



2017 Benefit Summary

Western PA Teamsters and Employers Welfare Fund

		178473	178475	178474	584549	
		Freedom Blue PPO High Option	Freedom Blue PPO Mid Option	Freedom Blue PPO Low Option	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%

**Western PA Teamsters
and Employers Welfare Fund**

		178473	178475	178474	584549
		Freedom Blue PPO High Option	Freedom Blue PPO Mid Option	Freedom Blue PPO Low Option	Community Blue Medicare HMO
FACILITY SERVICES	Outpatient Surgery	\$25 copay / 20%	10% / 20%	10% / 20%	\$25 copay
	Emergency Room Services (Worldwide Coverage)	\$50	\$50	\$50	\$50
	Urgently Needed Care (this is NOT emergency care)	\$40	\$40	\$40	\$40
	Inpatient Hospital Stay	\$50 per stay / 20%	10% per stay / 20%	10% per stay / 20%	\$50 per stay
	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 / \$40 allowance for eye exam	\$0 / \$40 allowance for eye exam	\$0 / \$40 allowance for eye exam	\$0
	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.
	Annual Routine Hearing Exam	\$30 / 20%	\$25 / 20%	\$30 / 20%	\$30

**Western PA Teamsters
and Employers Welfare Fund**

		178473	178475	178474	584549
		Freedom Blue PPO High Option	Freedom Blue PPO Mid Option	Freedom Blue PPO Low Option	Community Blue Medicare HMO
MENTAL HEALTH SERVICES	Hearing Aids (covered every three years)	\$500 allowance	\$500 allowance	\$500 allowance	\$499-\$799 copay for each hearing aid, depending on the type, 2 per year
	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 (<u>Emergent</u> 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%
	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

DRUGS	PART D DRUGS (<UP TO 31 DAY RETAIL SUPPLY>)	Initial Coverage Period (up to \$3,700 in total drug costs)	\$15 Pref Generic \$15 Generic \$30 Preferred Brand \$60 Non-Pref Brand 33% Specialty	\$15 Pref Generic \$15 Generic \$30 Preferred Brand \$60 Non-Pref Brand 33% Specialty	\$15 Pref Generic \$15 Generic \$40 Preferred Brand \$90 Non-Pref Brand 33% Specialty	\$15 Pref Generic \$15 Generic \$30 Preferred Brand \$60 Non-Pref Brand 33% Specialty
		Coverage Gap Period (from \$3,700 in total drug costs to \$4,950 in yearly out-of-pocket drug costs)	\$15 Pref Generic \$15 Generic 25% Preferred Brand 25% Non-Pref Brand 25% Specialty	\$15 Pref Generic \$15 Generic 40% Brand / Specialty (with manufacturer 50%)	\$15 Pref Generic \$15 Generic 40% Brand / Specialty (with manufacturer 50%)	\$15 Pref Generic \$15 Generic 25% Preferred Brand 25% Non-Pref Brand 25% Specialty
		Catastrophic Coverage Period (after \$4,950 in total out-of-pocket drug costs)	The greater of 5% or \$3.30 for generic or multi-source drugs or \$8.25 for all other drugs	The greater of 5% or \$3.30 for generic or multi-source drugs or \$8.25 for all other drugs	The greater of 5% or \$3.30 for generic or multi-source drugs or \$8.25 for all other drugs	The greater of 5% or \$3.30 for generic or multi-source drugs or \$8.25 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): **17FB8473** – High Option, **17FB8475** – Mid Option, **17FB8474** – Low Option and **17CB4549** – Community Blue HMO