

# IUOE Local 4 Health & Welfare **Benefit Summary**

The following chart updates the benefits listed in your Summary Plan Document (SPD) as of January 1, 2010. The page numbers on the left reference the page in the SPD or the *HealthLine* where you can get more information about the benefit. Full benefits can also be viewed on the Fund's Web site at [www.local4funds.org](http://www.local4funds.org). A new SPD will be issued this summer.

## YOUR HEALTH BENEFITS

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)		\$5,000 per participant or per family		
SPD PAGE	COVERED SERVICES	YOUR COST IN NETWORK		YOUR COST OUT OF NETWORK
<b>OUTPATIENT CARE</b>				
Page 24	<b>Ambulance</b>	10% after CYD		30% after CYD, or 10% CYD if medical emergency
<i>HealthLine</i> 12/08	<b>Colonoscopy</b> —for Routine Screening (after age 50)	10%		30% after CYD
<i>HealthLine</i> 12/08	<b>Delta Dental</b> —for Basic Rule eligibles	Delta PPO	Delta Premier	Out of Network
	Type 1—Diagnostic & Preventive	0%	20%	20%
	Type 2—Basic Restorative	20%	20%	20%
	Type 3—Major Restorative	40%	40%	40%
	Type 4—Orthodontic	50%	50%	50%
	\$2,500 calendar year limit per patient, \$2,000 Ortho limit to age 19 only Rollover max available—see details	Balances are less with Delta PPO providers, followed by Delta Premier providers.		
Page 40	<b>Diabetic Supplies</b> —use mail service or CVS retail	Caremark Mail Service copays, see below		
Page 28	<b>Diagnostic X-ray or Lab Tests</b>	\$10 in office or freestanding lab, 10% hospital-based		30% after CYD
Page 32	<b>Durable Medical Equipment</b> —includes oxygen, prosthetics, other equipment	10% after CYD to \$5,000 per calendar year, then 50%		30% after CYD to \$5,000 per calendar year, then 50%
Page 23	<b>Emergency Room</b> —MD and facility	10% after CYD		30% after CYD, or 10% CYD if medical emergency admit
<i>HealthLine</i> 12/07	<b>Fitness Benefit</b> —\$150 paid toward cost of gym, Weight Watchers, or hospital-based diet program. One of each type of program reimbursed per family per calendar year: gym or weight/diet.	Balance after \$150 for each of the two types of programs per family per calendar year: gym or weight/diet		
Page 32	<b>Holistic Care</b> —includes chiropractic, acupuncture, therapeutic massage	\$15 per visit to \$1,000 per calendar year		30% after CYD to \$1,000 per calendar year
Page 25	<b>Home Health Care</b> , including hospice	10% after CYD		30% after CYD
Page 23	<b>Hospital Outpatient Care</b> —includes OP surgery/non-routine colonoscopy	10% after CYD		30% after CYD
Page 33	<b>Mental Health Counseling</b> —Visits in excess of 15 may be borrowed from lifetime inpatient days if MAP criteria are met. Contact MAP for information.	\$15 per office visit or 10% after CYD per facility visit to 15-visit calendar year limit		30% after CYD to 15-visit calendar year limit

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**YOUR HEALTH BENEFITS** *Continued from front*

SPD PAGE	COVERED SERVICES	YOUR COST IN NETWORK	YOUR COST OUT OF NETWORK
<b>OUTPATIENT CARE</b>			
Page 26	<b>Office Visits</b>	\$15 per visit	30% after CYD
Page 31	<b>Physical Therapy</b> —as long as medically necessary	\$15 office or rehab hospital or 10% CYD acute hospital	30% after CYD
Page 40	<b>Prescription Drugs—Basic Rule</b> (Stop-smoking meds at no copay)	\$10-\$20-\$40 for 30-day supply at retail \$20-\$40-\$80 for 90-day supply at mail	
Page 40	<b>Prescription Drugs—Supplemental Rule</b> (Stop-smoking meds at no copay)	\$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	<b>Routine Physical</b> —by schedule for children or annually for adults	\$15 per visit \$10 lab fee	30% after CYD
Page 27	<b>Routine GYN</b> —annually	\$15 per visit \$10 lab fee	30% after CYD
Page 29	<b>Routine Mammogram</b> —annually	\$10 Imaging fee \$10 Radiologist fee	30% after CYD
Page 58	<b>Routine Vision</b> thru Davis Vision providers—annually	Limited out-of-pocket if extras purchased on lenses	Limited coverage
Page 29	<b>Scans—CT, MRI, PET</b>	10% after CYD	30% after CYD
Page 26	<b>Surgery</b>	\$15 in office or 10% CYD facility	30% after CYD
<b>INPATIENT CARE</b>			
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 authorization required	10% after CYD	Not covered
Page 33	Inpatient Substance Abuse—to lesser of \$7,500 or two admits per lifetime, MAP authorization required	10%	Not covered
Page 27	Inpatient Physician Care	10% after CYD	30% after CYD
<b>NOT COVERED</b>			
Pages 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	