SHOP IRONWORKERS LOCAL 790 WELFARE PLAN

SUMMARY OF ACTIVE MEDICAL PLAN BENEFITS – BARGAINED

BLUE CROSS PRUDENT BUYER

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Choice of Providers	In order to receive the highest benefits and lowest out-of-pocket expenses, participants should go to Blue Cross Prudent Buyer PPO contracted doctors, hospitals and other healthcare providers.	Participants may go to doctors, hospitals, and other healthcare providers who are NOT contracted with Blue Cross Prudent Buyer; however, out-of-pocket expenses will be higher. Some benefits are not covered.
Calendar Year Deductible	Individual: $250 Family: $750 The calendar year deductible does not apply to all services.	Individual: $500 Family: $1,500 The calendar year deductible always applies.
Accident Deductible	If 2 or more family members are injured in the same accident, only 1 deductible will apply for Covered Expenses related to that accident.	
Annual Maximum	No annual maximum for Essential Health Benefits	
Lifetime Maximum	Unlimited	
Annual Out-of-Pocket Calendar Year Maximum	Individual: $3,000 after Deductible; $9,000 Family Maximum.	Individual: $5,000 after Deductible; $15,000 Family Maximum.
Inpatient Hospital Room & Board, ICU, Ancillary Charges	80% of contract rate (1) Calendar Year Deductible Applies.	60% of Covered Expenses (1) after a $500 deductible per hospital admission * Calendar Year Deductible also Applies.
Pre-certification of Hospital Admission *You must call Blue Cross (800) 274-7767*	If pre-certification is not obtained for any hospital admission other than for the birth of a child, benefits usually payable will be *reduced by 10%.* For the birth of a child, a mother's hospital stay expected to be longer than 48-hours for a normal delivery or 96-hours for a caesarian delivery requires pre-certification for the extended period. If you are admitted on an emergency basis, Blue Cross must be notified within *24 hours.*	

NOTE: Blue Cross has negotiated fixed amounts that they will pay to providers for various services, referred to as the "contract rate". These negotiated amounts are often far less than normal billed charges. When you use a Prudent Buyer provider, you will not be responsible for the difference between the provider's billed charges and the negotiated amount. *Admission to a non-contracted hospital in a life-threatening emergency will be covered at 80% of Covered Expenses and the $500 deductible per admission to a non-contracted hospital applies.

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Anesthesia	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
EMERGENCY CARE		
Emergency Room (Facility)	80% of contract rate after you pay a $100 copayment; (Co-payment waived, if admitted)	80% of Covered Expenses; You pay a $100 co-payment; Deductible Applies (Co-payment waived, if admitted)
Emergency Room (Professional)	80% of contract rate;	80% of Covered Expenses;
Ambulance (Ground, Air or Water)	80% of contract rate; Deductible Applies.	80% of Covered Expense; Deductible Applies.
Skill Nursing Facility (SNF)	45% of contract rate; up to 55 days per disability; admission must occur after an inpatient hospital stay of at least 5 days; patient must be admitted to the SNF within 7 days of the hospital discharge; Deductible Applies.	35% of Covered Expenses; up to 55 days per disability; admission must occur after an inpatient hospital stay of at least 5 days; patient must be admitted to the SNF within 7 days of the hospital discharge; Deductible Applies.
Home Health Care	80% of contract rate, limitations apply; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
	Prior authorization is required.	
Hospice	100% of contract rate, Limitations apply; Deductible Does Not Apply.	100% of Covered Expenses, Limitations apply; Deductible Does Not Apply.
Physician Visits Office, Outpatient or Home	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Physician Charges - Other Hospital or Surgery (Professional Inpatient)	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Diagnostic X-Rays and Lab associated with office visit	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Diagnostic X-Rays Free-standing Facility or Outpatient Hospital	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Major Imaging Procedures CT Scan, PET Scan, MRI	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
OUTPATIENT SURGERY		
Facility and Professional Fee	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Ambulatory Surgical Center	80% of contract rate; Deductible Applies.	60% of Covered Expenses not to exceed $1,500 allowable per procedure; Deductible Applies.
	Prior Authorization for non-contracting Ambulatory Surgical Centers is required. If prior authorization is not obtained, payments may be denied. Please call the Administrative Office. It is your responsibility to confirm that the facility where the procedure is performed is contracted with Blue Cross Prudent Buyer. Also, certain surgeries also require prior authorization, please contact the Fund Office.	
PODIATRY		
Exam	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Orthotic Appliance	80% of contract rate, up to $200 per calendar year. Deductible Applies.	Not Covered.
Chiropractic	100% of contract rate after a $25 co-pay, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Does Not Apply.	60% of Covered Expenses, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Applies.
Acupuncture	100% of contract rate after a $25 co-pay, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Does Not Apply.	60% of Covered Expenses, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Applies.
	Up to a maximum of $2,000 per calendar year for PPO and Non-PPO charges combined for chiropractic and acupuncture.	

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
OUTPATIENT THERAPY		
Physical and Respiratory	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
SPEECH AND OCCUPATIONAL THERAPY	Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.	Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.
Speech	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Occupational	100% of contract rate after a $25 co-pay. Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Chemotherapy	80% of the contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Radiation Therapy	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
Intravenous Infusion Therapy	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
Dialysis	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
FAMILY PLANNING		
Infertility	NOT COVERED	NOT COVERED
Vasectomy	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Tubal Ligation	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
IUD	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Elective Abortions	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Routine Exams for Preventive Health	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
WELL BABY/CHILD CARE	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
	Charges for immunizations are included in well baby/childcare.	
WELL WOMAN CARE		
Examinations	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Pap Tests	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Mammogram	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
CARE FOR ALLERGIES		
Office Visit	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Testing	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Treatment and Serum	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Immunizations	Covered under routine exams and preventive health as shown previously.	Covered under routine exams and preventive health as shown previously.
Durable Medical Equipment	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies
Prosthetics, Orthopedic Braces, Other Equipment and Supplies	Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office. Compression Stockings & Mastectomy Bras – 2 Per Year. Wigs (A9282) – 1 per lifetime with a $500 lifetime maximum.	Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office. Compression Stockings & Mastectomy Bras – 2 Per Year. Wigs (A9282) – 1 per lifetime with a $500 lifetime maximum.
HEARING CARE		
Exam	Plan pays 100% of contract rate; Deductible Does Not Apply.	Plan pays 100% of Covered Expenses; Deductible Does Not Apply.
Molding	80% of contract rate – Dependent children only – Under 1 year old – once every 2 months - $100 maximum for each molding change up to a maximum of $600. 1 year old to 14 years old – once a year - $100 maximum for each molding change.	60% of Covered Expenses – Dependent children only – Under 1 year old – once every 2 months - $100 maximum for each molding change up to a maximum of $600. 1 year old to 14 years old – once a year - $100 maximum for each molding change.
Hearing Aid	Plan pays 80% up to a maximum of $1,500 for each hearing aid device (Left & Right) – including initial batteries. Plan covers one device per ear every four years. *Retirees are eligible for this benefit only until they reach age 65.*	Plan pays 80% up to a maximum of $1,500 for each hearing aid device (Left & Right) – including initial batteries. Plan covers one device per ear every four years. *Retirees are eligible for this benefit only until they reach age 65.*
TMJ	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Member Assistance Program	You may receive up to five face-to-face, telephonic, or web video consultations from MHN. You may also receive telephonic consultations for the following: legal, financial, child and elder care, identity theft prevention and recovery, and daily living issues.	
Substance Abuse	All inpatient benefits must be authorized by MHN. Call (800) 624-6864. If pre-authorization is not obtained, there will be a 10% reduction in benefits.	
Inpatient *(Includes detoxification)*	Plan pays 80% of the contract rate; Deductible Applies	Plan pays 60% of the Covered Expenses after a $500 deductible per hospital admission; Calendar Year Deductible also Applies.
Alternate Levels of Care *(Includes partial hospitalization, day treatment, and intensive outpatient)*	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of Covered Expenses; Deductible Applies.
Outpatient	100% of contract rate after a $25 co-pay; Deductible Does Not Apply	Plan pays 60% of Covered Expenses; Deductible Applies.
Maximum for all services	All benefits must be authorized by Health Management Companies/(MHN). Call (800) 526-6657.	
Annual Maximum	No annual maximum on Essential Health Benefits	
Mental Health	All inpatient services require preauthorization from MHN. Call (800) 624-6864. If pre-authorization is not obtained, there will be a 10% reduction in benefits.	
Inpatient	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of the Covered Expenses after a $500 deductible per hospital admission; Calendar Year Deductible also Applies.
Alternate Levels of Care *(Includes partial hospitalization, day treatment, and intensive outpatient)*	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of the Covered Expenses; Deductible Applies.
Outpatient	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	Plan pays 60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER / NON-CONTRACT PROVIDER
Supplemental Accident	100% of Covered Expenses incurred within 90 days of an accident; up to $300 for medical and $100 for X-ray/Lab services per accident; documentation must be provided to the Administrative Office. Deductible Does Not Apply. Charges remaining after the Supplemental Accident benefits have been paid will be subject to normal Plan provisions for Non-PPO claims – including coinsurance levels, calendar year deductible, and other applicable Plan provisions.
Prescription Drugs	All prescription Drugs must be obtained at pharmacies contracted with WellDyneRx.
All Generic Drugs	$15 Copayment – Retail – 30 days supply* $30 Copayment – Mail Order – 90 days supply*
Brand Name Drug on Formulary	$30 Copayment – Retail – 30 days supply $60 Copayment – Mail Order – 90 days supply
Brand Name Drug that is NOT on Formulary	$55 Copayment – Retail – 30 days supply $110 Copayment – Mail Order – 90 days supply

The above Summary of Benefits is only a SUMMARY of the coverage actually provided by the Comprehensive Medical Plan. Not all exclusions and limitations have been included. Please refer to the specific sections of this booklet for details. **No copayment is required for generic oral contraceptives.*