

IUOE LOCAL 4 HEALTH & WELFARE BENEFIT SUMMARY

The following chart updates the benefits listed in your Summary Plan Description (SPD) as of January 1, 2011. The page numbers on the left reference the page in the 2005 published version of your SPD or the HealthLine where you can get more information about the benefit. (These page numbers do not correspond to the page numbers in the on-line version of the SPD). Full benefits can be viewed on the Fund's web site at www.local4funds.org.

Plan Specifics		YOUR COST IN NETWORK	YOUR COST OUT OF NETWORK
Calendar Year Deductible CYD		\$300 per participant/\$600 per family	
Calendar Year Out-of- Pocket Maximum (includes deductible)		\$5000 per participant or family	\$5000 plus amounts above 80% coinsurance per participant or family
SPD PAGE	COVERED SERVICES	YOUR COST IN NETWORK	YOUR COST OUT OF NETWORK
	OUTPATIENT CARE		
Page 24	Ambulance	10% after CYD	30% after CYD/10% CYD if emergency
HealthLine 12/08	Colonoscopy- for Routine Screening (after age 50)	10%	30% after CYD
HealthLine 12/08	Delta Dental- for Basic Rule eligibles Type 1 - Diagnostic & Preventive Type 2 - Basic Restorative Type 3 - Major Restorative Type 4 - Orthodontic \$2500 calendar year limit per patient, \$2000 Ortho limit to age 19 only Rollover max available- see details	Delta PPO Delta Premier Out of Network 0% 20% 20% 20% 20% 20% 40% 40% 40% 50% 50% 50%	
Page 40	Diabetic Supplies - use mail service or CVS retail	Caremark Mail Service co-pays, see below	
Page 28	Diagnostic X-ray or Lab Tests	\$10 in office or freestanding lab, 10% hospital based	30% after CYD
Page 32	Durable Medical Equipment - includes oxygen, prosthetics, other equipment	10% after CYD to \$5000 annual, then 50%	30% after CYD to \$5000 annual, then 50%
Page 23	Emergency Room- MD and Facility	10% after CYD	30% after CYD, or 10% CYD if medical emergency admit
HealthLine 12/07	Fitness Benefit- \$150 paid towards cost of gym, weight watchers or hospital based diet program. One of each type of program reimbursed per family per year.(gym or weight/diet)	Balance after \$150 for each of the 2 types of programs per family per year: gym or weight/diet	
Page 32	Holistic Care- includes chiropractic, acupuncture, therapeutic massage	\$15 per visit to \$1000 per year	30% after CYD to \$1000 per year
Page 25	Home Health Care, including Hospice	10% after CYD	30% after CYD

SPD PAGE	COVERED SERVICES	YOUR COST IN NETWORK	YOUR COST OUT OF NETWORK
Page 23	Hospital Outpatient Care - includes OP Surgery/ non-routine colonoscopy	10% after CYD	30% after CYD
Page 33	Mental Health Counseling - Visits in excess of 15 may be borrowed from lifetime inpatient days if MAP criteria are met. Contact MAP for information.	\$15 per visit office or 10% after CYD facility to 15 visit annual limit	30% after CYD to 15 visit annual limit
Page 26	Office Visits	\$15 per visit	30% after CYD
Page 31	Physical Therapy - as long as medically necessary	\$15 office or rehab hospital or 10% CYD acute hospital	30% after CYD
Page 40	Prescription Drugs - Basic Rule (Stop Smoking meds at no co-pay)	\$10-\$20-\$40 for 30 day supply at retail \$20-\$40-\$80 for 90 day supply at mail	
Page 40	Prescription Drugs - Supplemental Rule (Stop Smoking meds at no co-pay)	\$20-\$40-\$80 after \$250/\$500 RX CYD for 30 day supply at retail \$40-\$80-\$160 after \$250/\$500 RX CYD for 90 day supply at mail	
Page 26	Routine Physical - by schedule for child or annually for adults	\$15 per visit \$10 lab fee	30% after CYD
Page 27	Routine GYN - annually	\$15 per visit \$10 lab fee	30% after CYD
Page 29	Routine Mammogram - annually	\$10 Imaging fee \$10 Radiologist fee	30% after CYD
Page 58	Routine Vision thru Davis Vision providers- annually	Limited out of pocket if extras purchased on lenses	Limited coverage
Page 29	Scans - CT, MRI, PET Hospital based (except Maine) Free Standing sites in MA Hospital based in Maine Shields Health Care Group MA Free Standing Sites outside MA	10% after CYD 10% after CYD 10% no deductible No cost No cost	30% after CYD
Page 26	Surgery	\$15 in office or 10% CYD facility	30% after CYD
	INPATIENT CARE		
Page 22	Inpatient admission (including maternity) at acute care hospital	10% after CYD	30% after CYD
Page 24	Inpatient Rehab or Skilled Nursing Facility Care - to 100 days per admission	10% after CYD	30% after CYD
Page 33	Inpatient Mental Health - to 60 day lifetime limit. MAP auth required	10% after CYD	Not covered
Page 33	Inpatient Substance Abuse - 2 admits per lifetime. MAP auth required	10%	Not covered
Page 27	Inpatient Physician Care	10% after CYD	30% after CYD
	NOT COVERED		
Page 36, 44, 46, 57, 61	What the Medical, Prescription, Dental, Hearing, and Vision Plans Do Not Cover	See detailed list in each section of SPD	