Your Medical Benefits

The Plan offers comprehensive health care coverage to help you and your family stay healthy. This coverage can provide financial protection against catastrophic health care bills. In addition, this benefit includes certain management provisions to help control costs and for the review as to whether the services you receive are appropriate. You and your family are also eligible for certain home health care benefits and an annual check-up to ensure your good health.

FAST FACTS:

- You save money when you use a participating provider from the PPO Network.
- You must use the Hospital Pre-Admission Certification Program (PAC) if your physician recommends a hospital stay.
- The Second Surgical Opinion option is covered at 100%.
- Modern Assistance Program can help you or your family with personal problems, drug and alcohol counseling, stress, and financial problems.
- Medical benefit coverage is for those services that are Medically Necessary.

Benefit Management Provisions

Your medical plan contains certain Benefit Management Provisions to help control the cost of health care benefits, but also to review whether the health services you receive are appropriate. The key features of the Benefit Management Provisions are:

- Preferred Provider Organization
- Hospital Pre-Admission Certification
- Second Surgical Opinion
- Modern Assistance Program (MAP)

You must follow the requirements of utilization review, pre-admission review, discharge planning, individual case management and tiered (or step) therapies. If you do not do so, your benefits involving these programs may be reduced or denied. Specifically, you may still be responsible for the difference between any allowed charge, as determined by these programs, and the provider's actual charge.

How to Use Your Medical Benefits

Simply present your ID card when you visit a provider so that the provider knows the correct location to contact for information, to bill, to pre-certify, etc. Certain services must be pre-certified in order to receive coverage. If you visit an out-of-network provider, you may have to file a claim to receive reimbursement.

How Your Coverage Works

While you must meet your annual deductible in order for the Plan to pay for some services, the Plan may pay for some services before you do so.

Annual Deductible

The annual deductible is the dollar amount you pay each year before the Plan pays benefits. The annual deductible for individual coverage is $300 per calendar year. The annual deductible for family coverage is $600 per calendar year. Your deductible does not count toward your out-of-pocket maximum.

Carryover Deducible

If you incur expenses in the last three months of the calendar year toward your deductible, in part or in full, the amount will be "carried over" to reduce the deductible for the following calendar year.

Family Deductible

Once the deductible amount per family has been satisfied by a combination of any number of covered family members in a calendar year, no further deductible will be required for the rest of that calendar year.

Do not Forget Your ID Card

It's important to present your Identification Card (ID Card) to medical care providers at the time of service, especially if you use the PPO. Your ID Card will identify you as a member of the Tufts CareLink and Cigna PPO, so providers will know the location to contact for information regarding pre-certification, billing, etc.

Coinsurance and Out-of-Pocket

Once you meet your annual deductible, you and the Plan share in the cost of your medical expenses. For most services, you pay a percentage and the Plan pays a percentage. For example, in the Active Plan, you pay 10% and the Plan pays 90% of the costs when you visit a provider who participates in the PPO network. This is called your "coinsurance."

Your coinsurance payments for most services count toward the out-of-pocket maximum. If your in-network coinsurance totals $1,500 per individual or $3,000 per family, you have reached the out-of-pocket maximum for that calendar year and the Plan will pay 100% of your eligible medical expenses for the remainder of the calendar year.

However, your deductible, copayments, amounts over maximums and any penalties do not count toward your out-of-pocket maximum.

Preferred Provider Organization (PPO)

The Plan offers benefits from a network of doctors and hospitals through Tufts CareLink and Cigna. A PPO network of physicians and hospitals agree to charge a negotiated dollar amount for medical services. You and your family always have the final say in determining which doctors and hospitals you select. When you use a PPO network provider, you save money for yourself and the Plan. If you select a non-participating provider, your out-of-pocket costs will be higher. To find out whether or not a certain provider participates in the PPO network, visit the online Provider Directory at **www.tuftshealthplan.com/carelink/ironworkers** or call 800-768-4695.

Consult the PPO Provider Directory

Sometimes medical care providers move into and out of the PPO. Check with your provider before making an appointment to verify that he or she participates in the PPO. The PPO Provider Directory is available online: **www.tuftshealthplan.com/carelink/ironworkers**

Non-PPO (or "out-of-network") providers can charge different rates for different services. The Plan will pay for out-of-network services, but at the "Reasonable and Customary" (R&C) rate only. The R&C rate is a "standard" fee charged by health care providers for a particular service in a particular geographic area. Generally, the Plan will pay 60% and you will pay 40% of the R&C rate for out-of-network services, although the amounts vary as indicated in the Schedule of Benefits. If the non-PPO provider charges more than the R&C rate, you must pay the difference between what the plan pays and what the provider charges. This is important to consider when selecting a provider.

The following example compares what Joe would pay if he goes to a PPO provider and a Non-PPO provider for an office visit for a routine illness, such as a sinus infection. For the purposes of this example, assume that Joe is an active employee and has met his deductible.

	PPO Provider	Non-PPO Provider
Office Visit	Joe pays his $20 copayment at the time of his office visit.	Joe's out-of-network doctor requires payment up front; Joe must pay $100 at the time of the visit.
	The plan pays 100% of the PPO provider's charges.	The Reasonable and Customary charge for an office visit in Joe's area is $50.
		Since Joe met his deductible, the Plan pays 60% of the Reasonable and Customary charges of $50, which equals $30.
Claim Forms	Provider files all claims for Joe.	Joe must file his own claim forms and wait for reimbursement.
Joe's Cost	Joe pays only the $20 copayment.	Joe's net cost after reimbursement is $70.

Hospital Pre-Admission Certification

Hospital Pre-Admission Certification (PAC) is a program that helps reduce Plan costs by determining whether a hospital stay is medically necessary. If your physician recommends a hospital stay, you must call the CareAllies unit at its toll-free number 800-768-4695 to obtain this review.

The CareAllies medical professional will consult with your physician, to determine whether hospitalization is medically necessary, or if equally effective treatment can be provided in an alternative setting. After the review, the CareAllies representative will notify you, your physician, and the hospital. If your hospital stay is approved, the CareAllies representative will assign an initial number of approved hospital days.

Make Sure You Know the Plan Rules

If your benefits are reduced because Plan rules were not followed, for example, failure to Pre-Certify a Hospital Admission, that reduction cannot be used to satisfy any deductible under this Plan.

If more days in the hospital are required, the CareAllies representative will discuss the Continued Stay Review process with your physician. If it is agreed that continued hospitalization is medically necessary, additional days will be approved.

Emergency Hospital Admissions

If you or your dependent is admitted to the hospital for an emergency, you, a responsible family member, or the attending physician must call the CareAllies unit at 800-768-4695 within 48 hours of the emergency admission. When the CareAllies representative is notified, he or she will be able to assign an initial number of approved hospital days.

Mental Health or Substance Abuse Disorder Admissions

If your physician recommends a hospital stay, you must call Modern Assistance Programs (MAP) at 617-774-0331 to obtain this review.

Benefit Reductions if Admissions are not Certified

If you or your dependents do not use the Hospital Pre-Admission Certification Program for a hospital stay, and that stay is not retroactively approved, any benefits payable for charges made by the hospital in connection with the stay will be reduced by 10% up to $500.

If you or your dependent does not use the Hospital Pre-Admission Certification Program a second time, and that stay is not retroactively approved, any benefits payable for hospital charges will be reduced by 20% up to $1,000.

Any subsequent stay that is not certified and retroactively approved will also be subject to a 20% reduction not to exceed $1,000 per confinement.

If you or your dependents do not use the Hospital Pre-Admission Certification Program for a hospital stay and it is determined through retroactive review that the services would not have been approved, you (and your dependents, if applicable) will be financially responsible for the charges.

Second Surgical Opinion

A second surgical opinion is an optional program that may help you and your eligible dependents determine whether to have an elective surgery that your doctor recommends.

The Plan will cover 100% of Reasonable and Customary charges for a second surgical opinion provided by a Participating Physician. The only requirement is that you must receive the results of the second surgical opinion physician's findings before deciding on the course of treatment.

What is a Participating Physician?

A Participating (or consulting) physician is a Board Certified physician who is on the Second Opinion Panel, contracted through CareAllies. The physician must be Board Certified in the field of the proposed surgery or in the field of medicine that applies to the medical condition.

The Plan will pay 100% of the Reasonable and Customary charges made for a second opinion consultation, including any additional tests and x-rays that the examining physician may feel are required to complete the second opinion review. If the second surgical opinion does not confirm the need for surgery, you or your dependents may request a third surgical opinion. The Plan will pay 100% of the Reasonable and Customary charges incurred for the third consultation by a Participating Physician.

Expenses Not Covered by Second Surgical Opinion

- Consultation with a non-participating physician;
- More than two consultations in connection with the proposed surgery, after you or your dependent have received an initial recommendation for surgery;
- X-rays and tests not related to the proposed surgery;
- Failure to be examined in person by the physician who is rendering the opinion;
- Failure on the part of the physician to send a written report to Iron Clad;
- Surgery performed by the consulting physician; or
- Any consultation made in connection with an injury or illness that is not covered by this Plan.

Employee Assistance Program (EAP)

EAP services are provided by Modern Assistance Programs (MAP). MAP will help identify and evaluate personal problems, facilitate mental health and substance abuse treatment, or make referrals. After a referral, the EAP counselor will monitor treatment. The services of the EAP are completely confidential and free of charge for you or your eligible dependents while you are a Plan participant.

Contact the EAP by calling 617-774-0331 or by writing to:

Modern Assistance Programs, Inc.
1400 Hancock Street
Second Floor
Quincy, MA 02169