NATIONAL IAM
BENEFIT TRUST FUND

MEDICAL PLAN C

	IN NETWORK	OUT OF NETWORK
FINANCIAL		
Lifetime Maximum:	Unlimited	Not covered
Deductible: This Plan has no deductible, only copayments		
Individual	None	Not covered
Family	None	Not covered
Out-of-Pocket Limit: Per calendar year, includes copayments (Prescription Drug coverage has a separate out-of-pocket limit)		
Individual	$6,000	Not covered
Family	$12,000	Not covered
MEDICAL BENEFITS		
Allowances based on:	Contract Rate	N/A
Coinsurance:	0%	N/A
Prior Authorization:	Prior authorization required for all inpatient and many outpatient services, including prescription drugs	
PREVENTIVE CARE		
Routine Examinations	No copayment - Plan pays 100%	Not covered
	Annual physical, gyn exam, routine well child visits, related routine lab & x-rays, routine Immunizations	
Routine Colonoscopy	No copayment - Plan pays 100%	Not covered
	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%	Not covered
	1 baseline covered between age 35-39; 1 routine mammogram covered per year from age 40	
PHYSICIAN SERVICES		
Primary Care Office Visit	$30 copayment per visit	Not covered
Specialist Office Visit	$50 copayment per visit	Not covered
Emergency Room Physician Visit	Facility copayment applies	Facility copayment applies if true emergency
		Not covered if not a true emergency
Inpatient Hospital Visit	Facility copayment applies	Not covered
Urgent Care Physician	Facility copayment applies	Not covered
Surgical Professionals	Facility copayment applies	Not covered
HOSPITAL / URGENT CARE FACILITY SERVICES		
Inpatient Hospital	$500 copayment per admission	Not covered
Outpatient Hospital	$200 copayment per visit	Not covered
Emergency Room	$200 copayment per visit	$200 copayment per visit if true emergency
		Not covered by Plan if not a true emergency
Urgent Care Facility	$50 copayment per visit	Not covered
OTHER SERVICES		
Allergy Tests/Treatment	Visit copayment applies	Not covered
Ambulance Transport	$100 copayment per event	Not covered
Ambulatory Surgery Ctr	$50 copayment per visit	Not covered
Bariatric Surgery	Facility copayment applies	Not covered
	Through CIGNA Centers of Excellence	
Chemotherapy	$200 copayment per visit	Not covered
Chiropractic Care	$50 copayment per visit	Not covered
	Maximum 20 days treatment per calendar year	
Diagnostic Lab	$20 copayment per visit	Not covered
Diagnostic X-Ray	$50 copayment per visit	Not covered
Coinsurance applies on charges from independent lab or x-ray facility. If done at a physician's visit, the office visit copayment applies.		

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	IN NETWORK	OUT OF NETWORK
OTHER SERVICES - *Continued*		
Durable Medical Equipment (DME)	$50 copayment per item	Not covered
	Rental benefit limited to purchase price (or contract rate) of medically necessary medical equipment	
Home Health Care	$100 copayment per visit	Not covered
Hospice Care	$100 copayment per visit	Not covered
Organ Transplant	Paid like any other illness based on the type of service that is received	
Podiatry Treatment	$50 copayment per visit	Not covered
	Max 30 days treatment per calendar year. Limit does not apply to covered surgical procedures.	
Prosthetics / Orthotics	$50 copayment per item	Not covered
Outpatient Rehabilitative Therapy	$50 copayment per visit	Not covered
	Max 50 days of treatment per calendar year for all therapies; physical, speech, occupational, cardiac. etc.	
Radiation Therapy	$200 copayment per visit	Not covered
Skilled Nursing Facility	$200 copayment per stay	Not covered
	Maximum 100 days of treatment per cal year	
MENTAL HEALTH CARE		
Inpatient	$500 copayment per admission	Not covered
Outpatient Facility	$200 copayment per visit	Not covered
Outpatient Visits	$50 copayment per visit	Not covered
SUBSTANCE ABUSE TREATMENT		
Inpatient	$500 copayment per admission	Not covered
Outpatient Facility	$200 copayment per visit	Not covered
Outpatient Visits	$50 copayment per visit	Not covered
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:** $1,900 **Family:** $3,800	
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 $50 max	20% up to $100 max
- Non-Preferred Brand	30% up to $100 max	30% up to $200 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 $200 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.		

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