GREATER ST. LOUIS CONSTRUCTION LABORERS' WELFARE FUND
2027 Medicare Benefit Options

Benefit Name	Traditional Federal Medicare	Laborers' Custom PPO Anthem Medicare Plan	Laborers' Street HMO Anthem Medicare Plan
Medicare Monthly Cost	**Medicare Part B - $TBD by Medicare (a)**	**Medicare Part B - $TBD by Medicare(a)**	**Medicare Part B - $TBD by Medicare(a)**
Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
Must Use Certain Providers?	**No**	**No-Medicare Provider; Referrals are not required.**	**Yes - Anthem Medicare Advantage HMO**
Limitations		**Medicare Approved Service, unless noted; PART D drugs.**	**Medicare Approved Service, unless noted. Member must designate a PCP.**
Out of Pocket Max	**No Limit**	**$0**	**$2,800.00 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	$0 per admission	$275 a day each day for day(s) 1-5 per admission
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	$0 per admission	$275 a day each day for day(s) 1-5 per admission
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	$0, days 1-100	$20/day for days 1-20; $178 copay days 21-100
24 Hour Nurse line	Not Covered	$0 Copay for 24/7 Nurse Line	$0 copay for 24/7 Nurse Line

(a) Higher if family income exceeds certain levels

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Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
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 Copay per visit	$0 copay for Medicare-covered home health visits
Hospice	You pay part of the cost for outpatient drugs and inpatient respite care.	$0 copay one time only consultation, 1 visit per lifetime - When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$0 copay one time only consultation, 1 visit per lifetime - When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.
Office Visit and/or Home Visit	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$5
Specialists Office Visit	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$40
Chiropractic Visits (manual manipulation of spine)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0 - Medicare Covered Services Only	$20

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Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
Podiatry	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$5 copay for each Medicare covered visit
Podiatry (Routine)	Not Covered	$0, 12 visits per year	$5, 12 visits per year
Outpatient Mental Health	Subject to $140.00 deductible, then 35% of Medicare contracted amount	$0	$30, Partial Hospital $55
Out Patient Substance Abuse Care	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$30, Partial Hospital $55
Outpatient Surgery (Facility & Physician)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$275
Ambulance	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$125
Emergency Room	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$90 - Waived if admitted after 72 hours
Urgent Care Center	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$65 - Waived if admitted after 72 hours

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Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
Out Patient Physical, Occupational or Speech Therapy	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$40
Durable Medical Equipment	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	20%
Prosthetic Devices	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	20% coinsurance for Medicare-Covered prosthetics and orthotics
Diabetes Self Monitoring Training	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$0
Diabetes Supplies	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0 - Includes Continuous Glucose Monitors (CGMs)	$0 copay for OneTouch (made by LifeScan) and ACCU-CHECK (made by Rouche Diagnostics) $10 copay for all other brands

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Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
Diagnostic X-Rays	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$0 copay for each Medicare-covered X-ray visit or/and simple diagnostic test $125 copay for Medicare-covered complex diagnostic test/radiology & visit
Diagnostic Laboratory	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$0 copay for each Medicare-covered diagnostic clinical/lab test
Radiation Therapy	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$40
Chemotherapy	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	20%
Renal Dialysis	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	20%
Cardiac Rehabilitation (Out Patient)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$0

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Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
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	$0	$275 a day each day for day(s) 1-5 per admission
Transplant Services (Physician)	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$0 Nutrition Therapy 20% for Medicare Part B Drugs and physician services
Bone Mass Measurement	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$0
Colorectal Screening Exams	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$0
Immunizations	No co-payment	$0	$0
Mammograms (Annual Screening)	No co-payment	$0	$0
Pap Smear	No co-payment	$0	$0
Pelvic Exams	No co-payment	$0	$0

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Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
Prostate Cancer Screening Exams	No co-payment for approved lab services. 20% copay for other related services	$0	$0
Pharmacy (30 days)	None	**Tier 1:** Select Generics - $0; Generics - $4/$5; **Tier 2:** Preferred Brands-20%; **Tier 3:** Non-Preferred Brand including Specialty-33% Coinsurance	**Tier 1:** Preferred Generics - $0/$15; Generics - $0/$20; **Tier 2:** Preferred Brands-$47; **Tier 3:** Non-Preferred Brand - $100 **Tier 4 :** Limited to one-month supply
Pharmacy Retail (90 days)		**Tier 1:** Select Generics - $0; Generics - $8/$10; **Tier 2:** Preferred Brands-20%; **Tier 3:** Non-Preferred Brand including Specialty-33% Coinsurance	**Tier 1:** Preferred Generics - $0/$45; Standard Generics - $0/$60; **Tier 2:** Preferred Brands-$141; **Tier 3:** Non-Preferred Brand - $300 **Tier 4:** Limited to one-month supply

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Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
Pharmacy - Mail Order (90 days)	None	**Tier 1:** Select Generics - $0; Generics - $10; **Tier 2:** Preferred Brands-20%; **Tier 3:** Non-Preferred Brand including Specialty-33% Coinsurance	**Tier 1:** Preferred Generics - $45; Standard Generics - $60; **Tier 2:** Preferred Brands-$141; **Tier 3:** Non-Preferred Brand - $300 **Tier 4:** Limited to one-month supply
Pharmacy - Out-of-Pocket Maximum	None	After $2,400 true out-of-pocket drug costs, you pay $0	After $2,400 true out-of-pocket drug costs, you pay $0
Wigs		$400 allowance per year	$400 allowance per year
Hearing Exams	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0 Routine Hearing Exam $0 Hearing Aid Fitting Evaluation	$0 Routine Hearing Exam 1 per year
Hearing Aids	Not Covered	$500 Hearing Aid Allowance per ear - $1,000 total every 3 years Must use TruHearing	$1,000 allowance every 12 months Must use TruHearing
Hearing Diagnostic	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0 Medicare-covered basic hearing and balance exams	$40 Medicare Covered Exam

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Monthly Premium	**None**	**2027--$233**	**2027--$35**
Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
Dental	Not Covered	$0 Copay In Network, 20% coinsurance OON $0 Deductible $1,000 Max Allowance per year 2 oral exams; 2 cleanings; 1 full mouth x-ray per year $0 Basic and Major Services	$0 Copay In Network, $0 Deductible $1,000 Max Allowance per year 2 oral exams; 2 cleanings; 1 full mouth x-ray per year $0 Basic and Major Services Must use Liberty Dental
Vision Exam after Cataract Surgery	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0	$40 for in-network specialist
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	$0 copay for covered eyeglass lenses	$0
Routine Refraction	Not Covered	$0 for routine eye exam annually; must use Blue View vision provider	$0 for routine eye exam annually; must use Blue View vision provider
Routine Glasses	Not Covered	$100 Frame allowance - every two calendar years. Must use Blue View Vision Provider	$100 Frame allowance - annually. Must use Blue View Vision Provider

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Coverage Included	**Medical**	**Medical and Prescription Drug Plan included.**	**Medical and Prescription Drug Plan included.**
Type of Benefit	**Member Pays**	**Member Pays after Anthem Medicare Benefit**	**Member Pays after Anthem Medicare Benefit**
Annual Routine Physical Exam; Welcome to Medicare Exam	Covered at 100%	$0 Copay for annual physical	$0 copay for annual physical exam
Health/Wellness Education & Training	Subject to $140.00 deductible, then 20% of Medicare contracted amount	$0 copay for Medicare Community Resource Support	$0 copay for Medicare Community Resource Support
Transportation	Not Covered	$0 copay for routine transportation - 24 one-way trips per year	Not Covered
Over-the-Counter	Not Covered	$75 maximum benefit every quarter; no rollover	$75 maximum benefit every quarter; no rollover
Fitness Benefit (SilverSneakers)	Not Covered	Silver Sneakers	Silver Sneakers
Acupuncture for the purpose of low back pain lasting over 12 weeks. Up to 12 visits available	Subject to deductible then 20%	$0 co-payment	$15 - Medicare covered acupuncture
Telehealth for primary care and urgent care	Subject to deductible then 20%	$0 copay for video doctor visits using LiveHealth Online	$0 copay for video doctor visits using LiveHealth Online

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Monthly Premium	None	2027--$233	2027--$35
Coverage Included	Medical	Medical and Prescription Drug Plan included.	Medical and Prescription Drug Plan included.
Type of Benefit	Member Pays	Member Pays after Anthem Medicare Benefit	Member Pays after Anthem Medicare Benefit

This comparison is a brief summary of your benefits. The Plan Documents has final authority in the case of any conflicts or confusion as to Plan benefits.

2027 Benefit Changes

- **The Out-of Pocket maximum for prescription drugs is $2,400.**

(a) Higher if family income exceeds certain levels