NATIONAL IAM
BENEFIT TRUST FUND

Benefits in Effect on January 1, 2017

Coparison of BTF Benefit Options	H001 OPTION		H002 OPTION		H003 OPTION	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
FINANCIAL:						
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Deductible (applies per calendar year - cross accumulates in and out of network - includes 4th quarter carry-over)						
- Individual	$100		$250		$400	
- Family	$300		$750		$1,200	
Out-of-Pocket Limit (applies per calendar year - cross accumulates in and out of network - includes deductible)						
- Individual	$2,100	$6,100	$3,250	$7,250	$4,400	$8,400
- Family	$4,300	$12,300	$6,750	$14,750	$9,200	$17,200
MEDICAL PLAN BENEFITS:						
Allowances based on:	Contract Rate	UC&R	Contract Rate	UC&R	Contract Rate	UC&R
PREVENTATIVE / WELLNESS:						
Routine Examinations:	Not subject to deductible		Not subject to deductible		Not subject to deductible	
Annual Physical Exam Annual Gyn Exam Routine Well Child Visits Related Routine Lab Related Routine X-rays Annual Pap Screening Annual PSA Screening Annual Flu Shot Routine Immunizations (excluding travel related)	100%	70%	100%	65%	100%	60%
Routine Colonoscopy:	Not subject to deductible		Not subject to deductible		Not subject to deductible	
Covered every 3 years from age 50. If doctor indicates high risk of colon cancer, benefit is provided every 2 years regardless of age	100%	70%	100%	65%	100%	60%
Routine Mammogram:	Not subject to deductible		Not subject to deductible		Not subject to deductible	
1 baseline age 35-39; 1 per year from age 40	100%	70%	100%	65%	100%	60%
PHYSICIAN SERVICES:						
Office Visit	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Emergency Room Visit	90% after deductible	90% after deductible 70% if not true emergency	85% after deductible	85% after deductible 65% if not true emergency	80% after deductible	80% after deductible 60% if not true emergency

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PHYSICIAN SERVICES (continued):						
Inpatient Hospital Visit	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Observation Visit	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Urgent Care Facility Visit	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Surgeon	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Assistant Surgeon	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Anesthesiologist	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
HOSPITAL / URGENT CARE FACILITY SERVICES:						
Inpatient Hospital	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Outpatient Hospital	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Emergency Room	90% after deductible	90% after deductible 70% if not true emergency	85% after deductible	85% after deductible 65% if not true emergency	80% after deductible	80% after deductible 60% if not true emergency
Urgent Care Facility	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
OTHER SERVICES:						
Allergy Tests/Treatment	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Ambulance Transport	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Ambulatory Surgery Ctr	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Bariatric Surgery	90% after deductible	Not covered	85% after deductible	Not covered	80% after deductible	Not covered
	In network coverage through CIGNA Centers of Excellence for Bariatric Surgery when clinical criteria is met - No out of network coverage					
Chemotherapy	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Chiropractic Care	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
	Maximum 20 days treatment per calendar year		Maximum 20 days treatment per calendar year		Maximum 20 days treatment per calendar year	
Diagnostic X-Ray & Lab	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Durable Medical	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Equipment (DME)	All Plans – Maximum rental benefit is limited to the purchase price (or contract rate) of medically necessary medical equipment					
Home Health Care	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Hospice Care	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Malignancy Treatment	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Organ Transplant	Paid like any other illness		Paid like any other illness		Paid like any other illness	
Podiatry – 30 days limit does not apply to surgery	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
	Maximum 30 days treatment per calendar year		Maximum 30 days treatment per calendar year		Maximum 30 days treatment per calendar year	
Pre-Admission Testing	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Radiation Therapy	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible

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OTHER SERVICES (continued):						
Rehabilitative Therapy Combined benefit–speech, physical, occupational, etc	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
	Maximum 50 days treatment per calendar year		Maximum 50 days treatment per calendar year		Maximum 50 days treatment per calendar year	
Skilled Nursing Facility	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
	Maximum 100 days treatment per cal year		Maximum 100 days treatment per cal year		Maximum 100 days treatment per cal year	
MENTAL HEALTH CARE:						
Inpatient	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Outpatient	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
ALCOHOL, DRUG & CHEMICAL DEPENDENCY TREATMENT:						
Inpatient	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
Outpatient	90% after deductible	70% after deductible	85% after deductible	65% after deductible	80% after deductible	60% after deductible
PRESCRIPTION DRUGS 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.

Category	H001 OPTION	H002 OPTION	H003 OPTION
Out-of Pocket Limit (per calendar year)	**Individual:** $1,600 **Family:** $3,200	**Individual:** $1,800 **Family:** $3,600	**Individual:** $2,000 **Family:** $4,000
34 Day Supply - Applies to covered prescription drugs at all retail pharmacies	$10 Generic $20 Preferred Brand $30 Non-Preferred Brand	$10 Generic $30 Preferred Brand $40 Non-Preferred Brand	$20 Generic $40 Preferred Brand $50 Non-Preferred Brand
90 Day Supply - Applies to maintenance drugs by mail-order or at CVS pharmacy	$20 Generic $30 Preferred Brand $40 Non-Preferred Brand	$20 Generic $60 Preferred Brand $80 Non-Preferred Brand	$40 Generic $80 Preferred Brand $100 Non-Preferred Brand
Specialty Drugs - Require prior-authorization and use of specialty pharmacy	$20 Generic $30 Preferred Brand $40 Non-Preferred Brand	$20 Generic $60 Preferred Brand $80 Non-Preferred Brand	$40 Generic $80 Preferred Brand $100 Non-Preferred Brand
AGE LIMIT FOR DEPENDENT CHILDREN:			
All National IAM Plans	Eligible dependent children are covered to age 26 (coverage ends the last day of the month in which the child turns age 26)		

Please note - The above is a summary of benefits only. Coverage is subject to medical necessity (except preventive care) and may be subject to limitations and/or exclusions. Please refer to the Summary Plan Description or contact the Fund Office for information about any limitations and/or exclusions.