Plumbers & Pipefitters Local #354
Reference Code 16SB4521

Security Blue HMO
Benefits at a Glance

Plan Deductible	$0
Plan Coinsurance (Member Cost Sharing)	No plan level Coinsurance applied
Plan Annual Out-of-Pocket Maximum (does not include Part D Drugs)	$3,400
Doctor Office Visit	$15 PCP, $15 Specialist cost sharing
Preventive Testing/Screenings	Covered in Full
Diagnostic Testing including Lab, X-Rays and Advanced Imaging (costs for these services may vary based on place of service)	$0 cost sharing
Outpatient Surgery	$0 cost sharing
Ambulance	$25 cost sharing
Emergency Room	$50 cost sharing
Inpatient Hospital Stay	$0 cost sharing per stay
Skilled Nursing Facility (days 1-100 per benefit period)	0% cost sharing per day
Outpatient Drugs (Medicare Part B)	10% cost sharing / $300 quarterly maximum
Durable Medical Equipment	15% coinsurance
Eyeglasses or Contact Lenses (covered every calendar year)	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames or specialty contact lenses.
Routine Hearing Services (covered every calendar year)	Routine hearing exam (for up to 1 every year): $15. Hearing aid: $499-$799 copay for each hearing aid, depending on the type
Routine Dental	50% coinsurance for restorative services. 50% coinsurance for dentures every 5 years. See the Summary of Benefits for a complete description.

Medicare Part D Drugs (Up to 31 Day Supply)

Initial Coverage (Up to $3,310 in total drug costs)	• $15 cost sharing Preferred Generic • $15 cost sharing Generic • $30 cost sharing Pref. Brand • $60 cost sharing Non-Pref. Brand • $60 cost sharing Specialty
Coverage Gap	• $15 cost sharing Preferred Generic • $15 cost sharing Generic • $30 cost sharing Pref. Brand • $60 cost sharing Non-Pref. Brand • $60 cost sharing Specialty
Catastrophic Coverage	Once in the Catastrophic Coverage Stage, you stay in this stage for the rest of the year. You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $4,850 limit for the calendar year. During this stage, the plan will pay most of the cost for your drugs. • 5% of the cost, or • $2.95 copayment for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

Question? Call 1-800-227-8195(TTY Users, call 711)7 days a week between 8 a.m. - 8 p.m.
Reference Code 16SB4521 Please have this number ready when you call.
Please see Summary of Benefits for detailed information.

2016 Summary of Benefits Employer Group Plan

	Plumbers & Pipefitters Local #354 584521
General Provisions	**Security Blue HMO Employer Group Plan**
Plan Deductible	None
Plan Coinsurance (Member Cost Sharing)	No Plan level coinsurance applied
Plan Annual Out-of-Pocket Maximum (does not include Part D Drugs)	$3,400
Benefit Category	**Security Blue HMO Employer Group Plan**

IMPORTANT INFORMATION

Premium and Other Important Information	You may pay a premium each month to your retiree/employer group/trust fund. In addition, you keep paying your Medicare Part B premium. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
Covered Medical and Hospital Benefits **Note:** Services with a 1 may require prior authorization.	

OUTPATIENT CARE AND SERVICES

Acupuncture and other alternative therapies	This plan does not cover acupuncture and other alternative therapies.
Ambulance Services (medically necessary ambulance services)	You pay cost sharing of $25.

Benefit Category	Security Blue HMO Employer Group Plan
Chiropractic Care[1]	Authorization rules may apply. You pay cost sharing of $15. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).
Dental Services[1] **Routine** exam and dental service cost sharing is not applied to the deductible or out of pocket maximums	Authorization rules may apply. $15 cost sharing for Medicare-covered dental benefits. You pay a $20 copay on the cost for an office visit consisting of an oral exam and cleaning up to 1 visit every 6 months. You pay a $20 copay on the cost for dental x-rays up to 1 visit every 12 months; full mouth x-rays every 5 years. You pay a 50% coinsurance for dentures every 5 years; preventive denture maintenance every 3 years. You pay a 50% oninsurance for restorative services.
Diabetes Supplies and Services[1] (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)	Authorization rules may apply. Diabetes self-management training: You pay nothing. You pay 15% of the cost for diabetes supplies and therapeutic shoes or inserts. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.

Benefit Category	Security Blue HMO Employer Group Plan
Diagnostic Tests, Lab, and Radiology Services (Such as MRIs and CT Scans), and X-rays **Costs for these services may vary based on place of service.**	Authorization rules may apply. You pay $0 cost sharing for the following: • Lab services • Diagnostic procedures and tests • X-rays • Diagnostic radiology services(not including X-rays) • Therapeutic radiology services If the doctor provides you additional services, separate doctor office visit cost sharing may apply.
Doctor Office Visits	Primary care physician visit: $15 Specialist visit: $15
Durable Medical Equipment (includes wheelchairs, oxygen, etc.) Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established.	Authorization rules may apply. You pay 15% of the cost for Medicare-covered items.
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay a $50 copay for each emergency room visit. **Worldwide coverage** If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.
Foot Care (Podiatry Services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $15

Benefit Category	Security Blue HMO Employer Group Plan
Hearing Services **Routine** exam and hearing aid cost sharing is not applied to the deductible or out of pocket maximums.	Exam to diagnose and treat hearing and balance issues: $15 copay Routine hearing exam (for up to 1 every year): $15 copay Hearing aid fitting/evaluation (for up to 1 every year): $15 copay Hearing aid: $499-$799 copay for each hearing aid, depending on the type
Home Health Care[1]	Authorization rules may apply. You pay cost sharing of $0.
Mental Health Care[1]	Authorization rules may apply. Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. You pay cost sharing of $0 for each stay at a network hospital. Outpatient group therapy visit: $15 Outpatient individual therapy visit: $15

Benefit Category	Security Blue HMO Employer Group Plan
Outpatient Prescription Drugs	**Drugs covered under Medicare Part B** **See Section 1 for more Information on Medicare Part B Drugs** You pay 10%; $300 quarterly out-of-pocket maximum of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. Part B Drugs are not available at retail pharmacies. **Drugs covered under Medicare Part D** Please refer to the prescription drug section of this book for more details.
Outpatient Rehabilitation Services[1] (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	Authorization rules may apply. Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing. You pay a $15 cost sharing for occupational therapy visits. You pay a $15 cost sharing for physical therapy and/or speech and language pathology visits.
Outpatient Substance Abuse Care[1]	Authorization rules may apply. You pay cost sharing of $15.
Outpatient Surgery[1]	Authorization rules may apply. You pay cost sharing of $0 for each ambulatory surgical center and/or outpatient hospital facility visit per provider/per day.
Over-the-Counter Items	Not covered
Prosthetic Devices[1] (includes braces, artificial limbs and eyes, etc.) Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established.	Authorization rules may apply. You pay 15% of the cost for prosthetic devices and supplies related to prosthetics, splints and other devices.
Renal Dialysis	You pay nothing.

Benefit Category	Security Blue HMO Employer Group Plan
Transportation (Routine) Cost sharing is not applied to the deductible or out of pocket maximums.	You pay $25 cost sharing per trip.
Urgent Care (This is **not** emergency care)	**Worldwide coverage** You pay cost sharing of $40.
Routine Vision **Routine** exam and eyewear cost sharing is not applied to the deductible or out-of-pocket maximums.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) $15. Routine eye exam (for up to 1 every year): You pay nothing. **Eye Wear** Limited to one pair of eyeglass frames with eyeglass lenses or contact lenses every calendar year. Davis Vision Fashion Collection eyeglass frames, standard eyeglass lenses and standard contact lenses are covered in full. $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye. A $100 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.
Wellness/Education and Other Supplemental Benefits & Services	The plan covers the following supplemental education/wellness programs: SilverSneakers Membership/Fitness Classes

Benefit Category	Security Blue HMO Employer Group Plan
Preventive Services	You pay nothing. Our plan covers many preventive services, including: • Abdominal Aortic Aneurysm Screening • Alcohol misuse counseling • Bone Mass Measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes Screening • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccine, including Flu shots,Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

Benefit Category	Security Blue HMO Employer Group Plan
INPATIENT CARE	
Inpatient Hospital Care[1] (includes Substance Abuse and Rehabilitation Services)	Authorization rules may apply. You pay cost sharing of $0 for each stay at a network hospital. Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet
Skilled Nursing Facility[1] (in a Medicare-certified skilled nursing facility)	Authorization rules may apply. You pay cost sharing of 0%. Plan covers up to 100 days each benefit period. No prior hospital stay is required.

Prescription Drugs	Security Blue HMO Employer Group Plan
Drugs Covered under Medicare Part D	This plan uses a formulary. You can also see the formulary at http://highmark.medicare-approvedformularies.com/ on the web. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long term care facility, you pay the same as at a retail pharmacy. Your coverage is better than standard Medicare Part D.
Deductible	No annual deductible
Initial Coverage	You pay the following until total yearly drug costs reach $3,310. Total yearly drug costs are the total drug cost paid by both you and a part D plan.
Network Retail Pharmacy	**Tier 1: Preferred Generic Drugs** • $15 cost sharing for a one-month (31-day) supply of drugs • $45 cost sharing for a three-month (90-day) supply of drugs **Tier 2: Generic Drugs** • $15 cost sharing for a one-month (31-day) supply of drugs • $45 cost sharing for a three-month (90-day) supply of drugs **Tier 3: Preferred Brand Drugs and certain single source generics** • $30 cost sharing for a one-month (31-day) supply of drugs • $90 cost sharing for a three-month (90-day) supply of drugs **Tier 4: Non-Preferred Brand Drugs and certain single source generics** • $60 cost sharing for a one-month (31-day) supply of drugs • $180 cost sharing for a three-month (90-day) supply of drugs **Tier 5: Specialty Drugs - specialty drugs consist of both generic and brand** • $60 cost sharing for a one-month (31-day) supply of drugs

Prescription Drugs	Security Blue HMO Employer Group Plan
Mail Order	**Tier 1: Preferred Generic Drugs** • $30 cost sharing for a one-month (31-day) supply of drugs • $30 cost sharing for a three-month (90-day) supply of drugs **Tier 2: Generic Drugs** • $30 cost sharing for a one-month (31-day) supply of drugs • $30 cost sharing for a three-month (90-day) supply of drugs **Tier 3: Preferred Brand Drugs and certain single source generics** • $60 cost sharing for a one-month (31-day) supply of drugs • $60 cost sharing for a three-month (90-day) supply of drugs **Tier 4: Non-Preferred Brand Drugs and certain single source generics** • $120 cost sharing for a one-month (31-day) supply of drugs • $120 cost sharing for a three-month (90-day) supply of drugs **Tier 5: Specialty Drugs - specialty drugs consist of both generic and brand** • $60 cost sharing for a one-month (31-day) supply of drugs
Coverage Gap	After your total yearly drug costs (including what your plan has paid and what you have paid) reach $3,310, you pay: **Tier 1: Preferred Generic Drugs** • $15 cost sharing for a one-month (31-day) supply of drugs • $45 cost sharing for a three-month (90-day) supply of drugs **Tier 2: Generic Drugs** • $15 cost sharing for a one-month (31-day) supply of drugs • $45 cost sharing for a three-month (90-day) supply of drugs **Tier 3: Preferred Brand Drugs and certain single source generics** • $30 cost sharing for a one-month (31-day) supply of drugs • $90 cost sharing for a three-month (90-day) supply of drugs **Tier 4: Non-Preferred Brand Drugs and certain single generics** • $60 cost sharing for a one-month (31-day) supply of drugs • $180 cost sharing for a three-month (90-day) supply of drugs **Tier 5: Specialty Drugs- specialty drugs consist of both generic and brand** • $60 cost sharing for a one-month (31-day) supply of drugs

Prescription Drugs	Security Blue HMO Employer Group Plan
Coverage Gap Mail Order	After your total yearly drug costs (including what your plan has paid and what you have paid) reach $3,310, you receive limited coverage by the plan on certain drugs. **Tier 1: Preferred Generic Drugs** • $30 cost sharing for a one-month (31-day) supply of drugs • $30 cost sharing for a three-month (90-day) supply of drugs **Tier 2: Generic Drugs** • $30 cost sharing for a one-month (31-day) supply of drugs • $30 cost sharing for a three-month (90-day) supply of drugs **Tier 3: Preferred Brand Drugs and certain single source generics** • $60 cost sharing for a one-month (31-day) supply of drugs • $60 cost sharing for a three-month (90-day) supply of drugs **Tier 4: Non-Preferred Brand Drugs and certain single generics** • $120 cost sharing for a one-month (31-day) supply of drugs • $120 cost sharing for a three-month (90-day) supply of drugs **Tier 5: Specialty Drugs- specialty drugs consist of both generic and brand** • $60 cost sharing for a one-month (31-day) supply of drugs
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copayment for generic (including brand drugs treated like a generic) and a $7.40 copayment for all other drugs.

Prescription Drugs	Security Blue HMO Employer Group Plan
General Information	You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost sharing amount for that drug, you will pay the actual cost, not the higher cost sharing amount. Some drugs have quantity limits. Your provider must get prior authorization for certain drugs. You may get drugs from an Out-of-Network pharmacy, but may pay more than you pay at an In-Network pharmacy. Please contact the plan for details.