MILWAUKEE DRIVERS HEALTH AND WELFARE TRUST FUND

SCHEDULE OF BENEFITS—Plan B (Medicare-Eligible Retiree)

The following chart highlights your level of coverage under the Plan, as of January 1, 2024. The percentage listed indicates the amount the Plan pays. These benefits are described in greater detail in your Summary Plan Description (SPD). Your monthly premium is based on your years of service, age, and number of dependents covered.

Medical Benefits	Coverage
Lifetime Maximum	Unlimited
Annual Deductible	No deductible
Annual Out-of-Pocket Limit	$3,000 per person
Coinsurance (except as otherwise specified; subject to any specific limitations)	100% after Medicare
Wellness	100% up to $300 per person each year; then 80%
LiveHealth Online	100% after Medicare
General Physician Office Visit (includes other diagnostic tests and x-rays)	100% after Medicare
Chiropractic Services (up to 36 visits per year)	100% after Medicare
Ambulance Service	100% after Medicare
Organ Transplant Hospital/Related	100% after Medicare (not covered unless network transplant provider is used)
Hospital Emergency Room	100% after Medicare
Ambulatory Surgical Center Care	100% after Medicare
Hospital Inpatient	100% after Medicare
Outpatient Hospital Care	100% after Medicare
Outpatient Surgery	100% after Medicare
In-Home Hospice Care	100% after Medicare
Skilled Nursing Facility Services	100% after Medicare
Physical, Respiratory, Occupational, or Speech Therapy (reviewed after 120 visits for continued medical necessity)[1]	100% after Medicare
Durable Medical Equipment	100% after Medicare
Oxygen	100% after Medicare
Immediate Care Facility	100% after Medicare
Other Services	
• Massage therapy (up to $1,500 per person per year)	80%
• Acupuncture	80%
• Outpatient Accident-Related Dental Services	80%
• Hearing Aids (one per ear per 36-month period)[4]	80%
Home Health Nursing Services	100% after Medicare
Home Health Custodial Care[1] Lifetime Maximum	80% $10,000
TMJ Treatment Non-Surgical Lifetime Maximum Surgical Lifetime Maximum	Same as any other illness or injury $1,500 per person $3,000 per person
Mental Health and Substance Abuse Benefits Inpatient[1]/Outpatient	100% of covered expenses

PRESCRIPTION DRUG BENEFIT	COVERAGE	
Network Pharmacy[2] Mail Order[2]	75% 75%	
Standard Dental Care Benefits[3]	**Network Provider**	**Non-Network Provider**
Class A		
• Type I (Diagnostic and Preventative)	100%	80%
• Type II (Basic Restorative)	80%	70%
• Type III (Major Restorative)	75%	60%
Class B (Orthodontia)	80%	80%
Lifetime Maximum Payment		
• Class A	Unlimited	Unlimited
• Class B	$3,000 per person	$3,000 per person
Routine Vision Care Benefits[3,4]	**Network Provider (Your Cost)**	**Non-Network Provider (Your Reimbursement)**
Eye Examination (Dilation, as necessary, and refraction)	$0	Up to $35
Exam Options (Contact Lenses)		
• Standard Fit and Follow-Up	Up to $55	N/A
• Premium Fit and Follow-Up	90% of retail price	N/A
Frames	80% of amount over $170	Up to $32
Standard Plastic Lenses		
• Single Vision	$0	Up to $40
• Bifocal	$0	Up to $60
• Trifocal	$0	Up to $80
• Standard Progressive	$0	Up to $60
• Premium Progressive	80% of charge less $120 allowance	Up to $60
Contact Lenses		
• Medically Necessary	$0	Up to $176
• Conventional	85% of amount over $125	Up to $72
• Disposable	100% of amount over $125	Up to $72

Note: Any expenses that are not covered by Medicare but that are covered expenses under this Plan will be paid in accordance with the Plan B Non-Medicare Eligible Retiree Schedule of Benefits. This means that the Plan will pay first. However, the Plan's coinsurance and in-network provisions will apply, and a Medicare Benefit Statement showing that your claim was denied by Medicare may be required.

[1] You must call Anthem at 833-952-2061 for precertification or coverage will be reduced.

[2] You must have your prescription filled at a preferred pharmacy and show your ID card or through the Sav-Rx Mail Order Pharmacy Program to receive your prescription at discounted prices Prescriptions will be dispensed in accordance with the Plan's drug formulary. When your physician prescribes a brand name medication which has a generic equivalent as determined by the U. S. Food and Drug Administration (FDA), the Plan will waive the difference in cost between the brand name drug and the equivalent generic drug ONLY if your prescribing physician provides Sav-Rx with a letter of "Medical Necessity" (LMN). In addition, the Plan includes a mandatory Step Therapy Program for most drugs, including non-sedating antihistamines (NSA) and proton pump inhibitors (PPIs). Specialty drugs will be delivered exclusively through the Sav-Rx Specialty Pharmacy after an initial retail fill.

[3] Dental and Vision are only available if you elected those coverages.

[4] Refer to your Summary of Routine Vision Care Benefits. All services are covered once every 12 months. Contact lenses are available in lieu of glasses. When you receive vision services out-of-network, you are responsible to pay the out-of-network provider in full at the time of service and then submit a request for reimbursement. You will be reimbursed up to the amount shown.