NATIONAL IAM BENEFIT TRUST FUND

Better Benefits · Better Life

Medical Option H003 – Schedule of Benefits

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

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OTHER MEDICAL SERVICES	IN NETWORK	OUT OF NETWORK
Allergy Testing and Treatment	80% after deductible	60% after deductible
Ambulance Transport	80% after deductible	60% after deductible
Ambulatory Surgical Facility	80% after deductible	60% after deductible
Bariatric Surgery At Centers of Excellence if clinical criteria met	80% after deductible	Not Covered
Chiropractic Care Maximum 20 days of treatment per year	80% after deductible	60% after deductible
Diagnostic Lab and X-ray	80% after deductible	60% after deductible
Durable Medical Equipment Rental coverage limited to purchase price	80% after deductible	60% after deductible
Home Health and Hospice Care	80% after deductible	60% after deductible
Infertility Work-up Diagnostic only – treatment is not covered	80% after deductible	60% after deductible
Malignancy Treatment	80% after deductible	60% after deductible
Mental Health Care	80% after deductible	60% after deductible
Organ Transplants	80% after deductible	60% after deductible
Podiatry Care Maximum 30 days of treatment per year	80% after deductible	60% after deductible
Rehabilitative Therapy Visits Speech, physical, occupational, cardiac, etc; Maximum 50 days of treatment per year	80% after deductible	60% after deductible
Skilled Nursing Facility Maximum 100 days of treatment per year	80% after deductible	60% after deductible
Substance Abuse Treatment	80% after deductible	60% after deductible

PRESCRIPTION DRUGS	COVERED THROUGH CVS CAREMARK	
Program includes generic step therapy 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 **female contraceptives**. Prior authorization is required for **compound drugs** over $300, for all **male androgens**, and for all **specialty drugs**. Formulary exclusions apply, but excluded items can be considered if medical necessity is pre-approved.		
Out-of-Pocket Limit (per calendar year)	$2,000 per individual	$4,000 per family
34 Day Supply - For covered prescription drugs at all retail pharmacies	Copayment: $20 Generic; $40 Preferred; $50 Non-preferred	
90 Day Supply - For maintenance drugs through mail order or at a CVS pharmacy	Copayment: $40 Generic; $80 Preferred; $100 Non-preferred	
Specialty Drugs - 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)

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.

Revised January 2015