

St. Louis Graphic Arts 1/1/2010 Medicare Retiree Benefits Comparison Chart

(This is the general outline of the benefits of each plan. It does not cover all the details of each plan. See the Fund's November 1, 2006 Summary Plan Description and all amendments and Secure Horizons Summary of Benefits for specific details.)

If you or your spouse are eligible for Medicare, the only plans available to you through the Fund are the Secure Horizons Medicare Complete HMO or the Open Access Medicare Plan.

<u>Benefit Category</u>	<u>Secure Horizon 2009 Benefits (a)</u>	<u>Secure Horizon 2010 Benefits (a)</u>	<u>2010 Open Access Medicare Benefits</u>
PCP/Specialist Office Visit	\$10 Copay – PCP \$25 Copay – Specialist	\$10 Copay – PCP \$30 Copay - Specialist	20% Coinsurance (b)
Retail Rx – Generic	\$4 Copay (d)	\$6 Copay (d)	20% Copay (minimum \$5)
Retail Rx – Brand	\$28 Copay (d)	\$38 Copay (d)	35% Copay (max \$50 certain drugs)
Retail Rx – Non-preferred	\$58 Copay (d)	\$72 Copay (d)	35% Copay (max \$50 certain drugs)
Outpatient Copayments:			
Medicare Required Part B Drugs	20% Coinsurance	20% Coinsurance	20% Coinsurance (b)
Durable Medical Equipment	20% Coinsurance	20% Coinsurance	20% Coinsurance (b)
Annual Routine Eye Exam	\$30; 1 visit every year	\$30; 1 visit every year	\$20; 1 visit every year
Annual Routine Hearing Exam	\$30; 1 visit every year	\$0 SouthWest; 1 visit every year	Not covered benefit
Hearing Aids	\$400 every 2 yrs (unlimited # devices)	\$500 every 2 yrs (unlimited # devices)	Not covered benefit
Dental	\$30 (Medicare Covered)	\$30 (Medicare Covered)	Not covered benefit
Diagnostic Lab Services	\$7 Copay	\$10 Copay	20% Coinsurance (b)
Standard Film X-rays	\$15 Copay	\$16 Copay	20% Coinsurance (b)
Surgery & Observation	25% Coinsurance	20% Coinsurance	20% Coinsurance (b)
Other Radiological Services & Therapeutic Lab Procdrs	20% Coinsurance	20% Coinsurance	20% Coinsurance (b)
Outpatient Therapy OT/PT/ST)	\$30 Copay	\$30 Copay	20% Coinsurance (b)
Ambulance	\$150 Copay	\$150 Copay	20% Coinsurance (b)
Emergency Room	\$50 Copay	\$50 Copay	20% Coinsurance (b)
Contracted Urgent Care Centers	\$40 Copay	\$30 Copay	20% Coinsurance (b)
Glucose Testing Supplies	\$0 Copay	\$0 Copay	20% Coinsurance (b)
OOA Urgently Needed Card	\$40 Copay	\$40 Copay	
Glasses Contacts	\$10 standard lenses/\$5 standard frames OR \$70 credit non-standard eyewear OR \$105 credit non-standard contact + post cataract	\$10 standard lenses/\$5 standard frames OR \$70 credit non-standard eyeglasses OR \$105 credit non-standard contact + post cataract	Prescription Glasses - \$20 Copay every calendar year Lenses – every calendar year - Single Vision, Lined Bifocal and Lined Trifocal lenses Frame – Every other calendar year \$130 allowance, 20% off over allowance. Contact Lenses \$130 allowance for contacts & exam every calendar year

<u>Benefit Category</u>	<u>Secure Horizon 2009 Benefits (a)</u>	<u>Secure Horizon 2010 Benefits (a)</u>	<u>2010 Open Access Medicare Benefits</u>
Inpatient Hospital Copayment	\$245 Copay, days 1-18 \$0 Copay, days 19-999	\$265 Copay, days 1-6 \$0 Copay, days 7-999	20% Coinsurance (b)
Inpatient Mental Health & Substance Abuse (190 day lifetime limit) Partial Hospitalization	\$245 Copay, days 1-18 \$0 Copay, days 19-90	\$265 Copay, days 1-6 \$0 Copay, days 7-90	20% Coinsurance (b)
OP Mental Health Grp Visit Individual Visit	\$40 Copay Individual \$30 Copay Group	\$40 Copay Individual \$30 Copay Group	20% Coinsurance (b)
Inpatient Skilled Nursing Facility (100 days each benefit period)	\$85 days 1-50 \$0 days 51-100	\$85 days 1-34 \$0 days 35-100	20% Coinsurance (b)
Home Health Care	100% per Medicare guidelines	100% per Medicare guidelines	20% Coinsurance (b)
Hospice Care	100% per Medicare guidelines	100% per Medicare guidelines	20% Coinsurance (b)
Renal Dialysis	20% Coinsurance	20% Coinsurance	20% Coinsurance (b)
Transplants	\$1,500 Copayment per transplant	Not Covered	20% Coinsurance (b)
Cardiac Rehabilitation	\$30 Copayment	\$30 Copayment	20% Coinsurance (b)
Annual Global Out of Pocket Maximum	\$4,200	\$4,550 (c)	Rx-\$1,500 per individual Medical-\$5,000 per individual
Monthly Self-Pay Premiums Per Person (In addition to Medicare Part B Premium)	\$20	\$20	\$289.07

- (a) You must reside in Secure Horizon's service area in order to participate in this option. Secure Horizon provides benefits only for Secure Horizon HMO providers and requires a Secure Horizon HMO PCP referral in order to see a Specialist.
- (b) You will receive up to 80% reimbursement of the difference between Medicare eligible charges and the benefits paid by Medicare.
- (c) There is an annual \$4,550 (calendar year) combined Out of Pocket limit for covered services EXCEPT: certain office visit copays; prescription drugs; eyewear; dental; hearing aids and non covered services.
- (d) Part D coverage has no deductible. Cost sharing listed is for drugs up to \$2,830. From \$2,830 to \$4,550 participant pays 100% of all brand drug costs (Part D coverage gap does not apply to covered generic drugs) The plan design includes the standard catastrophic coverage per CMS regulations. Specifically, once a member reaches **\$4,550** in True Out of Pocket prescription medication costs in the **2010** calendar year, the member will pay the greater of a **\$2.50** copay or 5% coinsurance for generic drugs, and the greater of a **\$6.30** copay or 5% coinsurance for brand name drugs, regardless of whether these drugs are received at a retail pharmacy or through our mail order program.