



# NATIONAL IAM BENEFIT TRUST FUND

*Better Benefits • Better Life*

## Medical Option H003 – Schedule of Benefits

FINANCIAL	IN NETWORK	OUT OF NETWORK
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Deductible</b> (per calendar year – cross accumulates in and out of network – includes 4th quarter carry-over)		
▪ <b>Individual</b>	\$400	\$400
▪ <b>Family</b>	\$1,200	\$1,200
<b>Out-of-Pocket Limit</b> (per calendar year – cross accumulates in and out of network – includes deductible)		
▪ <b>Individual</b>	\$4,400	\$8,400
▪ <b>Family</b>	\$9,200	\$17,200
PREVENTIVE / WELLNESS	IN NETWORK	OUT OF NETWORK
<i>The following “PREVENTIVE / WELLNESS” services are not subject to the deductible</i>		
<b>Routine Examinations</b> Annual physical exam, annual gynecologic exam, routine well child visits	100%	60%
<b>Routine Immunizations</b> Physician recommended immunizations, annual flu shot (excludes travel vaccines)	100%	60%
<b>Routine Lab and X-ray</b> Ordered or performed in conjunction with routine exam, including annual pap & PSA	100%	60%
<b>Routine Colonoscopy</b> Covered once every 3 years from age 50; or if high risk of colon cancer, per doctor, covered every 2 years regardless of age	100%	60%
<b>Routine Mammography</b> 1 baseline mammogram age 35-39 1 mammogram per year from age 40	100%	60%
PHYSICIAN SERVICES	IN NETWORK	OUT OF NETWORK
<b>Office Visits</b>	80% after deductible	60% after deductible
<b>Surgical Professional Fees</b> Surgeon, Assistant Surgeon, Anesthesiologist	80% after deductible	60% after deductible
<b>Inpatient Hospital Visits</b>	80% after deductible	60% after deductible
HOSPITAL FACILITY	IN NETWORK	OUT OF NETWORK
<b>Inpatient</b>	80% after deductible	60% after deductible
<b>Outpatient</b> (except emergency room)	80% after deductible	60% after deductible
<b>Emergency Room</b>	80% after deductible	80% after deductible (60% if not a true emergency)

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OTHER MEDICAL SERVICES	IN NETWORK	OUT OF NETWORK
<b>Allergy Testing and Treatment</b>	80% after deductible	60% after deductible
<b>Ambulance Transport</b>	80% after deductible	60% after deductible
<b>Ambulatory Surgical Facility</b>	80% after deductible	60% after deductible
<b>Bariatric Surgery</b> At Centers of Excellence if clinical criteria met	80% after deductible	Not Covered
<b>Chiropractic Care</b> Maximum 20 days of treatment per year	80% after deductible	60% after deductible
<b>Diagnostic Lab and X-ray</b>	80% after deductible	60% after deductible
<b>Durable Medical Equipment</b> Rental coverage limited to purchase price	80% after deductible	60% after deductible
<b>Home Health and Hospice Care</b>	80% after deductible	60% after deductible
<b>Infertility Work-up</b> Diagnostic only – treatment is not covered	80% after deductible	60% after deductible
<b>Malignancy Treatment</b>	80% after deductible	60% after deductible
<b>Mental Health Care</b>	80% after deductible	60% after deductible
<b>Organ Transplants</b>	80% after deductible	60% after deductible
<b>Podiatry Care</b> Maximum 30 days of treatment per year	80% after deductible	60% after deductible
<b>Rehabilitative Therapy Visits</b> Speech, physical, occupational, cardiac, etc; Maximum 50 days of treatment per year	80% after deductible	60% after deductible
<b>Skilled Nursing Facility</b> Maximum 100 days of treatment per year	80% after deductible	60% after deductible
<b>Substance Abuse Treatment</b>	80% after deductible	60% after deductible
PRESCRIPTION DRUGS	COVERED THROUGH CVS CAREMARK	
<p><b>Program includes generic step therapy</b> which requires generic or equivalent be tried before preferred or non-preferred brand is covered (unless brand is pre-authorized). No copayment required for generic and single source brand <b>female contraceptives</b>. Prior authorization is required for <b>compound drugs</b> over \$300, for all <b>male androgens</b>, and for all <b>specialty drugs</b>. Formulary exclusions apply, but excluded items can be considered if medical necessity is pre-approved.</p>		
<b>Out-of-Pocket Limit</b> (per calendar year)	\$2,000 per individual	\$4,000 per family
<b>34 Day Supply</b> - For covered prescription drugs at all retail pharmacies	Copayment: \$20 Generic; \$40 Preferred; \$50 Non-preferred	
<b>90 Day Supply</b> - For maintenance drugs through mail order or at a CVS pharmacy	Copayment: \$40 Generic; \$80 Preferred; \$100 Non-preferred	
<b>Specialty Drugs</b> - Specialty pharmacy use and pre-authorization required, quantities vary	Copayment: \$40 Generic; \$80 Preferred; \$100 Non-preferred	
AGE LIMIT FOR DEPENDENT CHILDREN		
Eligible dependent children are covered to age 26 (coverage ends the last day of the month child turns age 26)		
<p><i>Please note - The above is a summary of benefits only. Services are subject to medical necessity (except preventive care) and may be subject to limitations. Please refer to the Summary Plan Description or contact the Fund Office for information about limitations and exclusions.</i></p>		