NATIONAL IAM
BENEFIT TRUST FUND

BOWLING TRANSPORTATION INC. - 55930

Renewal Rates Effective March 1, 2020

Medical and Prescription Drug Plan			
Coverage Election		**Current Rates**	**Reserve Drawdown Renewal Rates**
Plan C	Employee Only	$712.21	$747.82
	Employee+Child(ren)	$1,358.48	$1,426.40
	Employee+Spouse	$1,631.11	$1,712.67
	Family	$2,277.30	$2,391.17

Dental Plan			
Coverage Election		**Current Rates**	**Renewal Rates**
Plan D002	Employee Only	$38.22	$38.22
	Family	$95.54	$95.54

Vision Plan			
Coverage Election		**Current Rates**	**Renewal Rates**
Enhanced Plan	Employee Only	$5.34	$5.34
	Family	$13.37	$13.37

Disability Plan			
Coverage Election		**Current Rates**	**Renewal Rates**
Plan S800	Employee Only	$30.36	$30.36

NATIONAL IAM
BENEFIT TRUST FUND

BOWLING TRANSPORTATION INC. - 55930

Renewal Rates Effective March 1, 2019

Medical and Prescription Drug Plan					
Current Plan and Rates		New Plan and Rates		Reserve Drawdown Rates	
Plan H003		Plan C		Plan C	
Employee Only	$678.29	Employee Only	$898.31	Employee Only	$712.21
Employee+Child(ren)	$1,293.79	Employee+Child(ren)	$1,713.45	Employee+Child(ren)	$1,358.48
Employee+Spouse	$1,553.44	Employee+Spouse	$2,057.33	Employee+Spouse	$1,631.11
Family	$2,168.85	Family	$2,872.37	Family	$2,277.30

Dental Plan			
Coverage Election		Current Rates	Renewal Rates
Plan D002	Employee Only	$38.22	$38.22
	Employee+Child(ren)	$95.54	$95.54
	Employee+Spouse	$95.54	$95.54
	Family	$95.54	$95.54

Vision Plan			
Coverage Election		Current Rates	Renewal Rates
Enhanced Plan	Employee Only	$5.34	$5.34
	Employee+Child(ren)	$13.37	$13.37
	Employee+Spouse	$13.37	$13.37
	Family	$13.37	$13.37

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BENEFIT TRUST FUND

BOWLING TRANSPORTATION INC. - 55930

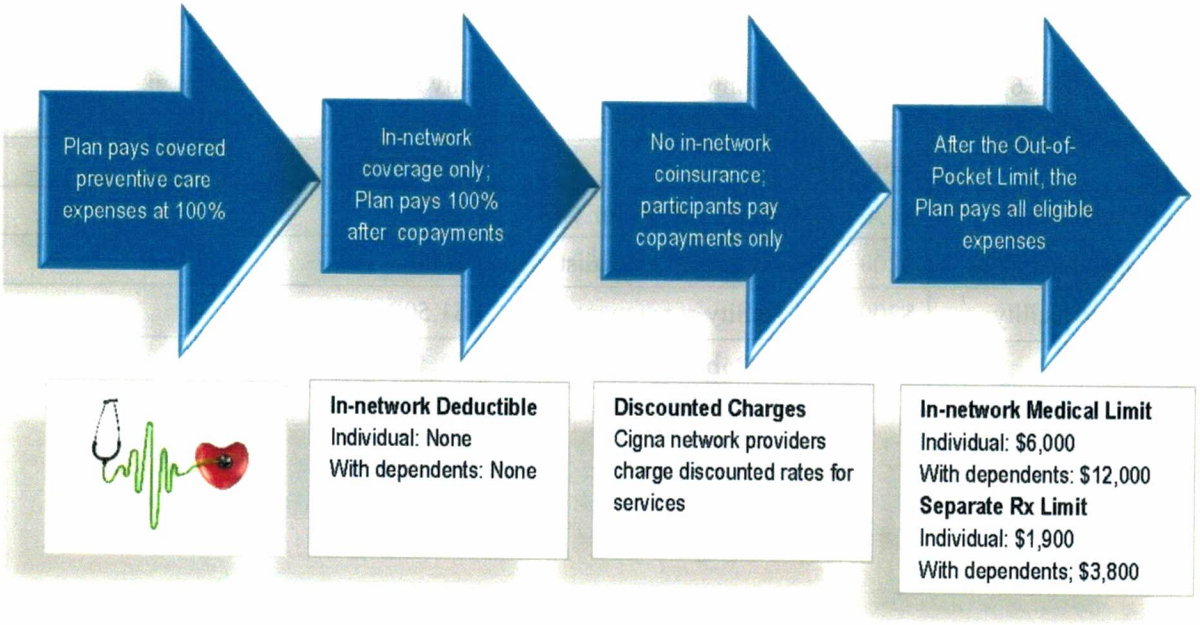
Renewal Rates Effective March 1, 2019

Disability Plan			
Coverage Election		Current Rates	Renewal Rates
Plan S600	Employee Only	$30.60	$30.60

How Medical and Prescription Drug Coverage Works Under Plan C

Plan C is a medical copayment plan administered by Cigna through its Open Access Plus (OAP) network of doctors, hospitals, urgent care centers, and other medical care professionals and facilities. Prescription drugs are administered by CVS Caremark. The plan does not cover out-of-network expenses. Plan C features:

- Coverage for medical expenses from in-network providers only. Plan C does not cover expenses from out-of-network providers.
- No deductible for expenses from providers who are members of the Cigna Open Access Plus (OAP) network. Most covered in-network services are subject to fixed copayments. The Plan pays 100% after copays.
- 100% coverage for preventive care services and certain preventive medications when obtained from in-network providers, no deductible or copayments.
- No coinsurance. Participants pay their share of medical expenses through copayments only. For prescription drugs, participants pay a percentage of the cost, but the percentage is limited to a copayment maximum.
- An out-of-pocket limit. When a participant's total copays reach the out-of-pocket limit, the Plan pays 100% of that participant's eligible expenses for the remainder of the calendar year. All copayments paid by a participant count toward the out-of-pocket limit.



Examples

These hypothetical examples are designed to show how Plan C and participants would share medical costs. The examples are for illustration purposes only. Actual costs will depend on an individual's actual medical expenses and plan coverage rules.

Example 1

Mary enrolls in individual coverage and has $4,000 of covered in-network medical expenses for the year which are subject to coinsurance rather than copayments. Her share of the cost in Plan C is summarized below.

Expense	Mary Pays	Plan Pays
$4,000 (no deductible)	$0	$4,000
Total $4,000	**$0 paid by Mary**	**$4,000 paid by Plan**

Example 2

Bob enrolls in family coverage and his family has $6,000 of covered in-network medical expenses for the year which are subject to coinsurance rather than copayments. His share of the cost in Plan C is summarized below.

Expense	Bob Pays	Plan Pays
$6,000 (no deductible)	$0 plus copays (see next table)	$6,000
Total $6,000	**$0 paid by Bob**	**$6,000 paid by Plan**

Example 3

In addition to the $6,000 in expenses in Example 2 above, Bob's family has $3,000 in medical expenses that are subject to copayments rather than coinsurance. His total cost for copays in Plan C is summarized below.

Expense	Bob Pays	Plan Pays
$500 - 5 doctor visits	$150 = $30 copay per doctor visit	$350
$800 - 4 specialist visits	$200 = $50 copay per specialist visit	$600
$1,700 - 1 ER facility	$200 = ER facility copayment	$1,500
Total $3,000	**$550 paid by Bob**	**$2,450 paid by Plan**

SIDE-BY-SIDE COMPARISON 2018 Plan C and Plan H003 What Participants Pay			
	PLAN C	PLAN H003	
	In-Network Only	In-Network	Out-of-Network
FINANCIAL			
Lifetime Maximum:	Unlimited	Unlimited	Unlimited
Deductible: **Individual** **With Dependents**	None None	$400 $1,200	$400 $1,200
Out-of-Pocket Limit: Applies per calendar year – Plan C, copays only. Plan H003 cross accumulates in and out of network - includes deductible, coinsurance, and copays			
Individual **With Dependents**	$6,000 $12,000	$4,400 $9,200	$8,400 $17,200
MEDICAL BENEFITS			
Allowances based on	Contract Rate	Contract Rate	UC&R
Coinsurance	0%	0% after deductible	35% after deductible
Prior Authorization	Requires prior authorization for most medical services and prescription drugs.		
PREVENTIVE CARE			
Routine Examinations: Annual Physical Exam Annual Gynecology 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)	Deductible waived $0	Deductible waived $0	Deductible waived 40% coinsurance
Routine Colonoscopy: Covered every 3 years from age 50. If doctor indicates high risk of colon cancer, benefit is provided every 2 years regardless of age	Deductible waived $0	Deductible waived $0	Deductible waived 40% coinsurance
Routine Mammogram: 1 baseline age 35-39; 1 per year from age 40	Deductible waived $0	Deductible waived $0	Deductible waived 40% coinsurance
PHYSICIAN SERVICES			
Primary Care Office Visit	$30 copay per visit	15% after deductible	40% after deductible
Specialist Office Visit	$50 copay per visit	15% after deductible	40% after deductible
Emergency Room	Facility copay applies, includes physician cost	20% after deductible	20% after deductible 40% after deductible if not a true emergency
Urgent Care	Facility copay applies, includes physician cost	20% after deductible	40% after deductible
Inpatient Hospital Visit	Facility copay applies, includes physician cost	20% after deductible	40% after deductible
Observation Visit	Facility copay applies, includes physician cost	20% after deductible	40% after deductible
Surgeon	Facility copay applies (office visit copay if done by physician in office)	20% after deductible	40% after deductible
Assistant Surgeon	Facility copay applies, includes physician cost	20% after deductible	40% after deductible
Anesthesiologist	Facility copay applies, includes physician cost	20% after deductible	40% after deductible

SIDE-BY-SIDE COMPARISON 2018 Plan C and Plan H003 What Participants Pay			
	PLAN C	PLAN H003	
	In-Network Only	In-Network	Out-of-Network
FACILITY SERVICES			
Inpatient Hospital	$500 facility copay per admission	20% after deductible	40% after deductible
Outpatient Hospital	$200 facility copay per visit	20% after deductible	40% after deductible
Emergency Room	$200 facility copay per visit	20% after deductible	20% after deductible
		20% after deductible	40% after deductible if not a true emergency
Urgent Care Facility	$50 facility copay per visit	20% after deductible	40% after deductible
OTHER SERVICES			
Allergy Tests/Treatment	Physician office visit copay applies	**20% after deductible**	**40% after deductible**
Ambulance Transport	$100 copay per event	**20% after deductible**	**40% after deductible**
Ambulatory Surgery Ctr	$50 copay per visit	20% after deductible	40% after deductible
Bariatric Surgery	Facility copay applies	20% after deductible	Not covered
	In-network coverage only through CIGNA Centers of Excellence for Bariatric Surgery after meeting clinical criteria.		
Chemotherapy	$200 copay per visit	20% after deductible	40% after deductible
Chiropractic Care	$50 copay per visit	20% after deductible	40% after deductible
	Maximum 20 days of chiropractic treatment per calendar year.		
Diagnostic Lab	$20 copay per visit	20% after deductible	40% after deductible
Diagnostic X-Ray	$50 copay per visit	20% after deductible	40% after deductible
For Plan C, Diagnostic Lab and X-Ray coinsurance applies to testing at an independent laboratory or x-ray facility. In a doctor's office, the applicable physician office visit copay applies.			
Durable Medical Equipment (DME)	$50 copay per item	20% after deductible	40% after deductible
	All benefit options – Maximum rental benefit is limited to the purchase price (or preferred provider contract rate) of medically necessary medical equipment.		
Home Health Care	$100 copay per visit	20% after deductible	40% after deductible
Hospice Care	$100 copay per visit	20% after deductible	40% after deductible
Organ Transplant	Paid like any other illness.	20% after deductible	40% after deductible
Podiatry Treatment	$50 copay per visit	20% after deductible	40% after deductible
	All benefit options have a maximum of 30 days of podiatry treatment per calendar year – the 30 days limit does not apply to covered surgical procedures.		
Pre-Admission Testing	$50 copay per visit	20% after deductible	40% after deductible
Prosthetics / Orthotics	$50 copay per visit	20% after deductible	40% after deductible
Outpatient Rehabilitative Therapy	$30 copay per visit	20% after deductible	40% after deductible
	Maximum 50 days treatment per calendar year for all types of rehabilitative therapy including physical therapy, speech therapy, occupational therapy, cardiac therapy, etc.		
Radiation Therapy	$200 copay per visit	20% after deductible	40% after deductible
Skilled Nursing Facility	$200 copay per visit	20% after deductible	40% after deductible
	Maximum 100 days of treatment per calendar year.		

SIDE-BY-SIDE COMPARISON 2018 Plan C and Plan H003 What Participants Pay			
	PLAN C	PLAN H003	
	In-Network Only	In-Network	Out-of-Network
MENTAL HEALTH CARE			
Inpatient	$500 copay per admission	20% after deductible	40% after deductible
Outpatient Facility	$200 copay per visit	20% after deductible	40% after deductible
Outpatient Visits	$50 copay per visit	20% after deductible	40% after deductible
ALCOHOL, DRUG and CHEMICAL DEPENDENCY TREATMENTS			
Inpatient	$50 copay per admission	20% after deductible	40% after deductible
Outpatient Facility	$200 copay per visit	20% after deductible	40% after deductible
Outpatient Visits	$50 copay per visit	20% after deductible	40% after deductible

PRESCRIPTION DRUG BENEFITS		
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 copay 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.		
Coverage Details	**CVS Caremark Network Pharmacies**	**Plan H003 – All Pharmacies**
Deductible	None	None
Out-of-Pocket Limit (per calendar year)	**Individual:** $1,900 **Family:** $3,800	**Individual:** $2,000 **Family:** $4,000
34 Day Supply - Applies to covered prescription drugs at all participating retail pharmacies		
• Generic	$10 copay per script	$20 copay per script
• Preferred Brand	20% up to $50 maximum	$40 copay per script
• Non-Preferred Brand	30% up to $100 maximum	$50 copay per script
90 Day Supply - Applies to maintenance drugs by mail-order or at CVS retail pharmacies		
• Generic	$20 copay per script	$40 copay per script
• Preferred Brand	20% up to $100 maximum	$80 copay per script
• Non-Preferred Brand	30% up to $200 maximum	$100 copay per script
Specialty Medications - Require prior-authorization and use of specialty pharmacy – quantities based on type of medication and dosage and handling requirements.		
All Specialty Meds	20% up to $120	Generic:$40 copay Preferred:$80 copay Non-preferred:$100

AGE LIMIT FOR DEPENDENT CHILDREN
Dependent children are covered to age 26. Coverage under the Plan ends the last day of the month in which a child reaches age 26.

NATIONAL IAM
BENEFIT TRUST FUND

Medical Benefits Effective January 1, 2018

Comparison of Benefit Options	Plan A and Plan A+		Plan B		Plan C	Plan D and Plan D+HSA	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
FINANCIAL					*NO OUT OF NETWORK*		
Lifetime Maximum:	Unlimited		Unlimited		Unlimited	Unlimited	
Deductible: Applies per calendar year - cross accumulates in and out of network (where applicable) - includes 4th quarter deductible carry-over							
- Individual	$100	$100	None	$3,000	None	$2,000 (includes Rx)	$3,000
- Family	$200	$200	None	$9,000	None	$4,000 (includes Rx)	$6,000
Out-of-Pocket Limit: Applies per calendar year - cross accumulates in and out of network - includes deductible, coinsurance, and copayments							
- Individual	$1,600	$3,100	$4,000	$13,000	$6,000	$6,000 (includes Rx)	$13,000
- Family	$3,200	$6,200	$10,000	$39,000	$12,000	$12,000 (includes Rx)	$26,000
MEDICAL BENEFITS							
Allowances based on:	Contract Rate	UC&R	Contract Rate	UC&R	Contract Rate	Contract Rate	UC&R
Coinsurance:	10% after deductible	30% after deductible	0%	50% after deductible	0%	20% after deductible	50% after deductible
Prior Authorization:	All benefit designs require prior authorization for most medical services. Many prescription drugs require prior authorization under both CVS/caremark and Cigna.						
PREVENTIVE CARE							
Routine Examinations:	Deductible waived	Deductible waived	No deductible	Deductible applies	No deductible	Deductible waived	Deductible applies
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)	0%	30%	0%	50% after deductible	0%	0%	50% after deductible
Routine Colonoscopy: Covered every 3 years from age 50. If doctor indicates high risk of colon cancer, benefit is provided every 2 years regardless of age	Deductible waived 0%	Deductible waived 30%	No deductible 0%	Deductible applies 50% after deductible	No deductible 0%	Deductible waived 0%	Deductible applies 50% after deductible
Routine Mammogram: 1 baseline age 35-39; 1 per year from age 40	Deductible waived 0%	Deductible waived 30%	No deductible 0%	Deductible applies 50% after deductible	No deductible 0%	Deductible waived 0%	Deductible applies 50% after deductible
PHYSICIAN SERVICES							
Primary Care Office Visit	$5 copay per visit	30% after deductible	$25 copay per visit	50% after deductible	$30 copay per visit	20% after deductible	50% after deductible
Specialist Office Visit	$10 copay per visit	30% after deductible	$40 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
Emergency Room Physician Visit	Facility copay applies	Facility copay applies 30% after deductible if not a true emergency	Facility copay applies	Facility copay applies 50% after deductible if not a true emergency	Facility copay applies	20% after deductible	20% after deductible 50% after deductible if not a true emergency
Inpatient Hospital Visit	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible

NATIONAL IAM
BENEFIT TRUST FUND

Medical Benefits Effective January 1, 2018

Comparison of Benefit Options	Plan A and Plan A+		Plan B		Plan C	Plan D and Plan D+HSA	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
PHYSICIAN SERVICES (continued)							
Observation Visit	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible
Urgent Care Physician	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible
Surgeon	Facility copay applies (office visit copay if done by physician in office)	30% after deductible	Facility copay applies (office visit copay if done by physician in office)	50% after deductible	Facility copay applies (office visit copay if done by physician in office)	20% after deductible	50% after deductible
Assistant Surgeon	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible
Anesthesiologist	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible
HOSPITAL / URGENT CARE FACILITY SERVICES:							
Inpatient Hospital	$75 copay per admit	30% after deductible	$350 copay per admit	50% after deductible	$500 copay per admit	20% after deductible	50% after deductible
Outpatient Hospital	$50 copay per visit	30% after deductible	$200 copay per visit	50% after deductible	$200 copay per visit	20% after deductible	50% after deductible
Emergency Room	$50 copay per visit	$50 copay per visit 30% after deductible if not a true emergency	$100 copay per visit	$100 copay per visit 50% after deductible if not a true emergency	$200 copay per visit	20% after deductible	20% after deductible 50% after deductible if not a true emergency
Urgent Care Facility	$25 copay per visit	30% after deductible	$50 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
OTHER SERVICES							
Allergy Tests/Treatment	Visit copay applies	30% after deductible	Visit copay applies	50% after deductible	Visit copay applies	20% after deductible	50% after deductible
Ambulance Transport	10% after deductible	30% after deductible	$50 copay per event	50% after deductible	$100 copay per event	20% after deductible	50% after deductible
Ambulatory Surgery Ctr	10% after deductible	30% after deductible	$50 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
Bariatric Surgery	Facility copay applies	Not covered	Facility copay applies	Not covered	Facility copay applies	20% after deductible	Not covered
	In network only coverage through CIGNA Centers of Excellence for Bariatric Surgery when clinical criteria is met - No out of network coverage						
Chemotherapy	10% after deductible	30% after deductible	$200 copay per visit	50% after deductible	$200 copay per visit	20% after deductible	50% after deductible
Chiropractic Care	$10 copay per visit	30% after deductible	$40 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
	Maximum 20 days treatment per calendar year		Maximum 20 days treatment per calendar year		Max 20 days per year	Maximum 20 days treatment per calendar year	
Diagnostic Lab	10% after deductible	30% after deductible	$10 copay per visit	50% after deductible	$20 copay per visit	20% after deductible	50% after deductible
Diagnostic X-Ray	10% after deductible	30% after deductible	$50 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
Diagnostic Lab and X-Ray coinsurance and copays noted above apply to testing at an independent laboratory or x-ray facility. In a doctor's office, the applicable physician office visit copay applies.							
Durable Medical Equipment (DME)	10% after deductible	30% after deductible	$50 copay per item	50% after deductible	$50 copay per item	20% after deductible	50% after deductible
	All benefit options – Maximum rental benefit is limited to the purchase price (or preferred provider contract rate) of medically necessary medical equipment						
Home Health Care	10% after deductible	30% after deductible	$50 copay per visit	50% after deductible	$100 copay per visit	20% after deductible	50% after deductible
Hospice Care	10% after deductible	30% after deductible	$40 copay per visit	50% after deductible	$100 copay per visit	20% after deductible	50% after deductible
Organ Transplant	Paid like any other illness		Paid like any other illness		Like any other illness	Paid like any other illness	
Podiatry Treatment	$10 copay per visit	30% after deductible	$40 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
	All benefit options have a maximum of 30 days of podiatry treatment per calendar year - the 30 days limit does not apply to covered surgical procedures						
Pre-Admission Testing	10% after deductible	30% after deductible	$40 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
Prosthetics / Orthotics	10% after deductible	30% after deductible	$50 copay per item	50% after deductible	$50 copay per item	20% after deductible	50% after deductible
Outpatient Rehabilitative Therapy	$10 copay per visit	30% after deductible	$25 copay per visit	50% after deductible	$30 copay per visit	20% after deductible	50% after deductible
	Maximum 50 days treatment per calendar year for all types of rehabilitative therapy including physical therapy, speech therapy, occupational therapy, cardiac therapy, etc.						
Radiation Therapy	10% after deductible	30% after deductible	$200 copay per visit	50% after deductible	$200 copay per visit	20% after deductible	50% after deductible

NATIONAL IAM BENEFIT TRUST FUND

Medical Benefits Effective January 1, 2018

Comparison of Benefit Options	Plan A and Plan A+		Plan B		Plan C	Plan D and Plan D+HSA	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
OTHER SERVICES (continued)							
Skilled Nursing Facility	10% after deductible	30% after deductible	$200 copay per stay	50% after deductible	$200 copay per stay	20% after deductible	50% after deductible
	Maximum 100 days treatment per cal year		Maximum 100 days treatment per cal year		Max 100 days per year	Maximum 100 days treatment per cal year	
MENTAL HEALTH CARE							
Inpatient	$75 copay per admit	30% after deductible	$350 copay per admit	50% after deductible	$500 copay per admit	20% after deductible	50% after deductible
Outpatient Facility	$50 copay per visit	30% after deductible	$200 copay per visit	50% after deductible	$200 copay per visit	20% after deductible	50% after deductible
Outpatient Visits	$10 copay per visit	30% after deductible	$40 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
ALCOHOL, DRUG & CHEMICAL DEPENDENCY TREATMENT							
Inpatient	$75 copay per admit	30% after deductible	$350 copay per admit	50% after deductible	$500 copay per admit	20% after deductible	50% after deductible
Outpatient Facility	$50 copay per visit	30% after deductible	$200 copay per visit	50% after deductible	$200 copay per visit	20% after deductible	50% after deductible
Outpatient Visits	$10 copay per visit	30% after deductible	$40 copay per visit	50% after deductible	$50 copay per visit	20% after deductible	50% after deductible
PRESCRIPTION DRUGS							
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.							
Coverage Details	CVS/caremark - All Pharmacies		CVS/caremark - CVS Network Only		CVS - Network Only	Cigna - Pharmacy Network Only	
Deductible	None		None		None	Combined - see page 1 deductible	
Out-of-Pocket Limit (per calendar year)	**Individual:** $1,600 **Family:** $3,200		**Individual:** $1,800 **Family:** $3,600		**Individual:** $1,900 **Family:** $3,800	Combined - see page 1 out-of-pocket	
34 Day Supply - Applies to covered prescription drugs at all participating retail pharmacies							
- Generic	$10 copay per script		$10 copay	Not covered	$10 copay	20% after deductible	Not covered
- Preferred Brand	$20 copay per script		20% up to $30 max	Not covered	20% up to $50 max	20% after deductible	Not covered
- Non-Preferred Brand	$30 copay per script		30% up to $60 max	Not covered	30% up to $100 max	20% after deductible	Not covered
90 Day Supply - Applies to maintenance drugs by mail-order or at CVS retail pharmacies							
- Generic	$20 copay per script		$20 copay	Not covered	$20 copay	20% after deductible	Not covered
- Preferred Brand	$30 copay per script		20% up to $60 max	Not covered	20% up to $100 max	20% after deductible	Not covered
- Non-Preferred Brand	$40 copay per script		30% up to $120 max	Not covered	30% up to $200 max	20% after deductible	Not covered
Specialty Medications - Require prior-authorization and use of specialty pharmacy - Days supply will be based on type of medication, and dosage and handling requirements							
- All Specialty Meds	$40 Copay		20% up to $120	Not covered	20% up to $200	20% after deductible	Not covered
OPTIONAL BENEFITS	Plan A+ (additional cost option)		Plan B (no options)		Plan C (no options)	Plan D+HSA (additional cost option)	
Surgical Vision Correction Benefits	10% after deductible	30% after deductible	Not available		Not available	Not available	
	Max $1,000 per eye to $2,000 per lifetime						
Hearing Aids	10% after deductible	30% after deductible	Not available		Not available	Not available	
Health Savings Account	Not available		Not available		Not available	Health Savings Account is optional	
AGE LIMIT FOR DEPENDENT CHILDREN:							
For all benefit options, 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.							

Updated 01/19/2018