RETIREE PLAN SCHEDULE OF BENEFITS FOR COVERED INDIVIDUALS

All Benefits Effective January 1, 2022

Benefits for covered individuals per Benefit Period*

MEDICARE-ELIGIBLE

AND ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS

Contracted Network Provider

BlueCross BlueShield of Illinois

For questions or information on claims or coverage, call Blue Cross Blue Shield at (855) 354-1858

Select services are available at the Carpenters Center for Health which are covered by the Plan at 100%.
deductibles and Coinsurance do not apply.

Carpenters Center for Health Powered by Premise Health. Your Family's Health Partner

4979 Indiana Ave, Suite 312, Lisle, IL • (312) 337-4150

OUT-OF-POCKET MAXIMUM per calendar year	**$2,000** per covered individual **$4,000** per family
MEDICARE PART A SUPPLEMENT **Hospital Benefit** Maximum **180 in-patient days** per calendar year	**Secondary to Medicare, Plan pays:** • **First 60 days:** Medicare Part A deductible • **Days 61 - 90:** Medicare Part A copayment • **Day 91 & After, while using 60 lifetime reserve days:** Medicare Part A copayment • **Additional 365 days:** 100% of Medicare-eligible expenses
MEDICARE PART B SUPPLEMENT	**Secondary to Medicare, Plan pays:** • **Medicare Part B deductible:** 100% • **Medical Expenses:** 20% of *most* Medicare-eligible expenses at the Medicare approved amount, after the Medicare Part B deductible
BLOOD	**Plan pays for first three (3) pints**
SKILLED NURSING CARE FACILITY Covered individual must meet Medicare's requirements, including having been in a hospital for at least three (3) days and enter a Medicare-approved facility within 30 days of leaving the hospital	**First 20 days:** Medicare pays all approved amounts **Days 21 - 100:** Plan pays Medicare Part A copayment
AT-HOME RECOVERY SERVICES Home care certified by a covered individual's doctor, for care during recovery from an injury or sickness for which Medicare-approved a home treatment plan	**Benefit for each visit:** Plan pays up to $40 per visit **Calendar year Maximum:** $1,600
FOREIGN TRAVEL The Plan does not pay for expenses in excess of the R & C allowance for non-PPO out-of-network providers; amounts over the R & C allowance are the responsibility of the covered individual	**Plan pays 80%** **Calendar year deductible:** $250 per covered individual **Lifetime maximum for Foreign Travel:** $50,000
HEARING BENEFIT	See **Hearing Benefits** schedule

*A "benefit period" begins on the first day the covered individual receives services as an inpatient in a Hospital and ends after the covered individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.

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MEDICARE-ELIGIBLE
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PRESCRIPTION BENEFITS
Not available to deferred lathers or to Medicare-eligible individuals with Medicare Part D coverage.

Claims must be submitted to the Plan's Contracted Network Providers

Express Scripts
(800) 939-2089
Representatives available 24/7
www.express-scripts.com

Accredo
(800) 803-2523
M – F: 7 a.m. to 10 p.m.
SAT: 7 a.m. to 4 p.m.
www.accredo.com

	EXPRESS SCRIPTS		ACCREDO
	Network Retail Pharmacy Lesser of 100 units or 30-day supply	**Mail Order Program or Walgreens** Up to a 90-day supply	**Specialty Medications** For complex conditions (cancer, hemophilia, etc.)
OUT-OF-POCKET MAXIMUM *Per calendar year* Excludes Select Specialty Medications	**For Single-Source Brand:** $1,500 per covered individual $3,000 per family **For Generic/Multi-Source (combined):** $1,500 per covered individual $3,000 per family		**For Non-Select Specialty:** $1,500/covered individual $3,000/family
GENERIC Copayment per drug	**$5.00**	**$12.50**	
SINGLE-SOURCE BRAND *Generic not available* Copayment per drug	**20%** **$10 minimum** **$100 maximum**	**20%** **$25 minimum** **$250 maximum**	
MULTI-SOURCE BRAND *Generic is available* Copayment per drug	**35%** **$20 minimum**	**35%** **$50 minimum**	
NON-SELECT SPECIALTY MEDICATIONS Copayment per drug Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care			**20%** **$20 minimum** **$100 maximum**
SELECT SPECIALTY MEDICATIONS *Must enroll in the SaveOn SP Program through Accredo for this benefit. For a list of covered specialty medications, please visit www.Accredo.com*			**$0 Copayment per Drug** for members enrolled in the *SaveOn SP Program*

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HEARING BENEFITS

***Plan's Preferred Contracted Network Provider for Hearing Aids:**

EPIC Hearing Healthcare
(866) 956-5400
Monday – Friday: 8:00 a.m. to 8:00 p.m.
www.epichearing.com

		BCBSIL PPO In-Network Provider % Amount Paid by Plan	BCBSIL Out-of-Network Provider % Amount Paid by Plan	EPIC Hearing Healthcare* % Amount Paid by Plan
HEARING EVALUATION/EXAM		**100% up to $150 Maximum** per covered individual once every two consecutive calendar years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)		
HEARING AID INSTRUMENT *Calendar year deductible does not apply*	**Retiree, spouse, & dependent children ages 19 and older**	**100% up to $5,000 Maximum** per covered individual once every five (5) consecutive calendar years		
	Dependent children through age 18	**100% up to $1,500 Maximum** per covered individual once every three (3) consecutive calendar years		

MEMBER ASSISTANCE PROGRAM

Plan's Preferred Contracted Network Provider:

Lyra Health
(877) 368-0644
Available 24/7
www.carpenterbenefits.lyrahealth.com

	Lyra In-Network Provider % and/or $ Amount Paid by Plan	Lyra Out-of-Network Provider % and/or $ Amount Paid by Plan
MEMBER ASSISTANCE PROGRAM *Calendar year deductible does not apply* **12 sessions** per calendar year	**100%**	**Not Covered**

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ADDITIONAL NETWORK PROVIDER OPTIONS

Vision Benefits	Dental Benefits	Life Insurance Benefit
VSP Vision Care 1-800-877-7195	**Delta Dental of Illinois** 1-800-323-1743	**The Hartford** **$25,000** Only Available for Retirees Under Age 65

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MEDICARE-ELIGIBLE

AND ENROLLED IN HOSPITAL BENEFITS ONLY

All claims must be submitted to the Plan's Contracted Network Provider

F For questions or information on claims or coverage, call Blue Cross Blue Shield at (855) 354-1858

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