GREATER ST. LOUIS CONSTRUCTION LABORERS' WELFARE FUND
2016 Medicare Benefit Options

Benefit Name	Traditional Federal Medicare	Laborers Medicare Supplemental/Rx		Coventry Advantra Enhanced	Coventry Gold Advantage	Aetna Medicare ESA PPO (S01)
Medicare Monthly Cost	**Medicare Part B - $_____ (a)**	**Medicare Part B - $TBD By Medicare (a)**		**Medicare Part B - $TBD By Medicare (a)**	**Medicare Part B - $TBD By Medicare (a)**	**Medicare Part B - $TBD By Medicare (a)**
Monthly Premium	**None**	**2016 Subsidized--$300.00 2016 Unsubsidized--$352.00**		**2016--$251.00**	**2016--$0**	**2016--$164.50**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan**		**Medical and Prescription Drug Plan included with full coverage through the gap.**	**Medical and Prescription Drug Plan included**	**Medical and Prescription Drug Plan included**
Type of Benefit	**Member Pays**	**Plan Pays**	**Member Pays**	**Member Pays after Advantra In Network Benefit**	**Member Pays after Gold Advantage In Network Benefit**	**Member Pays after Aetna Medicare Benefit**
Must Use Certain Providers?	**No**	**No**	**No**	**Yes - Advantra Network**	**Yes - Gold Advantage Network (b)**	**No--Medicare Provider**
Limitations				**Medicare Approved Service, unless noted. Member must designate a PCP**	**Medicare Approved Service, unless noted. Member must designate a PCP**	**Medicare Approved Service, unless noted; PART D drugs**
Out of Pocket Max	**No Limit**	**No Limit**	**N/A**	**N/A**	**$3,050.00 maximum Applies to all Medicare-Covered Services**	**$1,500.00 maximum Applies to all Medicare-Covered Services**
Inpatient Hospital Care (Includes substance abuse and rehabilitation)	$1,156 for the first 60 days confinement, then $289 from the 61st through the 90th day, $578 91st through 150th day	Part A Deductible; Medicare Co-pay	$0	$0	$500 a day each day for day(s) 1-3; Unlimited days.	$250 per stay
Inpatient Mental Health Care	$1,156 for the first 60 days confinement, then $289 from the 61st through the 90th day, $578 91st through 150th day	Part A Deductible; Medicare Co-pay	$0	$0	$1528 per stay	$250 per stay
Skilled Nursing Facility (In a Medicare certified skilled nursing facility)	All but $144.50 from the 21st day up to the 100 day, for each benefit period	Medicare Co-pay Day 21-100	All costs after Day 100	$0	$40/day for days 1-20; $150/day for days 21-75; $0 per Day 76-100	$0, days 1-20; $75 per Days 21-100; 100 day limit per benefit period
24 Hour Nurseline	Not Covered	Not Covered	Not Covered	24 hour Access to Nurseline	24 hour Access to Nurseline	24 hour Access to Nurseline
Home Health Care (Includes intermittent skilled nursing care, home health aide services and rehabilitation services, etc)	No co-payments for all covered home health visits.	$0	$0	No co-payments for Medicare covered home health visits.	No co-payments for Medicare covered home health visits.	$0
Hospice	You pay part of the cost for outpatient drugs and inpatient respite care.	Balance not covered by Medicare	$0	Services are paid at 100% if you receive care from a Medicare-certified hospice.	Services are paid at 100% if you receive care from a Medicare-certified hospice.	Covered by Medicare
Office Visit and/or Home Visit	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$15	$20
Specialists Office Visit	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$45	$20
Chiropractic Visits (manual manipulation of spine)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$20	$15
Podiatry	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$45	$20 for all Medicare covered services
Podiatry (Routine)	Not Covered	Not Covered	Not Covered	$0 per visit Maximum of 6 per year	$45 per visit Maximum of 6 per year	Not Covered

(a) Higher if family income exceeds certain levels
(b) Without BJC providers

October 2015

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Monthly Premium	None	2016 Subsidized--$300.00 2016 Unsubsidized--$352.00		2016--$251.00	2016--$0	2016--$164.50
Coverage Included	Medical	Medical and Prescription Drug Plan		Medical and Prescription Drug Plan included with full coverage through the gap.	Medical and Prescription Drug Plan included	Medical and Prescription Drug Plan included
Type of Benefit	Member Pays	Plan Pays	Member Pays	Member Pays after Advantra In Network Benefit	Member Pays after Gold Advantage In Network Benefit	Member Pays after Aetna Medicare Benefit
Outpatient Mental Health	Subject to $140.00 deductible, then 35% of Medicare contracted amount	Part B Deductible and 35% of Medicare-approved amount	$0	$0	$40	$20
Out Patient Substance Abuse Care	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$40	$20
Outpatient Surgery (Facility & Physician)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$150 copay at freestanding ASC; $250 coapy for outpatient hospital	$0
Asst Surgery (Physician Chgs)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0 of the cost for each Medicare covered outpatient surgery visit including the facility	20% of the cost for each Medicare covered outpatient surgery visit including the facility	$0
Ambulance	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$200	$20
Emergency Room	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0, waived if admitted	$65, waived if admitted	$50, waived if admitted
Urgent Care Center	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$30	$20
Out Patient Physical, Occupational or Speech Therapy	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$40	$20
Durable Medical Equipment	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	0%	20%	20%
Prosthetic Devices	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	0% of the cost of Medicare covered items	20% of the cost of Medicare covered items	20%
Diabetes Self Monitoring Training	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0 co-payment	$0 co-payment	$0
Diabetes Supplies	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$0 copay for Lifescan monitor and supplies; 20% for non-Lifescan;$10 copay for therapuetic shoes	$0
Diagnostic X-Rays	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$25 x-ray; MRI/CT/PET-$250; $100 for all other diagnostic	$20
Diagnostic Laboratory	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$0	$20
Radiation Therapy	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	20%	$20

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Medicare Monthly Cost	Medicare Part B - $_____ (a)	Medicare Part B - $TBD By Medicare (a)		Medicare Part B - $TBD By Medicare (a)	Medicare Part B - $TBD By Medicare (a)	Medicare Part B - $TBD By Medicare (a)
Monthly Premium	None	2016 Subsidized--$300.00 2016 Unsubsidized--$352.00		2016--$251.00	2016--$0	2016--$164.50
Coverage Included	Medical	Medical and Prescription Drug Plan		Medical and Prescription Drug Plan included with full coverage through the gap.	Medical and Prescription Drug Plan included	Medical and Prescription Drug Plan included
Type of Benefit	Member Pays	Plan Pays	Member Pays	Member Pays after Advantra In Network Benefit	Member Pays after Gold Advantage In Network Benefit	Member Pays after Aetna Medicare Benefit
Chemotherapy	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	20%	$20 copay
Renal Dialysis	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	20%	$20
Cardiac Rehabilitation (Out Patient)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0	$45	$20
Transplant Services (Hospital)	$1,156 for the first 60 days confinement, then $289 from the 61st through the 90th day, $578 91st through 150th day	Part B Deductible and 20% of Medicare-approved amount	$0	$0 a day each day for day(s); Unlimited days.	$315 a day each day for day(s) 1-7; Unlimited days.	$250 per stay
Transplant Services (Physician)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	0% co-payment	20% of the cost of Medicare covered items	$0
Bone Mass Measurement	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0 co-payment	$0 co-payment	$0 co-payment (every 24 months)
Colorectal Screening Exams	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Part B Deductible and 20% of Medicare-approved amount	$0	$0 co-payment	$0 co-payment	$0 co-payment
Immunizations	No co-payment	$0	$0	$0 co-payment	$0 co-payment	$0 co-payment
Mammograms (Annual Screening)	No co-payment	$0	$0	$0 co-payment	$0 co-payment	$0 co-payment
Pap Smear	No co-payment	$0	$0	$0 co-payment	$0 co-payment	$0 co-payment
Pelvic Exams	No co-payment	$0	$0	$0 co-payment	$0 co-payment	$0 co-payment
Prostate Cancer Screening Exams	No co-payment for approved lab services. 20% copay for other related services	20% of Medicare-approved amount	$0	$0 co-payment	$0 co-payment	$0 co-payment
Pharmacy (30 days)	None	67%	33%	Tier 1 - 25% Preferred Generics; Tier 2 - 25% non-Preferred Generic; Tier 3- 25% Preferred Brand; Tier 4 - 33% Non-Preferred Brand; Tier 5 - 33% coinsurance for Specialty Drugs	Tier 1 - $0 Preferred Generic, Tier 2 - $6 Non-Preferred Generic, Tier 3 - $45 Preferred Brand, Tier 4 - 50% coinsurance for Non-Preferred Brand, Tier 5 - 33% coinsurance for Specialty Drugs	Select Care Generics--$0; Tier 1, Generics--$5; Tier 2, Preferred Band--20% coinsurance; Tier 3, Non-Preferred Brand--35% Coinsurance
Pharmacy - Mail Order (90 days)	None	67%	33%	Tier 1 - 25% Preferred Generics; Tier 2 - 25% non-Preferred Generic; Tier 3- 25% Preferred Brand; Tier 4 - 33% Non-Preferred Brand; Tier 5 - 33% coinsurance for Specialty Drugs	Tier 1 - $0 Preferred Generic, Tier 2 - $18 Non-Preferred Brand Tier 3 - $135 Preferred Brand, Tier 4 - 50% coinsurance for Non-Preferred Brand, Tier 5 - N/A	Select Care Generics--$0; Tier 1, Generics--$10; Tier 2, Preferred Band--20% coinsurance; Tier 3, Non-Preferred Brand--35% Coinsurance

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Coverage Included	**Medical**	**Medical and Prescription Drug Plan**		**Medical and Prescription Drug Plan included with full coverage through the gap.**	**Medical and Prescription Drug Plan included**	**Medical and Prescription Drug Plan included**
Type of Benefit	**Member Pays**	**Plan Pays**	**Member Pays**	**Member Pays after Advantra In Network Benefit**	**Member Pays after Gold Advantage In Network Benefit**	**Member Pays after Aetna Medicare Benefit**
Pharmacy - Coverage Gap (Donut Hole)	None	67%	33%	Tier 1 - 25% Preferred Generics; Tier 2 - 25% non-Preferred Generic; Tier 3- 25% Preferred Brand; Tier 4 - 33% Non-Preferred Brand; Tier 5 - 33% coinsurance for Specialty Drugs	From $3,310 total drug costs to $4,850 true out-of-pocket drug costs: A discount on brand name drugs and generally pay no more than 58% of plan's costs for generics and 45% for brand.	Select Care Generics--$0; Tier 1, Generics--$5; Tier 2, Preferred Band--20% coinsurance; Tier 3, Non-Preferred Brand--35% Coinsurance
Pharmacy - Catastrophic	None	67%	After $4,850 true out-of-pocket drug costs, greater of $2.95 for covered genrics, greater of $7.40 for all others.	After $4,850 true out-of-pocket drug costs, greater of $2.95 for covered genrics, greater of $7.40 for all others.	After $4,850 true out-of-pocket drug costs of $2.95 for covered genrics, or $7.40 for all others.	After $4,850 true out-of-pocket drug costs of $2.95 or 5% for covered genrics of $7.40 for all others.
Hearing Exams	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Not Covered	Not Covered	$50 for each Medicare approved diagnostic hearing exam	$45 for each Medicare approved diagnostic hearing exam	$0, one exam every 12 months
Hearing Aids	Not Covered	Not Covered	Not Covered	Limited to $150 every three years from In-Network provider;	Not Covered	Not Covered
Hearing Diagnostic	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Not Covered	Not Covered	$50 for each Medicare approved diagnostic hearing exam	$30 for each Medicare approved diagnostic hearing exam	Routine Covered at 100%
Dental	Not Covered	Not Covered	Not Covered	2 oral exams; 2 cleaning, 1 x-ray annually. $50 copay for Medicare covered comprehensive dental services	2 oral exams; 2 cleaning, 1 x-ray annually. $45 copay for Medicare covered comprehensive dental services	Not Covered
Vision Exam after Cataract Surgery	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Not Covered	Not Covered	$25 for each Medicare covered eye exam	$0 for each Medicare covered eye exam	$0
Vision Lens and Frames after Cataract Surgery	One pair of eyeglasses with standard frames after cataract surgery that implants an intraocular lens per eye if done separately	Not Covered	Not Covered	$15 for one pair of eyeglasses or contacts after each cataract surgery	$15 for one pair of eyeglasses or contacts after each cataract surgery	$0
Vision Contacts after Cataract Surgery	One pair of contacts after catarct surgery that implants and intraocular lens per eye if done separately	Not Covered	Not Covered	$15 for one pair of eyeglasses or contacts after each cataract surgery	$15 for one pair of eyeglasses or contacts after each cataract surgery	Not Covered
Routine Refraction	Not Covered	Not Covered	Not Covered	$25.00 co-pay through Eye Med Managed Vision	$25.00 co-pay through Eye Med Managed Vision	$0 copayment for one annual exam
Routine Glasses	Not Covered	Not Covered	Not Covered	$15 copay for select frames ($100 Allowance) and lenses every two years through EyeMed Managed Vision	$15 copay for select frames ($100 Allowance) and lenses every two years through EyeMed Managed Vision	$70 reimbursement every 24 months

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Type of Benefit	**Member Pays**	**Plan Pays**	**Member Pays**	**Member Pays after Advantra In Network Benefit**	**Member Pays after Gold Advantage In Network Benefit**	**Member Pays after Aetna Medicare Benefit**
Annual Routine Physical Exam; Welcome to Medicare Exam	Covered at 100%	$0	$0	$0 copay for routine exam, limited to one exam per year	$0 copay for routine exam, limited to one exam per year	$0 copay for routine exam, limited to one exam per year
Health/Wellness Education & Training	Subject to $140.00 deductible, then 20% of Medicare contracted amount	Not Covered	Not Covered	Covered for Health Education Classes, Newsletter, Congestive Heart Program and Disease Managementc $0 copay for each Medicare-covered smoking cessation counseling session. $0 copay for each Medicare-covered HIV screening.	Covered for Health Education Classes, Newsletter, Congestive Heart Program and Disease Managementc $0 copay for each Medicare-covered smoking cessation counseling session. $0 copay for each Medicare-covered HIV screening.	Healthy Lifestyle Coaching, 1 phone call per week.
Transportation	Not Covered	Not Covered	Not Covered	No co-payment for each one way trip up to 24 trips to plan approved location every year	No co-payment for each one way trip up to 24 trips to plan approved location every year	Not Covered
Fitness Benefit (SilverSneakers)	Not Covered	Not Covered	Not Covered	Paid membership at participating fitness centers	Paid membership at participating fitness centers	Paid membership at participating fitness centers

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