CALIFORINIA 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%.

COMPREHENSIVE MAJOR MEDICAL BENEFITS EFFECTIVE JANUARY 1, 2007:

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 $1,000.00 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 Claims Department at (800) 527-4613 x2155.

BENEFIT	CONTRACT PROVIDER	NON-CONTRACT PROVIDER
Calendar Year Deductible	$250 per person / $750 per family	$500 per person / $1,500 per family
Inpatient Hospital	80% of contract rate	60% of covered charges plus an additional $500 deductible
Outpatient Hospital	80% of contract rate	60% of covered charges Facility maximum benefit of $1,500
Chiropractor/Acupuncture	80% of contract rate up to a maximum benefit of $2,000 per calendar year	60% of covered charges up to a maximum benefit of $2,000 per calendar year
Outpatient Therapy (Physical & Respiratory)	80% of contract rate up to a maximum benefit of $2,000 per calendar year	60% of covered charges up to a maximum benefit of $2,000 per calendar year
Routine Physical and Female Care	80% of contract rate up to a maximum benefit of $300 per calendar year	60% of covered charges up to a maximum benefit of $300 per calendar year
Well Baby Care	80% of contract rate up to a maximum benefit of $600 per calendar year	60% of covered charges up to a maximum $600 per calendar year
Ambulance	80% of UCR	80% of UCR
Anesthesia, Home Health Care, Hospital Visits, Medical Supplies, Office Visits, Orthopedic Braces, Prosthetic Appliances, Surgery and X-ray/ Laboratory Services	80% of contract rate	80% of covered charges
Extended Care Facility	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 **Prescription Solutions Network**		
Walk In Pharmacy Benefits **Generic**	$5 co-payment per prescription 30-day supply maximum	*All Prescriptions must be provided through a Prescription Solutions Retail Pharmacy or a Prescription Solutions Mail Order Pharmacy in order for benefits to be covered.
Preferred Brand *Please refer to Formulary*	$20 co-payment per prescription; 30-day supply maximum – *Generic Availability: $30 co-payment if you elect to take the Brand Name or if your Physician does not allow generic substitution.*	See Above*
Non-Preferred Brand *Brand Name drugs not included on Formulary*	$30 co-payment per prescription; 30-day supply maximum – *Generic Availability: $40 co-payment if you elect to take the Brand Name of if your Physician does not allow generic substitution.*	See Above*
Mail Order Benefits **Generic**	$10 co-payment per prescription 90-day supply maximum	See Above*
Preferred Brand *Please refer to Formulary*	$20 co-payment per prescription; 90-day supply maximum – *Generic Availability: $30 co-payment if you elect to take the Brand Name or if your Physician does not allow generic substitution*	See Above*
Non-Preferred Brand *Brand Name drugs not included on Formulary*	$30 co-payment per prescription; 90-day supply maximum – *Generic Availability: $40 co-payment if you elect to take the Brand Name or if your Physician does not allow generic substitution.*	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	Not Covered *(must use a VSP Provider)*
Spectera Vision	$10 co-payment; Vision exam once per year; one pair of lenses every 12 months; one	Not Covered *(must use a Spectera Provider)*

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