



## CALIFORNIA IRONWORKERS FIELD WELFARE PLAN Non-Medicare Retiree Fee-For-Service Benefit Summary

**Important: You must pre-certify your hospital confinements.**  
**If you do not pre-certify your hospital stay, the hospital benefits that would usually be payable will be reduced by 10%.**

**Maximum Lifetime Benefit:** \$1,000,000 per person

**Out of Pocket Maximum:** If you use a Contracting Provider, your out-of-pocket maximum expense will be \$2,000.00 per person, per calendar year (*excluding applicable deductibles*). If you use a Non-Contracting Provider, your out-of-pocket maximum expense will be \$3,000.00 per person, per calendar year (*excluding applicable deductibles*). When your applicable out-of-pocket maximum has been reached, benefits will be paid at 100% for the remainder of the calendar year (50% for extended care facility).

For additional information, please contact the Benefits Information Center at (800) 527-4613 x2155.

<u>BENEFIT</u>	<u>CONTRACT PROVIDER</u>	<u>NON-CONTRACT PROVIDER</u>
<b>Calendar Year Deductible</b>	\$250 per person / \$750 per family	\$500 per person / \$1,500 per family
<b>Inpatient Hospital</b>	80% of contract rate Deductible Applies	60% of covered charges plus an additional \$500 deductible; Deductible Applies
<b>Outpatient Hospital</b>	80% of contract rate Deductible Applies	60% of covered charges; Deductible Applies <b>Facility maximum benefit of \$1,500</b>
<b>Chiropractor/Acupuncture</b>	80% of contract rate up to a maximum benefit of \$2,000 per calendar year Deductible Applies	60% of covered charges up to a maximum benefit of \$2,000 per calendar year Deductible Applies
<b>Outpatient Therapy (Physical &amp; Respiratory)</b>	80% of contract rate up to a maximum benefit of \$2,000 per calendar year Deductible Applies	60% of covered charges up to a maximum benefit of \$2,000 per calendar year Deductible Applies
<b>Routine Physical and Female Care</b>	80% of contract rate up to a maximum benefit of \$300 per calendar year Deductible Applies	60% of covered charges up to a maximum benefit of \$300 per calendar year Deductible Applies
<b>Well Baby Care</b>	80% of contract rate up to a maximum benefit of \$600 per calendar year Deductible Applies	60% of covered charges up to a maximum \$600 per calendar year Deductible Applies
<b>Emergency Ambulance</b>	80% of covered charges Deductible Applies	80% of covered charges Deductible Applies
<b>Anesthesia, Home Health Care, Hospital Visits, Medical Supplies, Office Visits, Lab, Orthopedic Braces, Prosthetic Appliances, Surgery and X-ray</b>	80% of contract rate Deductible Applies	60% of covered charges Deductible Applies
<b>Extended Care Facility</b>	40% of covered charges; 55 days per period of disability; minimum 5 day inpatient hospital stay required prior to admission; must be readmitted within 7 days of discharge.	30% of covered charges; 55 days per period of disability; minimum 5 day inpatient hospital stay required prior to admission; must be readmitted within 7 days of discharge

**BENEFIT****CONTRACT PROVIDER****NON-CONTRACT PROVIDER**

**Prescription Drug Benefit  
EnvisionRxOptions**

**Walk In Retail Benefits  
Generic**

\$10 co-payment per prescription  
30-day supply maximum

\*All Prescriptions must be provided through a  
EnvisionRxOptions Retail Pharmacy or  
Orchard Mail Order in order for benefits to be  
covered.

**Formulary Brand Name**

\$20 co-payment per prescription; 30-day  
supply maximum – *Generic Availability:  
you may have a higher co-payment if you  
elect to take the Brand Name of if your  
Physician does not allow generic substitution.*

See Above\*

**Non- Formulary Brand Name**

\$40 co-payment per prescription; 30-day  
supply maximum – \$20 co-payment for  
*three month grace period for non-  
formulary drugs. \$40 co-payment if not  
changed to formulary brand name in the  
4<sup>th</sup> month.*

See Above\*

**Mail Order Benefits  
Generic**

\$20 co-payment per prescription  
90-day supply maximum

See Above\*

**Formulary Brand Name**

\$40 co-payment per prescription; 90-day  
supply maximum – *Generic Availability:  
you may have a higher co-payment if you  
elect to take the Brand Name of if your  
Physician does not allow generic substitution.*

See Above\*

**Non-Formulary Brand Name**

\$80 co-payment per prescription; 90-day  
supply maximum – \$40 co-payment for  
*three month grace period for non-  
formulary drugs. \$80 co-payment if not  
changed to formulary brand name in the  
4<sup>th</sup> month.*

See Above\*

**Supplemental Accident  
Benefit**

80% of contract rate

80% of covered charges incurred within 90-  
days of an accident up to a maximum  
payment of \$320 per accident

**Hearing Care  
Exam**

100% of covered charges up to a benefit  
maximum per calendar year of \$100.00

100% of covered charges up to a benefit  
maximum per calendar year of \$100.00

**Hearing Aid Benefit**

100% of covered charges up to a benefit  
maximum of \$2,000.00 per device; one  
device per ear, once every 3 years to date

100% of covered charges up to a benefit  
maximum of \$2,000.00 per device; one device  
per ear, once every 3 years to date.

**Mental & Nervous Disorders**

Not Covered

Not Covered

**Vision Care Benefits\*\*  
Vision Service Plan**

\$25 co-payment; Vision exam once per  
year; one pair of lenses every 12 months;  
**one pair of frames every 24 months**

**No Out-of-Network Coverage**

**Spectera Vision**

\$10 co-payment; Vision exam once per  
year; one pair of lenses every 12 months;  
**one pair of frames every 24 months**

**No Out-of-Network Coverage**

**\*\* Vision Care Benefits must be elected at the time of retirement and an additional monthly premium applies.**