

**SHEET METAL WORKERS LOCAL #46 - MEDICARE HIGH OPTION
2008 Excellus BlueCross BlueShield Benefit Summary**

| Service Category | Benefit |
|---|--|
| PHYSICIAN SERVICES | |
| Primary Care Office Visit (includes primary GYN visit) | \$15 Copayment |
| Specialist Office Visit | \$15 Copayment |
| Physician Office Surgery | \$15 Copayment |
| Physician services during hospital stay | Covered under Inpatient Hospital Services |
| Urgently Needed Care | \$15 Copayment |
| OUTPATIENT SERVICES | |
| Laboratory Services | Covered in full |
| Radiological Services (x-rays) | \$15 Copayment |
| Surgical Services (hospital or ambulatory surgical center) | \$15 Copayment |
| Emergency Room Services waived if admitted | \$50 Copayment |
| Ambulance | \$50 Copayment |
| Home Healthcare Services | Covered in full |
| Rehabilitation Services (Physical, Occupational, Respiratory & Speech Therapy) | \$15 Copayment |
| Medicare Covered Eye Exam | \$15 Copayment |
| Chiropractic Services (manual manipulation to correct subluxation) | \$15 Copayment |
| INPATIENT HOSPITAL | |
| Inpatient Hospitalization | \$100 Copayment |
| Skilled Nursing Facility | Covered in full days 1-20 & 50% Coinsurance Days 21 - 100 |
| DURABLE MEDICAL EQUIPMENT | |
| Durable Medical Equipment and Prosthetic Devices | 20% Coinsurance |
| PREVENTIVE CARE (Office Visit Copay may apply) | |
| Routine Physical Exam | \$15 Copayment |
| Immunizations | Covered in full |
| Mammography | Covered in full |
| Routine Hearing | \$15 Copayment |
| Routine Eye Exam | \$15 Copayment |
| Prostate Screening | Covered in full |
| Bone Mass Measuring | Covered in full |
| Pelvic Exam | Covered in full |
| PAP Smear | Covered in full |

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| Service Category | Benefit |
|--|-----------------|
| MENTAL HEALTH and CHEMICAL DEPENDENCY | |
| Inpatient Mental Health | \$100 Copayment |
| Inpatient Chemical Dependency | \$100 Copayment |
| Outpatient Mental Health | 50% Coinsurance |
| Outpatient Chemical Dependency | 50% Coinsurance |

PRESCRIPTION DRUGS

| | |
|---|--|
| Prescription Drugs (some restrictions may apply) | \$0 deductible, \$5/\$20/\$35 30 day supply, No "Donut Hole", Catastrophic Coverage |
|---|--|

Prescription Drug Benefit Explanation

There is no annual deductible. You pay \$5 for a 30 day supply of Tier 1 drugs. You pay \$20 for a 30 day supply of Tier 2 drugs. You pay \$35 for a 30 day supply of Tier 3 drugs. You pay these amounts until your total out of pocket drug costs reaches \$4,050, when the catastrophic coverage will begin. Under the catastrophic coverage, you will pay \$2.25 for a generic drug, \$5.60 for a brand drug or 5%, whichever is greater.

ADDITIONAL BENEFITS

| | |
|-------------------------------------|---------------------------------------|
| Eyewear (glasses or contact lenses) | \$60 annual allowance |
| Travel Benefit | 20% Coinsurance - \$5,000 annual max. |
| Hearing Aids | \$300 allowance every 3 years |
| GO GETTERS | Up to \$650 per year |

This fitness benefit allows you to select the health club membership that is best for you, nationwide. It is not limited to specific gyms. You can also use this benefit with any qualified weight management program, such as Weight Watchers. This benefit has virtually no claim forms.

This benefit summary is an overview of the benefits provided under this contract. To the extent of any discrepancy between this document and the Subscriber Agreement, the Subscriber Agreement terms take priority. Please consult your Subscriber Agreement for a detailed explanation of the benefits and any applicable restrictions.