No Prescription

Local 13
2012 Employee Group Retiree Plan
Medicare Blue Choice HMO/POS Benefit Summary

MEDICAL BENEFITS	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$3,400
Inpatient Hospitalization (Includes inpatient mental health, chemical dependency and rehabilitation services)	$250 copay 2 max
Skilled Nursing Facility (3 day inpatient stay waived)	$0/day, days 1-20; 50% days 21-100
Physician Services	
Primary Care Physician (PCP) Office Visit	$15 copay
Specialist Office Visit (includes urgent care visits)	$15 copay
Chiropractor Office Visit (manual manipulation to correct subluxation)	$15 copay
Podiatrist Office Visit (for medically necessary foot care)	$15 copay
Outpatient Care	
Emergency Room (waived if admitted within 23 hours, worldwide coverage	$50 copay
Urgent Care (nationwide coverage)	$15 copay
Ambulance	$50 copay
Outpatient Mental Health	40% coinsurance
Outpatient Chemical Dependency	50% coinsurance
Diagnostic Tests and Laboratory Services	Covered in full
Radiological Services (X-Ray, Chemotherapy, Radiation Therapy)	$15 copay
Outpatient Services/Surgery (an additional specialist copay may apply)	$50 copay
Rehabilitation Therapy (physical, occupational and speech)	$15 copay
Cardiac Rehabilitation	$15 copay
Durable Medical Equipment (DME) & Prosthetic Devices	20% coinsurance
Home Health Care (includes home infusion services)	Covered in full
Diabetic Supplies	20% coinsurance
Kidney Dialysis	Covered in full
Medicare Part B Drugs Including Part B-Covered Chemotherapy Drugs	20% coinsurance
Preventive Services (Office Visit Copay May Apply)	
Annual Wellness Exam	Covered in full
Immunizations (Flu, Pneumonia, H1N1 and Hepatitis B vaccines)	Covered in full
Mammograms	Covered in full
Prostate Cancer Screening	Covered in full
Bone Mass Measurement	Covered in full
Pap Smears/Pelvic Exams	Covered in full
Colorectal Screening	Covered in full
Medicare Covered Preventive Services	
Hearing Exams	$15 copay
Eye Exams	$15 copay

No Prescription

Additional Coverage	
Hearing Aid Allowance - once every 3 calendar years	$300 allowance every 3 years
Point of Service (POS) You may elect to receive covered services from out-of-network providers.	20% up to $5000
Fitness Benefit	Silver&Fit: $25 annually for gym membership
Annual Routine Eyewear Allowance	$60 annual allowance

MEDICARE PART D PRESCRIPTION DRUG BENEFITS

No Drug Coverage

NO Catastrophic Coverage

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.

Care must be provided or authorized by a participating primary care physician for full HMO benefits, except in emergencies. The copayments are applied per provider per day except where specifically noted otherwise.

A nonprofit independent licensee of the Blue Cross Blue Shield Association