NATIONAL IAM
BENEFIT TRUST FUND

MEDICAL PLAN B

	IN NETWORK	OUT OF NETWORK
FINANCIAL		
Lifetime Maximum:	Unlimited	Unlimited
Deductible: Applies per calendar year; includes 4th quarter deductible carry-over		
Individual	None	$3,000
Family	None	$9,000
Out-of-Pocket Limit: Per calendar year; cross accumulates in and out of network; includes deductible, coinsurance, and copayments		
Individual	$4,000	$13,000
Family	$10,000	$39,000
MEDICAL BENEFITS		
Allowances based on:	Contract Rate	Usual, Customary, and Reasonable (UC&R)
Coinsurance:	0%	50% after deductible
Prior Authorization:	Prior authorization required for all inpatient and many outpatient services, including prescription drugs	
PREVENTIVE CARE		
Routine Examinations	No copayment - Plan pays 100%	50% after deductible
	Annual physical, gyn exam, routine well child visits, related routine lab & x-rays, routine Immunizations	
Routine Colonoscopy	No copayment - Plan pays 100%	50% after deductible
	Covered every 3 years from age 50; If high risk of colon cancer, every 2 years regardless of age	
Routine Mammogram	No copayment - Plan pays 100%	50% after deductible
	1 baseline covered between age 35-39; 1 routine mammogram covered per year from age 40	
PHYSICIAN SERVICES		
Primary Care Office Visit	$25 copayment per visit	50% after deductible
Specialist Office Visit	$40 copayment per visit	50% after deductible
Emergency Room Physician Visit	Facility copayment applies	Facility copayment applies if true emergency
		50% after deductible if not a true emergency
Inpatient Hospital Visit	Facility copayment applies	50% after deductible
Urgent Care Physician	Facility copayment applies	50% after deductible
Surgical Professionals	Facility copayment applies	50% after deductible
HOSPITAL / URGENT CARE FACILITY SERVICES		
Inpatient Hospital	$350 copayment per admission	50% after deductible
Outpatient Hospital	$200 copayment per visit	50% after deductible
Emergency Room	$100 copayment per visit	$100 copayment per visit
		50% after deductible if not a true emergency
Urgent Care Facility	$50 copayment per visit	50% after deductible
OTHER SERVICES		
Allergy Tests/Treatment	Visit copayment applies	50% after deductible
Ambulance Transport	$50 copayment per event	50% after deductible
Ambulatory Surgery Ctr	$50 copayment per visit	50% after deductible
Bariatric Surgery	Facility copayment applies	Not covered
	In network only through CIGNA Centers of Excellence for Bariatric Surgery - No out of network coverage	
Chemotherapy	$200 copayment per visit	50% after deductible
Chiropractic Care	$40 copayment per visit	50% after deductible
	Maximum 20 days treatment per calendar year	
Diagnostic Lab	$10 copayment per visit	50% after deductible
Diagnostic X-Ray	$50 copayment per visit	50% after deductible
Coinsurance applies on charges from independent lab or x-ray facility. If done at a physician's visit, the office visit copayment applies.		

NATIONAL IAM
BENEFIT TRUST FUND

MEDICAL PLAN B

	IN NETWORK	OUT OF NETWORK
OTHER SERVICES - *Continued*		
Durable Medical Equipment (DME)	$50 copayment per item	50% after deductible
	Rental benefit limited to purchase price (or contract rate) of medically necessary medical equipment	
Home Health Care	$50 copayment per visit	50% after deductible
Hospice Care	$40 copayment per visit	50% after deductible
Organ Transplant	Paid like any other illness based on the type of service that is received	
Podiatry Treatment	$40 copayment per visit	50% after deductible
	Max 30 days treatment per calendar year. Limit does not apply to covered surgical procedures.	
Prosthetics / Orthotics	$50 copayment per item	50% after deductible
Outpatient Rehabilitative Therapy	$25 copayment per visit	50% after deductible
	Max 50 days of treatment per calendar year for all therapies; physical, speech, occupational, cardiac. etc.	
Radiation Therapy	$200 copayment per visit	50% after deductible
Skilled Nursing Facility	$200 copayment per stay	50% after deductible
	Maximum 100 days of treatment per cal year	
MENTAL HEALTH CARE		
Inpatient	$350 copayment per admission	50% after deductible
Outpatient Facility	$200 copayment per visit	50% after deductible
Outpatient Visits	$40 copayment per visit	50% after deductible
SUBSTANCE ABUSE TREATMENT		
Inpatient	$350 copayment per admission	50% after deductible
Outpatient Facility	$200 copayment per visit	50% after deductible
Outpatient Visits	$40 copayment per visit	50% after deductible
PRESCRIPTION DRUGS	**CVS/caremark is the Pharmacy Benefit Manager**	
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 or coinsurance is 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 may be considered with prior authorization of medical necessity. Separate out-of-pocket limit.		
Coverage Details	**Use of CVS network pharmacies is required - No coverage outside of CVS network**	
Deductible	None	
Out-of-Pocket Limit (per calendar year)	**Individual:** $1,800 **Family:** $3,600	
Medication Type	**34 Day Supply - CVS network retail pharmacies**	**90 Day Supply - CVS retail and Mail-Order**
- Generic	$10 copay	$20 copay
- Preferred Brand	20% up to $30 max	20% up to $60 max
- Non-Preferred Brand	30% up to $60 max	30% up to $120 max
Specialty Medications - Require prior authorization and use of specialty pharmacy. Days supply and/or quantity dispensed will be based on type of medication, and dosage and handling requirements.		
- All Specialty Meds	20% up to $120 per script	
AGE LIMIT FOR DEPENDENT CHILDREN		
Eligible dependent children are covered to age 26. Coverage ends the last day of the month in which a child reaches age 26.		
This is a summary of benefits only. Coverage is subject to medical necessity (except preventive care) and may be subject to limitations and exclusions. Refer to the Summary Plan Description or contact the Benefit Trust Fund for information about limitations/exclusions.		

Created 10/2017