LOCAL 731, I.B. OF T. WELFARE FUNDS

1000 Burr Ridge Parkway, Suite 301 ▪ Burr Ridge, IL 60527 ▪ (630) 887-4150 ▪ Fax (630) 887-4155

BENEFIT SUMMARY - ACTIVE MEMBERS ONLY
EFFECTIVE JANUARY 1, 2017

Life Insurance $25,000 per Member

AD&D $10,000 per Member / $2,000 per Dependent

Disability Benefit $400 per Week, Maximum of 26 weeks
Benefit begins on 1st day for Non-Occupational Accidental Injury OR on 8th day for an Illness

Medical
Annual Deductible: $400 per person
Annual Family Deductible: $1,200
Annual Out-Of Pocket Maximum (Including Deductible): $3,400 per person / $7,200 per family
Benefit Payment Levels: BCBS PPO*: Plan pays at 80% NON-PPO**: Plan pays at 70%
(BASED ON MEDICALLY NECESSARY COVERED BENEFITS ONLY – SOME EXCLUSIONS APPLY)

Hospital Benefits (In-Patient)
PRECERT REQUIRED - Paid at PPO* or NON-PPO** benefit levels.

Outpatient Surgery
PRECERT REQUIRED – Surgical Facilities in the BCBS PPO* network Paid at 80%.
NON-PPO Surgical Facilities are ***NOT*** covered.

Infertility
PRECERT REQUIRED (for related injectables and reproduction procedures only) – Paid at PPO* or NON-PPO** benefit levels, with a Maximum of $10,000 per Lifetime for all services related to infertility – Out of Pocket Maximum does not apply

Wellness Physicals (Member and Spouse)
Deductible is waived. Includes all related labs and x-rays. BCBS PPO: Plan pays 100% - Non-PPO**: Plan pays 70%

Child Wellness Benefit
Deductible is waived. Includes all related labs, immunizations and x-rays – PPO & NON-PPO: Paid at 100%

Other Office Visits, Labs, Diagnostic Testing…
Paid at PPO* or NON-PPO** benefit levels. Some services may require Pre-Cert. Please check with Fund Office.

Diagnostic Imaging (CAT Scan/MRI/PET Scan) by an Absolute Solutions Provider
To be Paid at 100% - Patient MUST schedule through Absolute Solutions (1-800-321-5040) – NOT affiliated with Blue Cross Blue Shield.

Hearing Aid Benefit
Call EPIC Hearing (866-956-5400) for preferred arrangement. Plan pays 100% up to $750 every 36 months - Deductible waived

Home Health Care
PRECERT REQUIRED – No limit – Paid at PPO* or NON-PPO** benefit levels.

Hospice Care
Paid at 100% - Lifetime Maximum: Inpatient 30 days / Home Hospice 62 days – Deductible is waived

Chiropractic Care
Paid at PPO* or NON-PPO** benefit levels with a Maximum of 25 treatments per calendar year.

Member Assistance Program (MAP)
Call 1-800-292-2780 for any substance abuse, chemical dependency, mental health, or any emotional issue.

Mental Health
All services Paid at PPO* or NON-PPO** benefit levels
PRECERT REQUIRED for Inpatient, Partial and Intensive Outpatient

PLEASE NOTE: The Board of Trustees may improve or reduce benefits at any time. Please refer to the Fund Office website at www.ibt731funds.org or contact the Fund Office at 630-887-4150.

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Substance Abuse
All services Paid at PPO* or NON-PPO** benefit levels.
PRECERT REQUIRED for Inpatient, Partial and Intensive Outpatient. Must complete full course of treatment.

TMJ Benefit
Maximum therapy visits per Calendar Year: 20 – Paid at PPO* or NON-PPO** benefit levels

Sleep Apnea
Sleep Apnea Device maximum coverage: $1,500 per C-Pap device and $2,000 per Bi-Pap device – PRECERT REQUIRED
Sleep Study and Sleep Apnea Devices & Supplies covered at 100% when negotiated and Pre-Certified by Med-Care Management.

Durable Medical Equipment (DME)
Paid at PPO* or NON-PPO** benefit levels. Based on Medical Necessity. PRECERT REQUIRED for all DME over $500 or $250 penalty.

Prosthetics / Appliances
Paid at PPO* or NON-PPO** benefit levels – PRECERT REQUIRED.

Prescription Drug Benefit – OptumRx

Up to 100-day Supply (Participating Pharmacy) Co-Payments
Generic: Greater of $7 or 20% of discounted price (Not to exceed the cost of the drug)
Formulary Brand Name: 20% of discounted price
Non-Formulary Brand Name: 40% of discounted price
(If Generic is available, co-payment is that of the Generic PLUS the difference between the cost of the Generic and the cost of the Brand Name)

100-day Supply (OptumRx Home Delivery) Co-Payments
Generic: $15 Formulary Brand Name: $45 Non-Formulary Brand Name: $95
Out of Pocket Maximum for prescriptions: $3,200 per person / $6,000 per family

STEP THERAPY REQUIREMENT
Step 1 Drugs – Patient must try generic drugs first
Step 2 Drugs – Brand-Name drugs
If you've already tried a Step 1 drug, or your doctor decides one of these drugs isn't appropriate for you, then Your doctor can prescribe a Step 2 drug. Ask your doctor to call 1-800-626-0072 and request a "prior authorization".
If prior authorization is not given, you will have to pay the full price of the drug.

Dental – Delta Dental
Annual Deductible: $25 per family – Annual Maximum $2,000 per calendar year
Diagnostic and Preventative Care: Maximum of 2 per calendar year – Deductible Waived
(For dependent children under age 19, Diagnostic and Preventative Care is in addition to Annual Maximum of $2,000 – 2 visit limit does apply)
Three Benefit Levels: PPO, Premier, Non-Contracted.
PPO covers 100% on diagnostic and preventative, Premier and Non-Contracted covers 80% on diagnostic and preventative.
PPO covers 80% for all other services, and Premier and Non-Contracted covers 80% of U&C for all other services.
(Premier providers will waive amount above U&C – Non-Contracted providers will not.)
To locate a Delta Dental provider, request Dental claim forms, or to check Dental claim status, call 1-800-323-1743.

Orthodontia – Delta Dental
Plan Pays up to $4,000 per person / per lifetime – No deductible – No age limit – Also follows Delta Benefit Levels.

Appeals
You have the right to appeal any determination made by the Fund. Please refer to the Summary Plan Description (SPD) or call the Fund office at 630-887-4150 for more information.

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Vision Benefit – VSP

In-Network covers 1 exam Every Calendar Year ***and***
EITHER $300 towards Contact Lenses and Contact Lens Fitting and Evaluation Fees Every Other Calendar Year
OR Prescription Glasses: Single Vision, Lined Bifocal, Lined Trifocal or Progressive Lenses (Lens options additional cost) *plus* $200 allowance for Frame Every Other Calendar Year.
Out-Of-Network covers $300 for **ALL** services (Applies to Exam, lenses, lens options, frame, contact lenses and contact lens fitting and evaluation fees) Every Other Calendar Year.
ALL Vision claims must go through VSP, whether In-Network or Out-Of-Network – The Fund Office cannot pay vision claims in-house, or forward receipts to VSP on the members behalf, as Out-Of-Network claims MUST be submitted to VSP with a signed claim form and copies of the Fully Itemized, Paid in Full receipts.
Members cannot utilize both In-Network and Out-Of-Network services during the same benefit period.
For all dependent children under age 19, there is no limit on routine spectacle exams nor are they included in their $300 Out-Of-Network allowance.
For all vision inquiries, please contact VSP at 1(800)877-7195.

Benefit Providers

Medical Coverage: Blue Cross / Blue Shield of Illinois
Telephone No: 800-810-2583 – *To locate PPO providers only (Contact the Fund Office for Benefit & Eligibility information)*
www.bcbsil.com
Claims Status Tel.: 630-920-1939

Medical Pre-certification: Med-Care Management
Telephone No.: 800-367-1934

Prescription Drug Plan: OptumRx (Formerly known as Catamaran)
Telephone No.: 800-880-1188
www.mycatamaranrx.com

Dental Plan Provider: Delta Dental of Illinois
Telephone No.: 800-323-1743
www.deltadentalil.com

Vision Plan: VSP
Telephone No.: 800-877-7195
www.vsp.com

Imaging Provider (CAT Scan/MRI/PET Scan): Absolute Solutions
Telephone No.: 800-321-5040
www.absolutedx.com

Hearing Aid Benefit Provider: Epic Hearing
Telephone No.: 866-956-5400
www.epichearing.com

Sleep Apnea / Equipment Coordinator (Pre-Cert Required): Med-Care Management
Telephone No.: 800-367-1934

Member Assistance Program: Employee Resource Systems, Inc.
Telephone No.: 800-292-2780
www.ers-eap.com (User Name: ibt731 / Password: teamsters)

Wellness Program: Interactive Health
Telephone No.: 800-840-6100
https://myinteractivehealth.com

To obtain information concerning benefits not listed in this summary, kindly contact the Benefit Fund Office.