# 2018 Benefit Summary

| Western PA Teamsters and Employers Welfare Fund | | | 178473<br>Freedom Blue PPO High Option | 178475<br>Freedom Blue PPO Mid Option | 178474<br>Freedom Blue PPO Low Option | 584549<br>Community Blue Medicare HMO |
|---|---|---|---|---|---|---|
| HEALTH | BASIC PLAN COSTS | Your Monthly Plan Premium | **$338** | **$268** | **$155** | **$303** |
| | | Deductible | $0 | $150 | $1,000 | $0 |
| | | Coinsurance | 0% / 20% | 10% / 20% | 10% / 20% | 0% |
| | | Out-of-Pocket Maximum | $3,400 | $1,000 / $3,400 | $2,400 / $3,400 | $3,400 |
| | PREVENTIVE CARE (OFFICE VISIT COST SHARING MAY APPLY) | Annual Physical Exam | Covered in Full | Covered in Full | Covered in Full | Covered in Full |
| | | Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement) | Covered in Full | Covered in Full | Covered in Full | Covered in Full |
| | PHYSICIAN SERVICES | Doctor Office Visit | $15 / 20% | $20 / 20% | $25 / 20% | $15 |
| | | Specialist Office Visit | $30 / 20% | $25 / 20% | $30 / 20% | $30 |
| | | X-ray or Radiology | 0% / 20% | 10% / 20% | 10% / 20% | 0% |
| | | Diagnostic Testing | 0% / 20% | 10% / 20% | 10% / 20% | 0% |

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| | FACILITY SERVICES | Outpatient Surgery | $25 copay / 20% | 10% / 20% | 10% / 20% | $25 copay |
| | FACILITY SERVICES | Emergency Room Services (Worldwide Coverage) | $50 | $50 | $50 | $50 |
| | FACILITY SERVICES | Urgently Needed Care (this is NOT emergency care) | $40 | $40 | $40 | $40 |
| | FACILITY SERVICES | Inpatient Hospital Stay | $50 per stay / 20% | 10% per stay / 20% | 10% per stay / 20% | $50 per stay |
| | FACILITY SERVICES | Skilled Nursing Facility Care (100 days per Medicare benefit period) | $0 per day / 20% | 10% per day / 20% | 10% per day / 20% | $0 per day |
| | ADDITIONAL BENEFITS | Annual Routine Vision Exam (Includes refraction) | $0 / $50 copay for eye exam | $0 / $50 copay for eye exam | $0 / $50 copay for eye exam | $0 |
| | ADDITIONAL BENEFITS | Eyeglasses or Contact Lenses (Covered every year) | Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses. | Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses. | Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses. | Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses. |
| | ADDITIONAL BENEFITS | Annual Routine Hearing Exam | $30 / 20% | $25 / 20% | $30 / 20% | $30 |

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| Hearing Aids (covered every three years) | $500 allowance | $500 allowance | $500 allowance | You pay a $499 copayment for Flyte 700 or a $799 copayment for Flyte 900.<br><br>Members are covered for up to two Flyte Hearing Aids every calendar year.<br><br>Hearing aid brand limited to TruHearing |
| Chiropractic Office Visits | $20 / 20% | $20 / 20% | $20 / 20% | $20 |
| Home Health | 0% / 20% | 10% / 20% | 10% / 20% | 0% |
| Physical, Speech and Occupational Therapy (per visit/per day/per provider) | $30 / 20% | $25 / 20% | $30 / 20% | $30 |
| Part B Drugs | 10% up to $300 Qtr max / 20% | 10% / 20% | 10% / 20% | 10% up to $300 Qtr max |
| Ambulance (Emergent Services per one way trip) | $75 | 10% | 10% | $75 |
| Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies, Oxygen/Oxygen Supplies) | 15% / 50% | 10% / 50% | 10% / 50% | 15% |

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| | MENTAL HEALTH SERVICES | Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime) | $50 per stay / 20% | 10% per stay / 20% | 10% per stay / 20% | $50 per stay |
| | | Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session) | $30 / 20% | $25 / 20% | $30 / 20% | $30 |

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|---|---|---|---|---|---|---|
| DRUGS | PART D DRUGS (<UP TO 31 DAY RETAIL SUPPLY>) | Initial Coverage Period (up to $3,750 in total drug costs) | $15 Pref Generic<br>$15 Generic<br>$30 Preferred Brand<br>$60 Non-Pref Brand<br>33% Specialty | $15 Pref Generic<br>$15 Generic<br>$30 Preferred Brand<br>$60 Non-Pref Brand<br>33% Specialty | $15 Pref Generic<br>$15 Generic<br>$40 Preferred Brand<br>$90 Non-Pref Brand<br>33% Specialty | $15 Pref Generic<br>$15 Generic<br>$30 Preferred Brand<br>$60 Non-Pref Brand<br>33% Specialty |
| | | Coverage Gap Period (from $3,750.01 in total drug costs to $5,000 in yearly out-of-pocket drug costs) | $15 Pref Generic<br>$15 Generic<br>25% Preferred Brand<br>25% Non-Pref Brand<br>25% Specialty | $15 Pref Generic<br>$15 Generic<br>35% Brand / Specialty (with manufacturer 50%) | $15 Pref Generic<br>$15 Generic<br>35% Brand / Specialty (with manufacturer 50%) | $15 Pref Generic<br>$15 Generic<br>25% Preferred Brand<br>25% Non-Pref Brand<br>25% Specialty |
| | | Catastrophic Coverage Period (after $5,000.01 in total out-of-pocket drug costs) | The greater of 5% or $3.35 for generic or multi-source drugs or $8.35 for all other drugs | The greater of 5% or $3.35 for generic or multi-source drugs or $8.35 for all other drugs | The greater of 5% or $3.35 for generic or multi-source drugs or $8.35 for all other drugs | The greater of 5% or $3.35 for generic or multi-source drugs or $8.35 for all other drugs |
| | | Mail Order (up to 90-day supply, Specialty Drug up to 31-day supply) | 2.5 times retail copay | 2.5 times retail copay | 2.5 times retail copay | 2.5 times retail copay |

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.

- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications.  Medicare Part B drugs are not available via retail pharmacy network.

This information is not a complete description of benefits.  Contact the plan for more information.  Limitations, copayments, and restrictions may apply.  Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.  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. Highmark Senior Health Company is a PPO plan with a Medicare contract.  Enrollment in Highmark Senior Health Company depends on contract renewal.  Highmark is a registered mark of Highmark Inc. Highmark Senior Health Company is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association.

Questions on Freedom Blue PPO benefits?  Call 1-866-456-7739 (TTY users call 711)
Reference Code (Please have this number ready when you call):  **18FB8473** – High Option, **18FB8475** – Mid Option, **18FB8474** – Low Option and **18CB4549 –** Community Blue HMO

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