PPO

Local 13
2012 Employee Group Retiree Plan
Medicare Blue PPO Benefit Summary

MEDICAL BENEFITS	IN NETWORK	OUT-OF-NETWORK
Annual Deductible	None	$250
Annual Out-of-Pocket Maximum	$1,250	$10,000
Combined Annual Out-of-Pocket Maximum-In Network and Out of Network combined to a total of $10,000 max		
Inpatient Care		
Inpatient Hospitalization (Includes inpatient mental health, chemical dependency and rehabilitation services)	$250 copay 2 max	20% coinsurance
Skilled Nursing Facility (3 day inpatient stay waived)	$0/day 1-20; 50% days 21-100	50% coinsurance
Physician Services		
Primary Care Physician (PCP) Office Visit	$15 copay	$25 copay
Specialist Office Visit	$15 copay	$25 copay
Chiropractor Office Visit (manual manipulation to correct subluxation)	$15 copay	$25 copay
Podiatrist Office Visit (for medically necessary foot care)	$15 copay	20% coinsurance
Outpatient Care		
Emergency Room (waived if admitted within 23 hours, worldwide coverage)	$50 copay	$50 copay
Urgent Care (nationwide coverage)	$15 copay	$15 copay
Ambulance	$50 copay	$50 copay
Outpatient Mental Health	40% coinsurance	60% coinsurance
Outpatient Chemical Dependency	50% coinsurance	60% coinsurance
Diagnostic Tests and Laboratory Services	Covered in full	20% coinsurance
Radiological Services (X-ray, Chemotherapy, Radiation Therapy)	$15 copay	20% coinsurance
Outpatient Services/Surgery (an additional specialist copay may apply)	$50 copay	20% coinsurance
Rehabilitation Therapy (physical, occupational and speech)	$15 copay	20% coinsurance
Cardiac Rehabilitation	$15 copay	20% coinsurance
Durable Medical Equipment (DME) & Prosthetic Devices	20% coinsurance	20% coinsurance
Home Health Care (Includes home infusion services)	Covered in full	20% coinsurance
Diabetic Supplies	20% coinsurance	20% coinsurance
Kidney Dialysis	Covered in full	Covered in full
Medicare Part B Drugs Including Part B-Covered Chemotherapy Drugs.	20% coinurance	20% coinsurance
Preventive Services (Office visit copay may apply)		
Annual Wellness Exam	Covered in full	$25 copay
Immunizations (Flu, Pneumonia, H1N1 and Hepatitis B vaccines)	Covered in full	20% coinsurance, flu and pneumonia vaccines covered in full
Mammograms	Covered in full	20% coinsurance
Prostate Cancer Screening	Covered in full	$25 copay
Bone Mass Measurement	Covered in full	$25 copay
Pap Smears/Pelvic Exams	Covered in full	$25 copay
Colorectal Screening	Covered in full	$25 copay
Medicare Covered Preventive Services		
Hearing Exams	$15 copay	$25 copay
Eye Exams	$15 copay	$25 copay

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Additional Coverage	IN NETWORK	OUT-OF-NETWORK
Annual Routine Eyewear Allowance	$60 annual allowance	
Hearing Aid Allowance—once every 3 calendar years	$300 allowance	
Fitness Benefit	Silver&Fit: $25 annually for gym membership	
Optional Benefit	Not Selected	

Annual Deductible: $0.00

Initial Coverage:

	30-Day Supply	90-Day Supply
Tier 1:	$10 copay	$30 copay
Tier 2:	$25 copay	$75 copay
Tier 3:	$40 copay	$120 copay

Coverage Gap:

After total yearly drug costs paid by both the member and the plan for Part D eligible drugs reach $2,930, the member will continue to be responsible for the same copayments listed above for all generic and brand drugs. Coverage for generic drugs will be provided by the Part D plan. Coverage for brand name drugs will be provided by a wraparound group health plan.

Catastrophic Coverage:

After yearly out-of-pocket drug costs paid by the member reach $4,700, the member pays the greater of $2.60 copayment for generic and a $6.50 copayment for all other drugs, or 5% coinsurance.

The benefit information provided is not comprehensive. Please consult your Evidence of Coverage for a detailed explanation of benefits and any applicable restrictions. To the extent of any discrepancy between this document and the Evidence of Coverage, the Evidence of Coverage terms take priority.