NATIONAL IAM
BENEFIT TRUST FUND

Medical Option H002 – 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**	$250	$250
▪ **Family**	$750	$750
Out-of-Pocket Limit (per calendar year – cross accumulates in and out of network – includes deductible)		
▪ **Individual**	$3,250	$7,250
▪ **Family**	$6,750	$14,750
Prior Authorization is required for inpatient and many outpatient services – Call Cigna at 1-800-244-6224		
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%	65%
Routine Immunizations - Physician recommended immunizations, annual flu shot (excludes travel vaccines)	100%	65%
Routine Lab and X-ray - Ordered or performed in conjunction with routine exam, including annual pap & PSA	100%	65%
Routine Colonoscopy Covered once every 3 years from age 50. If high risk of colon cancer, per doctor, covered every 2 years regardless of age	100%	65%
Routine Mammography 1 baseline mammogram age 35-39 1 mammogram per year from age 40	100%	65%
PHYSICIAN SERVICES	**IN NETWORK**	**OUT OF NETWORK**
Office Visits	85% after deductible	65% after deductible
Surgical Professional Fees - Surgeon, Assistant Surgeon, Anesthesiologist	85% after deductible	65% after deductible
Inpatient Hospital Visits	85% after deductible	65% after deductible
HOSPITAL FACILITY	**IN NETWORK**	**OUT OF NETWORK**
Inpatient	85% after deductible	65% after deductible
Outpatient (except emergency room)	85% after deductible	65% after deductible
Emergency Room	85% after deductible	85% after deductible (65% if not a true emergency)

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OTHER MEDICAL SERVICES	IN NETWORK	OUT OF NETWORK
Allergy Testing and Treatment	85% after deductible	65% after deductible
Ambulance Transport	85% after deductible	65% after deductible
Ambulatory Surgical Facility	85% after deductible	65% after deductible
Bariatric Surgery - At Centers of Excellence if clinical criteria met	85% after deductible	Not Covered
Chiropractic Care Maximum 20 days of treatment per year	85% after deductible	65% after deductible
Diagnostic Lab and X-ray	85% after deductible	65% after deductible
Durable Medical Equipment Rental coverage limited to purchase price	85% after deductible	65% after deductible
Home Health and Hospice Care	85% after deductible	65% after deductible
Infertility Work-up Diagnostic only – treatment is not covered	85% after deductible	65% after deductible
Malignancy Treatment	85% after deductible	65% after deductible
Mental Health Care	85% after deductible	65% after deductible
Organ Transplants	85% after deductible	65% after deductible
Podiatry Care Maximum 30 days of treatment per year	85% after deductible	65% after deductible
Rehabilitative Therapy Visits - Speech, physical, occupational, cardiac, etc.; Maximum 50 days of treatment per year	85% after deductible	65% after deductible
Skilled Nursing Facility Maximum 100 days of treatment per year	85% after deductible	65% after deductible
Substance Abuse Treatment	85% after deductible	65% 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)	$1,800 per individual	$3,600 per family
34 Day Supply - For covered prescription drugs at all retail pharmacies	Copayment: $10 Generic; $30 Preferred; $40 Non-preferred	
90 Day Supply - For maintenance drugs through mail order or at a CVS pharmacy	Copayment: $20 Generic; $60 Preferred; $80 Non-preferred	
Specialty Drugs - Specialty pharmacy and pre-authorization required, quantities vary	Copayment: $20 Generic; $60 Preferred; $80 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.		

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