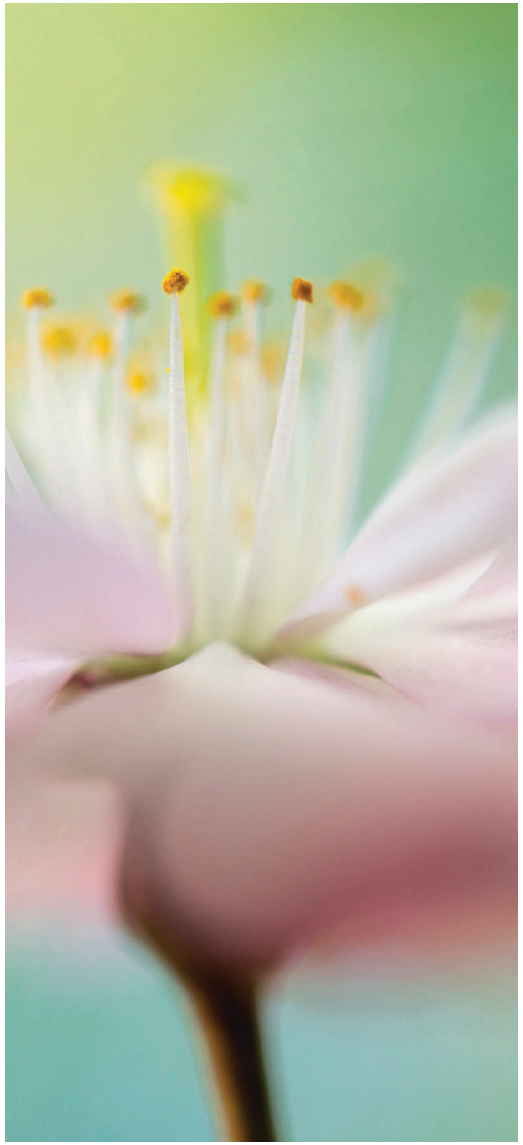
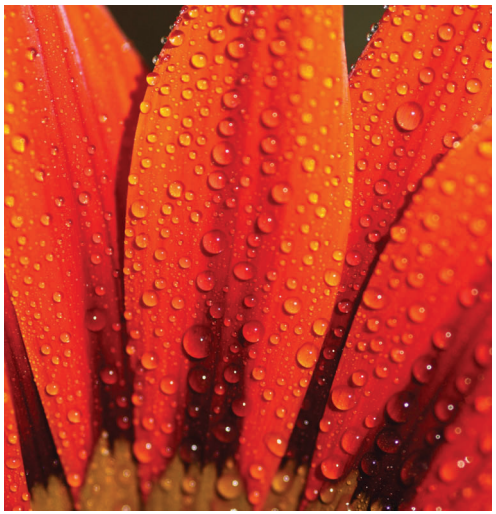
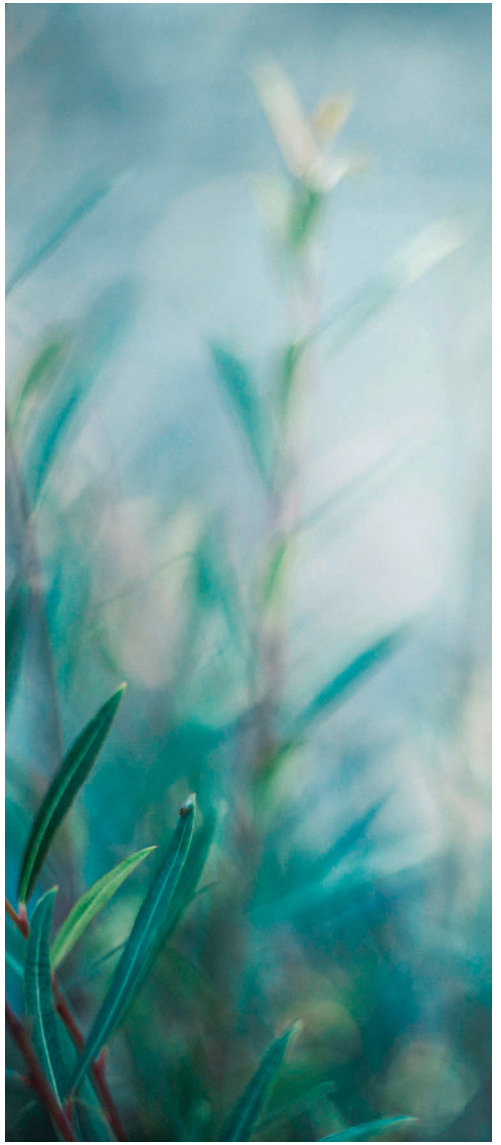
IATSE NATIONAL BENEFIT FUNDS

## Benefits At A Glance

# I.A.T.S.E. NATIONAL HEALTH & WELFARE FUND PLAN C









**If you have questions or want more information about the Plan or a copy of the SPD, please log on to www.iatsenbf.org or call the Fund Office at 212-580-9092 in New York or 800-456-FUND (3863) outside New York.**

# Introduction

It's important to understand that this brochure includes only highlights of Health & Welfare Plan C. Additional information concerning your benefits is included in the Summary Plan Description (SPD) and other related documents, such as insurance contracts and/or certificates of coverage. If there is ever a conflict between this summary and the official Plan documents, the official documents will govern.

The IATSE National Health & Welfare Fund was set up to provide health care benefits to eligible participants. It was established as the result of various collective bargaining agreements between employers and the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts of the United States, its Territories and Canada and its Affiliated Locals. Among other provisions, these agreements require employers to contribute to the Health & Welfare Fund on behalf of employees who are covered by the IATSE National Health & Welfare Fund Plan C (the "Plan" or "Plan C").

This Benefits at a Glance provides a brief overview of the requirements for enrolling in Plan C and the benefits available under the Plan. Plan C benefits include the following:

- **hospital** and **medical** coverage for you and your covered dependents through Empire BlueCross BlueShield
- **prescription drug** benefits for you and your covered dependents through CVS Health
  - in Puerto Rico, **Triple-S** as an alternative to Empire and CVS Health
- **dental benefits** for you and your covered dependents through Delta Dental or, if you live in New York, Administrative Services Only, Inc./Self-Insured Dental Services (ASO/SIDS)
- **vision services** for you and your covered dependents through Davis Vision
- a **Medical Reimbursement Program** for certain unreimbursed medical expenses incurred by "active" Plan C participants and their covered dependents
- a **Retiree-Only Medical Reimbursement Program** for certain unreimbursed medical expenses incurred by participants who are "not active" under Plan C and their covered dependents
- **life insurance** for you through the Metropolitan Life Insurance Company (MetLife)
- a **retiree health benefit plan** for you and your spouse if you meet the eligibility requirements.

# Enrollment

The earliest you can participate in the Health & Welfare Fund Plan C is when you become eligible for what is known as optional enrollment. If you do not enroll at that time, you will have another opportunity to enroll when you become eligible for automatic enrollment. If you waive optional enrollment and fail to choose a coverage option when you become eligible for automatic enrollment, you will be enrolled automatically in the Plan's default option, Plan C-2 single coverage.

## Optional Enrollment

You are entitled to optional enrollment when your CAPP account balance equals the **current monthly charge for Plan C-2 single coverage plus a $150 administrative fee.** When you become eligible for optional enrollment, the Fund Office will send you a Plan C CAPP Statement and Enrollment/Payment Form. If you enroll, your coverage will begin on the first day of the next coverage quarter.

When you become eligible for optional enrollment, you will have the following choices for medical coverage:

- **Plan C-1** (single or family coverage), which provides the highest level of in-network and out-of-network coverage at the highest cost
- **Plan C-2** (single or family coverage), which provides a lower level of in-network and out-of-network coverage at a lower cost than Plan C-1
- **Plan C-3** (single or family coverage), which provides only in-network coverage at a lower cost than Plan C-1 or C-2
- **Plan C-4** (single or family coverage), which is a high deductible plan that provides only in-network coverage at a lower cost than Plan C-1, C-2 or C-3
- **Plan C-MRP (**Medical Reimbursement Program) as a stand-alone option, if you provide acceptable proof that you have employer- or union-sponsored group medical coverage from another source—for example, through your spouse's employer and you certify that your other coverage provides "minimum value" (as defined by the Affordable Care Act).
- **Waive coverage entirely.** If you waive coverage, you will not have another opportunity to enroll in Plan C until you become eligible for automatic enrollment.

You will be required to self-pay a portion of the cost of coverage if your available employer contributions are insufficient to cover the cost of the coverage you elected. See page 4 for more information about self-paying.

**Your CAPP account is a notional account that represents the amount of employer contributions received on your behalf for coverage under Plan C. It is maintained by the Health & Welfare Fund for the sole purpose of providing you with the ability to obtain health coverage or reimbursement for qualifying medical expenses. It is not a vested benefit nor does it have cash value.**

## Automatic Enrollment

If you choose to waive coverage when you become eligible for optional enrollment, you cannot enroll until you become eligible for automatic enrollment (or if you have a special enrollment right, as defined in the Summary Plan Description). You are entitled to automatic enrollment when your CAPP account balance equals the **current quarterly charge for Plan C-2 single coverage plus a $150 administrative fee.** If you waived optional coverage and become eligible for automatic enrollment, the Fund Office will send you a Plan C CAPP Statement and Enrollment/Payment Form.

You have the following choices when you become eligible for automatic enrollment:

- **Plan C-1** (single or family coverage), which provides the highest level of in-network and out-of-network coverage at the highest cost
- **Plan C-2** (single or family coverage), which provides a lower level of in-network and out-of-network coverage at a lower cost than Plan C-1
- **Plan C-3** (single or family coverage), which provides only in-network coverage at a lower cost than Plan C-1 or C-2
- **Plan C-4** (single or family coverage), which is a high deductible plan that provides only in-network coverage at a lower cost than Plan C-1, C-2 or C-3
- **Plan C-MRP** (Medical Reimbursement Program) as a stand-alone option, if you provide acceptable proof that you have employer- or union-sponsored group medical coverage from another source—for example, through your spouse's employer—and you certify that your other coverage provides "minimum value" (as defined by the Affordable Care Act).

You cannot waive coverage once you become eligible for automatic enrollment.

Depending on your coverage election, you may be required to self-pay a portion of the cost of coverage if your available employer contributions are insufficient to cover the cost of the coverage you elected. See the next page for more information about self-paying.

If you do not make an election when you become eligible for automatic participation, you will be enrolled automatically in Plan C-2 single coverage. (Participants in Puerto Rico will be enrolled automatically in single coverage under Triple-S or other equivalent plan.)

## Participation Termination (Loss of Eligibility)

If you have been self-paying all or part of the charge for your coverage, you lose your eligibility for continued participation in Plan C when both of the following happen:

- your CAPP account balance for the next coverage quarter is zero, and
- over the preceding 24-month period, the Fund Office has not received employer contributions on your behalf equal to at least the quarterly charge for Plan C-2 single coverage.

In order to regain coverage, employer contributions in your CAPP account must equal at least the cost of one month of Plan C-3 single coverage plus the initial $150 administrative fee.

## Self-Payments

Once you become enrolled in Plan C, employer contributions are deducted from your CAPP account prior to each coverage quarter to pay for your coverage. However, your coverage option may require a quarterly contribution that exceeds the amount in your CAPP account. In such a case, you may pay the difference by making a self-payment.

The Fund Office will mail you a statement quarterly (the chart below shows the approximate mailing dates) indicating your CAPP account balance, your current coverage choice, your coverage options (if applicable) and any self-payment that may be required. **You are responsible for this payment whether or not you actually receive your statement.** That is why the Fund provides a number of resources for you to track your CAPP account balance, know what payment may be due and understand your payment options. The chart below shows when each quarterly payment (if required) is due. You can also find or confirm this information by contacting the Fund Office, logging on to **www.iatsenbf.org** or calling the interactive voice response (IVR) system at **800-456-FUND (3863).**

The following chart shows the timing for continuing your participation each coverage quarter.

| Employer Contribution Period | Mail Date for CAPP Account Statement | Deadline for Fund's Receipt of Self-Payments | Coverage Quarter |
|---|---|---|---|
| August 1–October 31 | mid–November | December 15 | January 1–March 31 |
| November 1–January 31 | mid–February | March 15 | April 1–June 30 |
| February 1–April 30 | mid–May | June 15 | July 1–September 30 |
| May 1–July 31 | mid–August | September 15 | October 1–December 31 |

# Hospital & Medical Benefits Through Empire Blue Cross Blue Shield

## (Effective April 1, 2019)

### Plans C-1 & C-2

**Plans C-1 and C-2** both offer in-network and out-of-network benefits.

All reimbursements of eligible out-of-network expenses are paid as a percentage of Empire BlueCross BlueShield's maximum allowed amount, which is the maximum Empire will pay for any service or supply. If an out-of-network provider charges more than the maximum allowed amount, you will be responsible for the excess, in addition to your normal coinsurance. In addition, applicable services or service frequencies are applied to both in-network and out-of-network care combined.

### Plan C-3

**Plan C-3** requires you to use an in-network provider.

The doctor's office copays apply to exams and evaluations only. Other services you receive may be subject to the applicable deductible and coinsurance.

If you go to an out-of-network provider, no benefits will be paid.

### Plan C-4

Plan C-4 is a catastrophic plan with a high deductible. It requires that you use an in-network provider.

If you go to an out-of-network provider, no benefits will be paid except in the case of an emergency.



## Hospital & Health Benefits

| | Plan C-1 | | Plan C-2 | | Plan C-3 | Plan C-4 |
|---|---|---|---|---|---|---|
| Features | In-Network | Out-Of-Network | In-Network | Out-Of-Network | In-Network Only | In-Network Only |
| **Calendar Year Deductible** | $0 | $200/Individual<br>$500/Family | $0 | $750/Individual<br>$1,875/Family | $1,000/Individual<br>$2,500/Family | $3,000/Individual<br>$7,500/Family |
| **Coinsurance** | N/A | You pay 25% of maximum allowed amount and Plan pays 75% of maximum allowed amount. | You pay 20% of maximum allowed amount and Plan pays 80%. | You pay 40% of maximum allowed amount and Plan pays 60% of maximum allowed amount. | You pay 20% of maximum allowed amount and Plan pays 80%. | You pay 50% of maximum allowed amount and Plan pays 50%. |
| **Annual Out-Of-Pocket Maximum*** | $750/Individual<br>$1,875/Family | $1,700/Individual<br>$4,250/Family | $1,750/Individual<br>$4,375/Family | $8,250/Individual<br>$20,625/Family | $4,000/Individual<br>$10,000/Family | $7,000/Individual<br>$14,000/Family |
| **Lifetime Maximum** | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| **Annual Maximum Benefit** | N/A | N/A | N/A | N/A | N/A | N/A |
| **Claim Forms To File** | None | Yes | None | Yes | None | None |

* Includes deductible, copays and coinsurance for medical, hospital and prescription drugs

## SPECIAL NOTE ON COVERAGE FOR PREVENTIVE CARE

Preventive care (including physical exams, screenings, tests and counseling) that meets certain government standards under the Affordable Care Act is covered in full if provided in network. Office visits will be covered in full only if the primary purpose is preventive care that meets these standards. For more information as to whether a particular service will be covered in full, please contact Empire BlueCross at 1-844-243-5566.

A benefit listed with a telephone symbol in the first column indicates that precertification is required. If you fail to precertify, certain penalties may apply, or you may lose coverage entirely.

| | Plan C-1 | | Plan C-2 | | Plan C-3 | Plan C-4 |
|---|---|---|---|---|---|---|
| **Benefits** | **In-Network** | **Out-Of-Network** | **In-Network** | **Out-Of-Network** | **In-Network Only** | **In-Network Only** |
| **Doctor's Office Visits, Including Specialists** | $20 per visit | Deductible & 25% coinsurance | $25 per primary care physician office visit.<br>$50 per specialist office visit | Deductible & 40% coinsurance | $30 per primary care physician office visit<br>$60 per specialist office visit (not subject to deductible) | Deductible & 50% coinsurance* |
| **Chiropractic Visits** | $20 per visit | Deductible & 25% coinsurance | $50 for exam and evaluation, other services subject to 20% coinsurance | Deductible & 40% coinsurance | $60 for exam and evaluation, other services subject to deductible and 20% coinsurance | Not covered |
| **Annual Physical Exam** | $0 for one wellness exam per calendar year | See the Summary Plan Description regarding a $300 benefit | $0 for one wellness exam per calendar year | See the Summary Plan Description regarding a $300 benefit | $0 for one wellness exam per calendar year | $0 for one wellness exam per calendar year |
| **Acupuncture** | $20 per visit | Deductible and 25% coinsurance | $50 per visit | Deductible and 40% coinsurance | $60 per visit | Deductible and 50% coinsurance |
| **Allergy Care**<br>Office visit | $20 per visit | Deductible & 25% coinsurance | $50 per visit | Deductible & 40% coinsurance | $60 per visit | Deductible & 50% coinsurance |
| **Allergy Testing** | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Allergy Treatment** | $0 | Deductible & 25% coinsurance | $0 | Deductible & 40% coinsurance | $0 | Deductible & 50% coinsurance |
| **Well Woman Care**<br>Office visits | $0 per visit | Deductible & 25% coinsurance | $0 per visit | Deductible & 40% coinsurance | $0 per visit | $0 per visit |
| **Pap Smears** | $0 | Deductible & 25% coinsurance | $0 if preventative, otherwise, 20% coinsurance | Deductible & 40% coinsurance | $0 if preventative otherwise subject to deductible and 20% coinsurance | $0 if preventative otherwise subject to deductible and 50% coinsurance |
| **Mammogram**<br>(based on age & medical history) | $0 | Deductible & 25% coinsurance | $0 if preventitive, otherwise 20% coinsurance | Deductible & 40% coinsurance | $0 per visit if preventitive, otherwise subject to deductible and 20% coinsurance | $0 per visit if preventitive, otherwise subject to deductible and 50% coinsurance |

* $0 for first three visits in a calendar year to a primary care physician (not subject to deductible)

| Benefits | Plan C-1 In-Network | Plan C-1 Out-Of-Network | Plan C-2 In-Network | Plan C-2 Out-Of-Network | Plan C-3 In-Network Only | Plan C-4 In-Network Only |
|---|---|---|---|---|---|---|
| **Well Child Care** Office visits & associated lab services provided within 5 days of visit, with certain frequency limits; Immunizations | $0 | Deductible & 25% coinsurance | $0 | Deductible & 40% coinsurance | $0 | $0 |
| **Diagnostic Procedures** X-rays & Other Imaging; MRIs/MRAs &; All lab tests | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Emergency Room** | $35 per visit (waived if admitted within 24 hours) | | $100 per visit (waived if admitted within 24 hours) | | $100 per visit (waived if admitted within 24 hours) | $250 per visit (waived if admitted within 24 hours) |
| **Ambulance** Local professional ground ambulance to nearest hospital | $0 | $0 as long as the ambulance charge does not exceed the maximum allowed amount. You pay any difference between maximum allowed amount and actual charge. | 20% coinsurance | $0 as long as the ambulance charge does not exceed the maximum allowed amount. You pay any difference between maximum allowed amount and actual charge. | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Air Ambulance** Transportation to nearest acute care hospital for emergency or inpatient admissions | $0 | You pay the difference between the maximum allowed amount and the total charge. | 20% coinsurance | You pay the difference between the maximum allowed amount and the total charge. | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Maternity Care** Prenatal & postnatal care in doctor's office | $20 for initial visit | Deductible & 25% coinsurance | $25 for initial exam and evaluation, other services subject to 20% coinsurance | Deductible & 40% coinsurance | $30 for initial exam and evaluation, other services subject to deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Maternity Lab Tests, Sonograms & Other Diagnostic Procedures** | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Obstetrical Care** (in hospital) | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Routine newborn nursery care** (in hospital) | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible & 50% coinsurance |

Semi-private room & board; general, special & critical nursing care; intensive care; services of physicians & surgeons; anesthesia, oxygen, blood work, diagnostic x-rays & lab tests; chemotherapy & radiation therapy; drugs & dressings; presurgical testing; surgery (inpatient & outpatient)

Both outpatient hospital surgery and inpatient admissions need to be precertified.

| Benefits | Plan C-1 | | Plan C-2 | | Plan C-3 | Plan C-4 |
|---|---|---|---|---|---|---|
| | In-Network | Out-Of-Network | In-Network | Out-Of-Network | In-Network Only | In-Network Only |
| **Obstetrical Care** (in birthing center) | $0 | Not covered | 20% coinsurance | Not covered | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Hospital Services** | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | $200 copayment per day for first 10 days, per confinement. then $0 (not subject to deductible) |
| **Chemotherapy, X-Ray, Radium & Radionuclide Therapy** | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Durable Medical Equipment,** for example, hospital-type bed, wheelchair, sleep apnea monitor, orthotics and prosthetics | $0 | Not covered | 20% coinsurance | Not covered | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Medical Supplies**, for example, catheters, oxygen, syringes | $0 | Difference between the maximum allowed amount and the total charge (deductible & coinsurance do not apply) | 20% coinsurance | Difference between the maximum allowed amount and the total charge (deductible & coinsurance do not apply) | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Nutritional Supplement** for example enteral formulas and modified, solidfood products | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Skilled Nursing Facility** Up to 60 days per calendar year | $0 | Not covered | 20% coinsurance | Not covered | Deductible & 20% coinsurance | Not covered |
| **Hospice Care** Up to 365 days maximum | $0 | Not covered | 20% coinsurance | Not covered | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Home Health Care** Up to 200 visits per calendar year (a visit equals 4 hours of care) (treatment maximums are combined for in-network and out-of-network services) | $0 | 25% coinsurance no deductible | 20% coinsurance | 40% coinsurance no deductible | 20% coinsurance no deductible | 50% coinsurance no deductible |
| **Home Infusion Therapy** | $0 | Not covered | 20% coinsurance | Not covered | Deductible & 20% coinsurance | Deductible & 50% coinsurance |

| | Plan C-1 | | Plan C-2 | | Plan C-3 | Plan C-4 |
|---|---|---|---|---|---|---|
| **Benefits** | **In-Network** | **Out-Of-Network** | **In-Network** | **Out-Of-Network** | **In-Network Only** | **In-Network Only** |
| **Physical Therapy & Rehabilitation**<br>Up to 30 days of in-patient service per calendar year (treatment maximums are combined for in-network and out- of-network care)<br>Up to 50 visits combined in home, office or outpatient facility per calendar year | $0<br>$20 per visit | Deductible & 25% coinsurance<br>Not covered | 20% coinsurance<br>$50 per visit | Deductible & 40% coinsurance<br>Not covered | Deductible & 20% coinsurance<br>$60 for exam and evaluation, other services subject to deductible and coinsurance | $200 per day for first 10 days, then $0 (not subject to deductible)<br>Not covered |
| **Occupational, Speech Or Vision Therapy**<br>Up to 50 visits combined in home, office or outpatient facility per calendar year | $20 per visit | Not covered | $50 per visit | Not covered | $60 for exam and evaluation, other services subject to deductible and coinsurance | Not covered |
| **Cardiac Rehabilitation** | $20 per outpatient visit | Deductible & 25% coinsurance | $50 per outpatient visit | Deductible & 40% coinsurance | $60 for exam and evaluation, other services subject to deductible and 20% coinsurance | Deductible & 50% coinsurance |
| **Mental Health Care Outpatient** | $20 per visit | Deductible & 25% coinsurance | $25 per visit | Deductible & 40% coinsurance | $30 per visit | $0 for first three visits in a calendar year, then deductible & 50% coinsurance. These are in addition to the primary care three visits. |
| **Mental Health Care Outpatient Facility** | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible & 50% coinsurance |
| **Mental Health Care Inpatient Facility** | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | $200 per day for first 10 days, then $0 (not subject to deductible) |
| **Alcohol Or Substance Abuse Treatment Outpatient** | $20 per visit | Deductible & 25% coinsurance | $25 per visit | Deductible & 40% coinsurance | $30 per visit | $0 for first three visits in a calendar year (not subject to deductible), then deductible & 50% coinsurance |
| **Alchol or Substance Abuse Treatment Outpatient Facility** | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | Deductible and 50% coinsurance |
| **Alchol or Substance Abuse Treatment Inpatient** | $0 | Deductible & 25% coinsurance | 20% coinsurance | Deductible & 40% coinsurance | Deductible & 20% coinsurance | $200 per day for first 10 days, then $0 (not subject to deductible) |

# Prescription Drug Benefits Through CVS Health

(Effective April 1, 2019)

**Plan C-1**

**Plan C-2**

**Plan C-3**

**Plan C-4**

### CVS HEALTH STANDARD CONTROL FORMULARY

The Fund only covers drugs listed on the CVS Health "Standard Control Formulary." A "formulary" is a list of drugs that are preferred to treat specific conditions because of the effectiveness of the drug and/or the cost of the therapy. CVS Health decides which drugs are listed on the formulary and which are excluded. If your doctor prescribes a drug that is not on the CVS Health "Standard Formulary," an alternative drug may be covered. There is a medical appeal process if your doctor indicates that there are medical reasons that you need an excluded formulary drug. If you meet those medical conditions, you will be able to receive the excluded drug.

### MANDATORY GENERIC PRICING

If you are prescribed a brand-name prescription drug that has a generic equivalent, you will be asked to switch to the generic drug when you fill the prescription at the pharmacy. If you choose to obtain the brand-name drug rather than its generic equivalent, you will be charged the generic drug copayment and the full difference in cost between the generic drug and the brand-name drug. If there is a medical reason why you must take the brand-name drug, there is a medical appeals process that would allow your doctor to provide information showing the medical necessity for the brand-name prescription.

**PREVENTIVE PRESCRIPTIONS:**

You will not have to pay anything for any prescription considered preventive care under the Affordable Care Act. For more information as to whether a particular service is preventive, please contact CVS Health at **1-800-896-1997**

The table below shows the amount that you have to pay toward the cost of specific drugs. “Preferred” drugs are those listed as preferred on the CVS Health standard formulary, as described on the prior page.

| Type of Drug | Plan C-1 | Plan C-2 | Plan C-3 | Plan C-4 |
|---|---|---|---|---|
| **At An In-Network Pharmacy You can receive a 30-day supply or refill of a medication through a CVS Health network pharmacy** | | | | |
| **Generic Drugs** | $5 | $5 | $5 | The purchase is subject to the deductible and 50% coinsurance ($200 maximum for specialty drug) |
| **Preferred Brand Name Drugs** | 20% coinsurance ($25 minimum and $40 maximum) | 20% coinsurance ($40 minimum and $60 maximum) | 20% coinsurance ($40 minimum and $60 maximum) | |
| **Non-Preferred Brand Name Drugs** | 40% coinsurance ($35 minimum and $50 maximum) | 40% coinsurance ($50 minimum and $70 maximum) | 40% coinsurance ($50 minimum and $70 maximum) | |
| **Preferred Specialty Drugs** | 20% coinsurance ($25 minimum and $150 maximum) | 20% coinsurance ($40 minimum and $150 maximum) | 20% coinsurance ($40 minimum and $150 maximum) | |
| **Non-Preferred Specialty Drugs** | 40% coinsurance ($35 minimum and $150 maximum) | 40% coinsurance ($50 minimum and $150 maximum) | 40% coinsurance ($50 minimum and $150 maximum) | |
| **Mail Order Pharmacy You can receive a 90-day supply via mail order or at a CVS Health network pharmacy** | | | | |
| **Generic Drugs** | $10 | $10 | $10 | The purchase is subject to the deductible and 50% coinsurance |
| **Preferred Brand Name Drugs** | 20% coinsurance ($60 minimum and $100 maximum) | 20% coinsurance ($90 minimum and $140 maximum) | 20% coinsurance ($90 minimum and $140 maximum) | |
| **Non-Preferred Brand Name Drugs** | 40% coinsurance ($100 minimum and $130 maximum) | 40% coinsurance ($115 minimum and $175 maximum) | 40% coinsurance ($115 minimum and $175 maximum) | |
| **Preferred Specialty Drugs** | 20% coinsurance ($60 minimum and $300 maximum) | 20% coinsurance ($90 minimum and $300 maximum) | 20% coinsurance ($90 minimum and $300 maximum) | |
| **Non-Preferred Specialty Drugs** | 40% coinsurance ($100 minimum and $300 maximum) | 40% coinsurance ($115 minimum and $300 maximum) | 40% coinsurance ($115 minimum and $300 maximum) | |
| **At An Out of Network Pharmacy** | | | | |
| You must pay the full charge of a drug you received from an out of network pharmacy, and then file a claim for reimbursement with CVS Health. You will receive the difference between the pharmacy’s charge and the applicable co-pay. | | | | |
| Certain limitations and exclusions may apply to some medications. If you have any questions about a specific medication, please call CVS Health at 1-800-896-1997 | | | | |

# Other Welfare Fund Benefits (Effective January 1, 2019)

| | Plans C-1 & C-2 | Plans C-3 | Plans C-4 |
|---|---|---|---|
|  | **Vision Care**<br>Through Davis Vision, Plans C-1 and C-2 offer one eye exam and one pair of glasses or contact lenses from the Davis Collection every 24 months. For covered children up through age 18, an exam and lenses are provided every 12 months, while frames are available only every 24 months. There may be an additional charge for contact lenses or frames that are not in the approved group.<br>For out-of-network vision services, reimbursement of up to $100 is available every 24 months (every 12 months for exams and lenses for children). The Plan will cover the cost of out-of -network annual exams for children through age 18 up to the in-network reimbursement amount. | Vision care is not covered under Plan C-3 or C-4. If you use a Davis Vision provider for an eye exam or to purchase glasses and/or contact lenses, you can get discounts on those services, but you must pay for them yourself. | |
|  | **Physical Exam**<br>If you do not go to a BlueCross provider for a physical exam, the Plan pays up to $300 per calendar year for a physical examination.<br>Please see the Summary Plan Description (SPD) or contact the Fund Office for more details. | Not covered | Not covered |
|  | **Hearing Aid Benefit**<br>The Plan pays up to $1,500 in a 36-month period for a hearing aid, batteries and/or repairs | Not covered | Not covered |
|  | **Puerto Rico**<br>Triple-S (or other equivalent plan) is available only in Puerto Rico. If you elect this coverage, you will not be eligible for the hospital, medical and prescription drug benefits described above, but you will be entitled to the vision care, dental and life insurance benefits. Contact the plan for more information at 800-981-1352. | N/A | N/A |

## Dental Care

| Plans C-1 & C-2 | Plans C-3 | Plans C-4 |
|---|---|---|
| Up to $2,000 per year per covered person paid according to a set fee schedule. The $2,000 limit does not apply to diagnostic, preventive and basic services for children under age 19.<br>In-network dentists have agreed to charge a negotiated fee set by Delta Dental.<br>Out-of-network dentists are paid the same amount under the fee schedule as in-network dentists, but an out-of-network dentist may charge you an additional amount.<br>Orthodontia not covered. | Covers only basic preventive care in accordance with schedule of dental benefits.<br>Oral exams and cleanings, up to two of each per calendar year. X-rays, once per calendar year | Not covered |

## Plan C-MRP For "Active" Participants/Retiree-Only MRP For Participants Who Are "Not Active"

You may use certain excess funds in your CAPP account as reimbursement for qualified medical expenses.

Please see the Summary Plan Description (SPD) or contact the Fund Office for more details.

## Life Insurance

| Plans C-1 & C-2 | Plans C-3 | Plans C-4 |
|---|---|---|
| Pays a benefit of $20,000 if you die (not available for covered dependents). | Pays a benefit of $10,000 if you die (not available for covered dependents). | Pays a benefit of $10,000 if you die (not available for covered dependents). |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