non-Network combined, up to \$25,000
Lifetime limit		
Hearing Benefit	Up to \$4,000 per Participant every 3 years	
Fitness Benefit	\$250 per Participant per year	

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Health Reimbursement Account	\$1,250 Single; \$2,500 Family
No Place Like Home Benefit	Home Modification Benefit - \$1,250 lifetime maximum per participant

¹ Non-Network Covered Services are paid based on Usual and Customary Charges

Prescription Drug Benefits ^{2,3}		
Maximum Supply	30-day supply (retail or mail)	90-day supply (retail or mail)
Type of Medication	For up to a 30-day supply, you pay:	For up to a 90-day supply, you pay:
Generic	\$0 per prescription	\$0 per prescription
Preferred Brand	\$5 per prescription	\$10 per prescription
Non-Preferred Brand	\$20 per prescription	\$40 per prescription

² See page 31 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

Dental Benefits	
Dental Annual Maximum	\$6,000
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
Coverage for Orthodontia	100% for participating dentists; \$4,000 lifetime benefit
Vision Benefits	
Annual exam	\$0 copay for network providers
Frames (once/calendar year)	\$0 copay for network providers up to \$290 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