

MEDICARE RETIREE FEE-FOR-SERVICE BENEFIT SUMMARY

The following comparison is **only a summary** of the major features of the Plan. Not all exclusions and limitations have been included.

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%.

COMPREHENSIVE MAJOR MEDICAL BENEFIT COVERAGE EFFECTIVE JANUARY 1, 2011

Maximum Lifetime Benefit: Not Applicable

Co-Payment Limit: If you use a Contracting Provider, your out-of-pocket maximum expense will be \$600.00 per person per calendar year. If you use a Non-Contracting Provider, your out-of-pocket maximum expense will be \$1,800 per person per calendar year. When your applicable co-payment limit is reached, benefits will be paid at 100% for the remainder of the calendar year. **All benefits for Medicare Participants are paid secondary to Medicare upon receipt of a Medicare Explanation of Benefits (EOB).**

For more information, please contact the Trust Fund Benefits Information Center at (800) 527-4613

IRONWORKERS FEE FOR SERVICE PLAN MEDICARE RETIREE BENEFITS

	Fee For Service Plan Contracted Provider Benefits	Fee For Service Plan Non-Contracted Provider Benefits
Choice of Providers	Participants must utilize an Anthem / Blue Cross Contracted Provider in California and a First Health Network Provider in all other states	The following benefits will be applicable if a contracted provider is not utilized
Calendar Year Deductible	Not Applicable	Not Applicable
Lifetime Maximum	Not Applicable	Not Applicable
Annual Out of Pocket Maximum	\$600 per person	\$1,800 per person
Inpatient Hospital	\$250 co-payment per admit	60% of the covered charges per admit
Emergency Room	90% of the allowable amount after a \$100 co-payment (<i>waived if patient is admitted</i>)	90% of the covered charges after a \$100 co-payment (<i>waived if patient is admitted</i>)
Ambulance Service	90% of the allowable amount after a \$50 co-payment	90% of the covered charges after a \$50 co-payment
Physician Office Visits	90% of the allowable amount after a \$20 co-payment	60% of the covered charges after a \$20 co-payment
Physician Home Visits	90% of the allowable amount after a \$20 co-payment	60% of the covered charges after a \$20 co-payment
Skilled Nursing Facility	45% of the allowable amount up to a maximum benefit of 55 days per calendar year	35% of the covered charges up to a maximum 55 days per calendar year
Home Health Care	90% of the allowable amount	60% of the covered charges
X-ray and Lab Services	90% of the allowable amount	60% of the covered charges
Outpatient Surgery	90% of the allowable amount	60% of the covered charges
Podiatry Exam	90% of the allowable amount after a \$20 co-payment	60% of the covered charges after a \$20 co-payment
Orthotics	90% of the allowable amount	Not Covered
Chiropractic	90% of the allowable amount	60% of the covered charges
Acupuncture	90% of the allowable amount	60% of the covered charges
Outpatient Physical, Respiratory and Speech Therapy	90% of the allowable amount	60% of the covered charges
Routine Preventative Care Exams	100% of the allowable amount with no maximum calendar year benefit	60% of the covered charges up to a maximum calendar year benefit of \$300
Periodic Female Care	100% of the allowable amount with no maximum calendar year benefit	60% of the covered charges up to a maximum calendar year benefit of \$300
Immunizations	100% of the allowable amount	60% of the covered charges
Substance Abuse	Not Covered	Not Covered

Mental Health	Not Covered	Not Covered
Durable Medical Equipment	90% of the allowable amount	60% of the covered charges
<u>Care for Allergies</u>		
Office Visit (including testing)	90% of the allowable amount after a \$20 co-payment	60% of covered charges after a \$20 co-payment
Treatment and Serum	90% of the allowable amount	60% of the covered charges
<u>Hearing Care</u>		
Hearing Exam	90% of the allowable amount after a \$20 co-payment	90% of the covered charges after a \$20 co-payment
Hearing Aids	90% of the allowable amount up to a maximum benefit of \$2,000 per device every 3 years from the last date of purchase	60% of the covered charges up to a maximum benefit of \$2,000 per device every 3 years from the last date of purchase
<u>Prescription Drug Benefits</u> <i>*Prior to Coverage Gap</i>	All prescription drugs must be obtained through a participating EnvisionRx pharmacy or Orchard mail order service	There is no out of network coverage for prescription drugs
<u>Walk In Retail</u>	<i>Walk in retail co-payments below are for a 34-day supply</i>	
Preferred Generic	\$5 co-payment	
Non-Preferred Generic	\$5 co-payment	
Preferred Brand Name	\$20 co-payment	
Non-Preferred Brand Name	\$40 co-payment	
Specialty Drugs	\$40 co-payment	
<u>Orchard Mail Order</u>	<i>Mail order co-payments below are for up to a 90-day supply</i>	
Preferred Generic	\$13 co-payment	
Non-Preferred Generic	\$13 co-payment	
Preferred Brand Name	\$40 co-payment	
Non-Preferred Brand Name	\$80 co-payment	
Specialty Drugs	\$80 co-payment	
<i>EnvisionRx Customer Service (800) 361-4542</i>	<i>*This year, the prescription benefit plan does include a coverage gap. A change in co-payment will occur once your total yearly drug costs reach \$2,840. Once you have reached this point, your co-payment amounts will change until your yearly out of pocket drug costs reach \$4,550. Coverage gap co-payment will be as follows:</i>	
<i>Orchard Mail Order Customer Service (866) 909-5170</i>		
<u>Walk In Retail</u>		
Preferred Generic	\$5 co-payment	There is no out of network coverage for prescription drugs
Non-Preferred Generic	\$5 co-payment	
Preferred Brand Name	\$40 co-payment (\$20 after POS Rebate)	
Non-Preferred Brand Name	\$80 co-payment (\$40 after POS Rebate)	
Specialty Drugs	\$80 co-payment (\$40 after POS Rebate)	
<u>Orchard Mail Order</u>		
Preferred Generic	\$13 co-payment	
Non-Preferred Generic	\$13 co-payment	
Preferred Brand Name	\$80 co-payment (\$40 after POS Rebate)	
Non-Preferred Brand Name	\$160 co-payment (\$80 after POS Rebate)	
Specialty Drugs	\$160 co-payment (\$80 after POS Rebate)	
Generics(Including brand drugs treated as generic)	After your yearly out of pocket drug costs reach \$4,550, you will pay the greater of:	
All other drugs	\$2.50 co-payment or 5%	
	\$6.30 co-payment or 5%	