

**SHOP IRONWORKERS LOCAL 790 WELFARE PLAN**  
**SUMMARY OF ACTIVE MEDICAL PLAN BENEFITS**  
**BLUE CROSS PRUDENT BUYER**

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
<b>Choice of Providers</b>	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.
<b>Calendar Year Deductible</b>	<b>Individual: \$250</b> <b>Family: \$750</b> The calendar year deductible does not apply to all services.	<b>Individual: \$500</b> <b>Family: \$1,500</b> The calendar year deductible always applies.
<b>Accident Deductible</b>	<b>If 2 or more family members are injured in the same accident, only 1 deductible will apply for Covered Expenses related to that accident.</b>	
<b>Annual Maximum</b>	<b>No annual maximum for Essential Health Benefits</b>	
<b>Lifetime Maximum</b>	<b>Unlimited</b>	
<b>Annual Out-of-Pocket Calendar Year Maximum</b>	<b>Individual: \$3,000</b> <b>after Deductible;</b> <b>\$9,000 Family Maximum</b>	<b>Individual: \$5,000</b> <b>after Deductible;</b> <b>\$15,000 Family Maximum</b>
<b>Inpatient Hospital Room &amp; Board, ICU, Ancillary Charges</b>	<b>80% of contract rate; <sup>(1)</sup></b>  Calendar Year Deductible Applies	<b>60% of Covered Expenses <sup>(1)</sup></b> <b>after a \$500 deductible per hospital admission. *</b> Calendar Year Deductible also Applies
<b>Pre-certification of Hospital Admission</b> <i>You must call Blue Cross (800) 274-7767</i>	<b>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.</b>	

*(1) 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 will not apply.*

<b>MEDICAL BENEFIT</b>	<b>BLUE CROSS PROVIDER</b>	<b>NON-CONTRACT PROVIDER</b>
Anesthesia	<b>80% of contract rate;</b> Deductible Applies	<b>60% of Covered Expenses;</b> Deductible Applies
<b>EMERGENCY CARE</b>		
<b>Emergency Room</b>	<b>80% of contract rate after you pay a \$100 copayment;</b>	<b>80% of Covered Expenses;</b>
<b>(Facility)</b>	<b>80% of contract rate;</b>	<b>80% of Covered Expenses;</b>
<b>Emergency Room (Professional)</b>	<b>80% of contract rate;</b>	<b>80% of Covered Expenses;</b>
<b>Ambulance</b>	<b>80% of contract rate;</b> Deductible Applies	<b>80% of Covered Expenses;</b> Deductible Applies
Skilled Nursing Facility (SNF)	<b>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;</b> Deductible Applies	<b>35% of Covered Expenses; up to 55 days per disability and 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;</b> Deductible Applies
Additional benefits are available in the case of an accident.		
Home Health Care	<b>80% of contract rate;</b> Deductible Applies	<b>60% of Covered Expenses;</b> Deductible Applies
Prior authorization is required.		
Hospice	<b>100% of contract rate, limitations apply;</b> Deductible Does Not Apply	<b>100% of Covered Expenses, limitations apply;</b> Deductible Does Not Apply
Prior authorization is required.		
<b>Physician Visits Office, Outpatient or Home</b>	<b>100% of contract rate after a \$25 co-pay;</b> Deductible Does Not Apply	<b>60% of Covered Expenses;</b> Deductible Applies
<b>Physician Charges – Other Hospital or Surgery (Professional Inpatient)</b>	<b>80% of contract rate;</b> Deductible Applies	<b>60% of Covered Expenses;</b> Deductible Applies
Routine Diagnostic X-Ray and Lab associated with office visit	<b>80% of contract rate;</b> Deductible Does Not Apply	<b>60% of Covered Expenses;</b> Deductible Applies

<b>MEDICAL BENEFIT</b>	<b>BLUE CROSS PROVIDER</b>	<b>NON-CONTRACT PROVIDER</b>
Routine Diagnostic X-Ray Free-standing Facility or Outpatient Hospital	<b>80% of contract rate;</b> Deductible Does Not Apply	<b>60% of Covered Expenses;</b> Deductible Applies
Major Imaging Procedures <b>CT Scan, PET Scan, MRI</b>	<b>80% of contract rate;</b> Deductible Applies	<b>60% of Covered Expenses;</b> Deductible Applies
<b>OUTPATIENT SURGERY</b>		
<b>Facility and Professional Fee</b>	<b>80% of contract rate;</b> <b>Deductible Applies</b>	<b>60% of Covered Expenses;</b> <b>Deductible Applies</b>
<b>Ambulatory Surgical Center</b>	<b>80% of contract rate;</b>  <b>Deductible Applies</b>	<b>60% of Covered Expenses</b> <b>not to exceed \$1,500</b> <b>allowable per procedure;</b> <b>Deductible Applies</b>
<b>Prior Authorization for non-contracting Ambulatory Surgical Centers is required. 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.</b>		
<b>PODIATRY</b>		
<b>Exam</b>	<b>100% of contract rate after a \$25 co-pay;</b> Deductible Does Not Apply	<b>60% of Covered Expenses;</b> Deductible Applies
<b>Orthotic Appliance</b>	<b>80% of contract rate; up to \$200 per calendar year</b>	Not Covered
Chiropractic	<b>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;</b> Deductible Does Not Apply	<b>60% of Covered Expenses, up to a maximum of \$35 per visit, with a maximum of \$2,000 per calendar year.</b>  Deductible Applies
Acupuncture	<b>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;</b> Deductible Does Not Apply	<b>60% of Covered Expenses; up to a maximum of \$35 per visit, with a maximum of \$2,000 per calendar year.</b>  Deductible Applies
Up to a maximum of \$2,000 per calendar year for PPO and Non-PPO charges combined for chiropractic and acupuncture.		

<b>MEDICAL BENEFIT</b>	<b>BLUE CROSS PROVIDER</b>	<b>NON-CONTRACT PROVIDER</b>
<b>OUTPATIENT THERAPY</b>		
<b>Physical and Respiratory</b>	<b>100% of contract rate after a \$25 co-pay; Deductible Does Not Apply</b>	<b>60% of Covered Expenses; Deductible Applies</b>
<b>SPEECH AND OCCUPATIONAL THERAPY</b>	<b>Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.</b>	<b>Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.</b>
<b>Speech</b>	<b>100% of contract rate after a \$25 co-pay. Deductible Does Not Apply.</b>	<b>60% of Covered Expenses; Deductible Applies.</b>
<b>Occupational</b>	<b>100% of contract rate after a \$25 co-pay. Deductible Does Not Apply.</b>	<b>60% of Covered Expenses; Deductible Applies.</b>
<b>Chemotherapy</b>	<b>80% of the contract rate Deductible Applies.</b>	<b>60% of the Covered Expenses; Deductible Applies.</b>
<b>Radiation Therapy</b>	<b>80% of contract rate; Deductible Applies</b>	<b>60% of the Covered Expenses; Deductible Applies</b>
<b>Intravenous Infusion Therapy</b>	<b>80% of contract rate; Deductible Applies</b>	<b>60% of the Covered Expenses; Deductible Applies</b>
<b>Dialysis</b>	<b>80% of contract rate; Deductible Applies</b>	<b>60% of the Covered Expenses; Deductible Applies</b>
<b>FAMILY PLANNING</b>		
<b>Infertility</b>	<b>NOT COVERED</b>	<b>NOT COVERED</b>
<b>Vasectomy</b>	<b>80% of contract rate; Deductible Applies</b>	<b>60% of the Covered Expenses; Deductible Applies</b>
<b>Tubal Ligation</b>	<b>80% of contract rate; Deductible Applies</b>	<b>60% of the Covered Expenses; Deductible Applies</b>
<b>IUD</b>	<b>80% of contract rate; Deductible Applies</b>	<b>60% of the Covered Expenses; Deductible Applies</b>

<b>MEDICAL BENEFIT</b>	<b>BLUE CROSS PROVIDER</b>	<b>NON-CONTRACT PROVIDER</b>
<b>Elective Abortions</b>	80% of contract rate; <b>Deductible Applies</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
Routine Exams for Preventive Health	100% of contract rate; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
<b>WELL BABY/CHILD CARE</b>	100% of contract rate; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
	<b>Charges for immunizations are included in well baby/childcare.</b>	
<b>WELL WOMAN CARE</b>		
<b>Examinations</b>	100% of contract rate; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
<b>Pap Tests</b>	100% of contract rate; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
<b>Mammogram</b>	100% of contract rate; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
<b>CARE FOR ALLERGIES</b>		
<b>Office Visit</b>	100% of contract rate after a \$25 co-pay; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
<b>Testing</b>	80% of contract rate; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
<b>Treatment and Serum</b>	80% of contract rate; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>
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; <b>Deductible Applies</b>	60% of the Covered Expenses; <b>Deductible Applies</b>

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
<b>Prosthetics, Orthopedic Braces, Other Equipment and Supplies</b>	<p>Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office</p> <p>Compression Stockings &amp; Mastectomy Bras – 2 Per Year</p> <p>Wigs (A9282) – 1 per lifetime with a \$500 lifetime maximum</p>	<p>Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office</p> <p>Compression Stockings &amp; Mastectomy Bras – 2 Per Year</p> <p>Wigs (A9282) – 1 per lifetime with a \$500 lifetime maximum</p>
<b>HEARING CARE</b>		
<b>Exam</b>	Plan pays 100% of contract rate	Plan pays 100% of Covered Expenses
<b>Molding</b>	<p>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.</p> <p>1 year old to 14 years old – once a year - \$100 maximum for each molding change.</p>	<p>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.</p> <p>1 year old to 14 years old – once a year - \$100 maximum for each molding change.</p>
<b>Hearing Aid</b>	<p>Plan pays 80% up to a maximum of \$1,500 for each hearing aid device (Left &amp; Right) – including initial batteries.</p> <p>Plan covers one device per ear every four years.</p> <p><i>Retirees are eligible for this benefit only until they reach age 65.</i></p>	<p>Plan pays 80% up to a maximum of \$1,500 for each hearing aid device (Left &amp; Right) – including initial batteries.</p> <p>Plan covers one device per ear every four years.</p> <p><i>Retirees are eligible for this benefit only until they reach age 65.</i></p>
<b>TMJ</b>	80% of contract rate; <b>Deductible Does Not Apply</b>	60% of the Covered Expenses; <b>Deductible Applies</b>

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	<b>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.</b>	
<b>Inpatient</b> <i>(Includes detoxification)</i>	Plan pays 80% of the contract rate; <b>Deductible Applies</b>	Plan pays 60% of the Covered Expenses after a \$500 deductible per hospital admission; <b>Calendar Year Deductible also Applies</b>
<b>Alternate Levels of Care</b> <i>(Includes partial hospitalization, day treatment, and intensive outpatient)</i>	Plan pays 80% of the contract rate; <b>Deductible Applies</b>	Plan pays 60% of Covered Expenses; <b>Deductible Applies</b>
<b>Outpatient</b>	\$25 copayment; <b>Deductible Does Not Apply</b>	<b>Plan pays 60% of Covered Expenses; Deductible Applies</b>
<b>Maximum for all services</b>	<b>All benefits must be authorized by Health Management Companies/(MHN). Call (800) 526-6657.</b>	
<b>Annual Maximum</b>	No annual maximum on Essential Health Benefits	
<b>Mental Health</b>	<b>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.</b>	
<b>Inpatient</b>	Plan pays 80% of the contract rate; <b>Deductible Applies</b>	<b>Plan pays 60% of Covered Expenses after a \$500 deductible per hospital admission; Calendar Year Deductible also Applies</b>
<b>Alternate Levels of Care</b> <i>(Includes partial hospitalization, day treatment, and intensive outpatient)</i>	Plan pays 80% of the contract rate; <b>Deductible Applies</b>	Plan pays 60% of the Covered Expenses; <b>Deductible Applies</b>
<b>Outpatient</b>	\$25 co-pay; <b>Deductible Does Not Apply</b>	Plan pays 60% of the Covered Expenses; <b>Deductible Applies</b>

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Supplemental Accident	<p>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. <b>Deductible Does Not Apply.</b></p> <p>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.</p>	
Prescription Drugs	<b>All prescription Drugs must be obtained at pharmacies contracted with WellDyneRx.</b>	
All Generic Drugs	\$15 Copayment – Retail – 30 days supply* \$30 Copayment – Mail Order – 30 days supply*	
Brand Name Drug on Formulary	\$30 Copayment – Retail – 30 days supply \$60 Copayment – Mail Order – 30 days supply	
Brand Name Drug that is NOT on Formulary	\$55 Copayment – Retail – 30 days supply \$110 Copayment – Mail Order – 30 days supply	
<p><b>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. <i>*No copayment is required for generic oral contraceptives.</i></b></p>		