NATIONAL IAM BENEFIT TRUST FUND

Better Benefits · Better Life

Medical Option H003 – 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**	$400	$400
▪ **Family**	$1,200	$1,200
Participant Percentage (per calendar year – cross accumulates in and out of network)		
▪ **Individual**	20% of the first $20,000 in covered charges per individual (equals $4,000 out-of-pocket)	40% of the first $20,000 in covered charges per individual (equals $8,000 out-of-pocket)
▪ **Family**	20% of the first $40,000 in covered charges per family (equals $8,000 out-of-pocket)	40% of the first $40,000 in covered charges per family (equals $16,000 out-of-pocket)
Out-of-Pocket Maximum is the sum of deductible and participant percentage amounts shown above		
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%	60%
Routine Immunizations Physician recommended immunizations, annual flu shot (excludes travel vaccines)	100%	60%
Routine Lab and X-ray Ordered or performed in conjunction with routine exam, including annual pap & PSA	100%	60%
Routine Colonoscopy Covered once every 3 years from age 50; or if high risk of colon cancer, per doctor, covered every 2 years regardless of age	100%	60%
Routine Mammography 1 baseline mammogram age 35-39 1 mammogram per year from age 40	100%	60%
PHYSICIAN SERVICES	**IN NETWORK**	**OUT OF NETWORK**
Office Visits	80% after deductible	60% after deductible
Surgical Professional Fees Surgeon, Assistant Surgeon, Anesthesiologist	80% after deductible	60% after deductible
Inpatient Hospital Visits	80% after deductible	60% after deductible
HOSPITAL FACILITY	**IN NETWORK**	**OUT OF NETWORK**
Inpatient	80% after deductible	60% after deductible
Outpatient (except emergency room)	80% after deductible	60% after deductible
Emergency Room	80% after deductible	80% after deductible (60% if not a true emergency)

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OTHER MEDICAL SERVICES	IN NETWORK	OUT OF NETWORK
Allergy Testing and Treatment	80% after deductible	60% after deductible
Ambulance Transport	80% after deductible	60% after deductible
Ambulatory Surgical Facility	80% after deductible	60% after deductible
Bariatric Surgery At Centers of Excellence if clinical criteria met	80% after deductible	Not Covered
Chiropractic Care Maximum 20 days of treatment per year	80% after deductible	60% after deductible
Diagnostic Lab and X-ray	80% after deductible	60% after deductible
Durable Medical Equipment Rental coverage limited to purchase price	80% after deductible	60% after deductible
Home Health and Hospice Care	80% after deductible	60% after deductible
Infertility Work-up Diagnostic only – treatment is not covered	80% after deductible	60% after deductible
Malignancy Treatment	80% after deductible	60% after deductible
Organ Transplants	80% after deductible	60% after deductible
Podiatry Care Maximum 30 days of treatment per year	80% after deductible	60% after deductible
Rehabilitative Therapy Visits Speech, physical, occupational, cardiac, etc; Maximum 50 days of treatment per year	80% after deductible	60% after deductible
Skilled Nursing Facility Maximum 100 days of treatment per year	80% after deductible	60% after deductible
MENTAL HEALTH CARE	**IN NETWORK**	**OUT OF NETWORK**
Inpatient Treatment	80% after deductible	60% after deductible
Outpatient Treatment	80% after deductible	60% after deductible
SUBSTANCE ABUSE TREATMENT	**IN NETWORK**	**OUT OF NETWORK**
Inpatient Treatment	80% after deductible	60% after deductible
Outpatient Treatment	80% after deductible	60% after deductible
PRESCRIPTION DRUG COVERAGE	**COVERED THROUGH CVS CAREMARK**	
Program Includes generic substitution. There is no copayment required for generic and single source brand **female contraceptives** (normal copayments apply for other brand).		
34 Day Supply - For covered prescription drugs at all retail pharmacies	Copayment: $20 Generic; $40 Preferred; $50 Non-preferred	
90 Day Supply - For maintenance drugs from mail order or at a CVS pharmacy	Copayment: $40 Generic; $80 Preferred; $100 Non-preferred	
Specialty Drugs - Specialty pharmacy use and pre-authorization required, quantities vary	Copayment: $40 Generic; $80 Preferred; $100 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)		

Revised 2014

NATIONAL IAM BENEFIT TRUST FUND

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Schedule of Dental Benefits

Coverage \ Option	A	A25	B	B25	C	D	E	G	H
Deductible:									
▪ Individual	None	$25	None	$25	None	None	None	None	$50
▪ Family	None	$75	None	$75	None	None	None	None	$150
Diagnostic / Preventive	90%	90%	90%	90%	100%	90%	100%	90%	80%
Basic	80%	80%	80%	80%	100%	80%	80%	80%	80%
Major	50%	50%	50%	50%	80%	50%	50%	80%	50%
Orthodontia	N/C	N/C	50%	50%	50%	50%	50%	N/C	N/C
Calendar Year Benefit Maximum	$1,000	$1,000	$1,000	$1,000	None	$1,000	$2,000	$1,000	$1,000
Orthodontia Lifetime Maximum	N/A	N/A	$500	$500	$5,000	$1,000	$1,500	N/A	N/A
Monthly Contribution Rates									
▪ Single	$22.11	$20.10	$25.21	$22.82	$56.03	$26.72	$38.35	$30.05	$17.62
▪ Family	$55.29	$50.23	$63.02	$57.05	$140.09	$66.81	$95.87	$75.13	$44.06

Summary of Covered Dental Procedures	
Diagnostic / Preventive	Exams, x-rays, cleaning of teeth, topical application of fluoride solutions, and space maintainers (to preserve existing space)
Basic	Fillings, endodontics (root canals), oral surgery (including surgical preparation for dentures and general anesthesia for covered oral surgery when administered by a licensed dentist), periodontics (surgical and non-surgical treatment of the gums), and denture repair
Major	Crowns, bridges, partial and complete dentures, and denture adjustments
Orthodontia	All necessary procedures for treatment to correct malposed teeth (braces) performed by a licensed dentist

Note – This is only a basic summary of dental benefits. Please refer to the specific Dental booklet or contact the Fund Office for information about applicable benefit limitations and exclusions.

- The deductible does not apply to Diagnostic and Preventive services.
- N/C = Not Covered.
- All services are subject to review for necessity of treatment and may be subject to limitations.
- Participants should use a Delta Dental PPO or Premier Network Provider for the lowest possible out-of-pocket cost.
- The rates shown in this schedule apply for new dental coverage and renewals effective September 2014 or later. If you are reviewing this schedule after 2014, please contact the Fund Office to confirm that the listed rates are still accurate.

National IAM Benefit Trust Fund
1300 Connecticut Ave., NW, Suite 300
Washington, DC 20036
www.iambtf.org

For additional information, or to add Dental coverage, please feel free to contact the Benefit Trust Fund Education Department at 800-457-3481 or 202-785-8148

7/14 Revision

NATIONAL IAM BENEFIT TRUST FUND

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Schedule of Vision Benefits

Basic Coverage	Option 1	Option 2	Option 3	Option 4
The Plan will pay covered charges up to the following maximum benefits per calendar year				
Eye Exam – Including refraction	$70	$80	$95	$95
Eyeglass Lenses – When first acquired or when new lenses are required by a change in prescription. The rates shown are for a pair of lenses (two lenses). If one lens is required, the plan will pay one-half of the listed benefit. The yearly benefit for eyeglass lenses and frames can be paid toward prescription sunglasses, but the plan does not cover any tints or coatings.				
▪ Single Vision Lenses	$60	$70	$85	$85
▪ Bifocal Lenses	$68	$82	$102	$102
▪ Trifocal Lenses	$85	$107.50	$132	$132
Eyeglass Frames	$75	$90	$105	$130
Contact Lenses – Contacts lenses can be paid in lieu of benefits for lenses and frames. Special lens benefit applies for contacts required following cataract surgery or when visual acuity cannot be corrected to 20/70 in the better eye. The rates shown are for a pair of lenses (two lenses). If one lens is required, the plan will pay one-half of the listed benefit.				
▪ Contact Lenses	$135	$160	$190	$215
▪ Special Lenses	$205	$280	$280	$280
Monthly Contribution Rates for Basic Coverage				
▪ Single	$2.55	$3.43	$4.86	$5.39
▪ Family	$6.36	$8.58	$12.15	$13.48
Optional Coverage	**Option 1A**	**Option 2A**	**Option 3A**	**Option 4A**
Optional Benefit: Contact Lens Fitting	$85	$135	$170	$170
Monthly Contribution Rates with the Addition of Optional Coverage				
▪ Single	$2.95	$4.06	$5.64	$6.17
▪ Family	$7.37	$10.13	$14.10	$15.44

Note – This is only a basic summary of vision benefits. Please refer to the specific Vision booklet or contact the Fund Office for information about applicable benefit limitations and exclusions.

- Covered participants can use any licensed Vision Care Provider they choose for their routine vision services. The plan does not pay providers directly. Vision benefits are paid directly to the covered employee.
- The rates shown in this schedule apply for new vision coverage and renewals effective September 2014 or later. If you are reviewing this schedule after 2014, please contact the Fund Office to confirm that the listed rates are still accurate.

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Schedule of Short Term Disability Income Coverage

Plan	Coverage	Rate
S200	Plan pays 70% of gross weekly wages up to $200 per week for a maximum of 26 weeks (182 days).	$10.00
S300	Plan pays 70% of gross weekly wages up to $300 per week for a maximum of 26 weeks (182 days).	$15.00
S400	Plan pays 70% of gross weekly wages up to $400 per week for a maximum of 26 weeks (182 days).	$20.00
S500	Plan pays 70% of gross weekly wages up to $500 per week for a maximum of 26 weeks (182 days).	$25.00
S600	Plan pays 70% of gross weekly wages up to $600 per week for a maximum of 26 weeks (182 days).	$30.00
S800	Plan pays 70% of gross weekly wages up to $800 per week for a maximum of 26 weeks (182 days).	$40.00
S01K	Plan pays 70% of gross weekly wages up to $1,000 per week for a maximum of 26 weeks (182 days).	$50.00

Disability Plans have a 7 day waiting period after all employer pay is exhausted (unless the Collective Bargaining Agreement provides otherwise, all sick pay must be exhausted before the disability waiting period starts or any Disability Income Benefits are paid). The waiting period is waived for accident or inpatient hospital admission. This means benefits will pay on the first unpaid day following an accident or inpatient hospitalization, and on the eighth unpaid day for an illness.

Disability benefits apply to the EMPLOYEE ONLY. The Plan will pay the employee portion of FICA taxes and notify the employer of payments weekly and in a year-end summary, but does not issue W2 forms. The employer is responsible for other taxes and for reporting sick pay on W2 form.

Life and Accidental Death and Dismemberment

The Benefit Trust Fund has multiple Life and AD&D plan options	
Contact the Benefit Trust Fund Office for information about benefit options and rates.	
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