Tri-State Joint Fund: Teamster Plus Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2016 - 06/30/2017

Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.trifund.com** or by calling your Local Plan's toll-free number.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Major Medical: **$150/**person, **$300/**family*. Doesn't apply to preventive care, "Basic Benefits", hospital ER copay, prescription drugs, or vision. Balance billing, penalties for failing to pre-certify, and excluded services do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$400/**person or **$550** if the **deductible** applies.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, all **copayments**, balance billing, health care this plan does not cover, and penalties for failure to obtain pre-authorization for services. In other words, this only applies to most **coinsurance** (including the **deductible**).	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Questions: Call **your Local Plan's toll-free number** or visit us at **www.trifund.com**.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or contact the Fund to request a copy.

* One individual must satisfy the $150 individual **deductible** and the remaining $150 can be met in aggregate by the other family members

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, call (800) 810-2583 or see **www.anthem.com/health-insurance/home/overview#**.	If you use an in-network or an out-of-network doctor or other health care **provider**, this Plan will pay some or all of the costs of covered services. If you use an out-of-network **provider**, your costs and the costs of the Plan may be higher. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a diagnostic test is $1,000, the Plan would pay $250 under the Basic Benefit, and your **coinsurance** payment of 20% would be $150. This may change if you haven't met your **deductible**.
- Your cost sharing does not depend on whether a provider is in a **network**.

Common Medical Event	Service You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	Same as Network	None
	Specialist visit	20% coinsurance after deductible	Same as Network	None
	Other practitioner office visit	No charge up to limit	Same as Network	Chiropractic limited to 40 visits/year; physical therapy limited to 60 visits/year; medical massage and acupuncture limited to 24 visits/year
	Preventive care/ screening/immunization	No charge	Same as Network	1 physical exam/year; $200/year for lyme vaccine; 1 mammogram/year age 40+. Well-child visits: Birth to 6 months - 3 visits, 9 to 24 months - 5 visits, annually thereafter

Common Medical Event	Service You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	No charge up to $250 under Basic Benefit, then 20% coinsurance after deductible	Same as Network	None
	Imaging (CT/PET scans, MRIs)		Same as Network	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.teamstersrx.com.	Generic drugs	$10 copay retail, $15 copay mail order	No coverage	30-day maximum retail, 90-day maximum mail order. Some prescription may be subject to mandatory mail order for maintenance drugs, prior authorization, and/or high utilization monitoring programs. Participation in optional programs (e.g. Take Charge Diabetes) may eliminate copays on certain medications/testing supplies.
	Single-Source brand drugs (no generic equivalent available)	$20 copay retail, $35 copay mail order	No coverage	
	Multi-Source brand drugs (generic equivalent available) are only covered when physician indicates "DAW" or "Dispense as Written"	Retail: $10 copay plus difference in cost between brand name drug and generic drug; Mail order: $15 copay plus difference in cost between brand name drug and generic drug	No coverage	
	Specialty drugs	Same as single-source brand drugs	No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Same as Network	Pre-certify by calling (800) 888-9255 or benefits are reduced by 20%
	Physician/surgeon fees	No charge	Same as Network	
If you need immediate medical attention	Emergency room services	$50 copay for an illness; waived if admitted	Same as Network	None
	Emergency medical transportation	20% coinsurance after deductible; no charge if admitted	Same as Network	Must be a local service, to nearest facility and medically necessary
	Urgent care	No charge	Same as Network	None

Common Medical Event	Service You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Same as Network	Pre-certify by calling (800) 888-9255 or benefits are reduced by 20%
	Physician/surgeon fees	Physician fees: 20% coinsurance after deductible; Surgeon fees: No charge	Same as Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge for up to 3 visits then 20% coinsurance after deductible	Same as Network	Pre-certify inpatient mental health (MH) and inpatient substance use disorder (SD) by calling (877) 733-9205 or benefits reduced by 20%. Inpatient facilities must be accredited by JCAHO
	Mental/Behavioral health inpatient services	No charge	Same as Network	
	Substance use disorder outpatient services	No charge for up to 3 visits then 20% coinsurance after deductible	Same as Network	
	Substance use disorder inpatient services	No charge	Same as Network	
If you are pregnant	Prenatal and postnatal care	Outpatient: 20% coinsurance after deductible; inpatient: no charge	Same as Network	Limited coverage for medically necessary genetic testing; must pre-certify, see SPD for details
	Delivery and all inpatient services	No charge	Same as Network	Pre-certify for hospital stays in excess of government mandated minimum stays (48/96 hour)

Common Medical Event	Service You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Same as Network	For care of post-hospitalization and terminal conditions; pre-certify by calling (800) 888-9255
	Rehabilitation services	No charge up to Basic Benefit	Same as Network	Physical therapy/medical massage treatment may require pre-certification, call (800) 888-9255
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network
	Skilled nursing care	No charge	Same as Network	Payable under home health care benefit; must pre-cert at (800) 888-9255; limited to 60 days per disability
	Durable medical equipment	No charge on certain equipment, otherwise 20% coinsurance after deductible	Same as Network	Call (203) 876-3100 x 272 to determine whether pre-certification is necessary
	Hospice service	No charge	Same as Network	Pre-certify by calling (800) 888-9255; must be diagnosed as terminally ill with life expectancy of less than 6 months
If your child needs dental or eye care	Eye exam	No charge up to covered amount in the Northeast (CT, MA, NH, VT etc.)	No coverage	Copay in Regions II, III and IV
	Glasses	No charge up to covered amount for regular glasses with standard lenses	No coverage	Copay required for hi-index, polarized, anti-reflective coated and contact lenses
	Dental check-up	No charge up to dental schedule maximum amount for covered services	Same as Network	Covered once every six months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
● Habilitation services	● Long-term care	● Routine foot care
● Infertility treatment	● Private-duty nursing	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
● Acupuncture (to Plan limits)	● Dental care (Adult) (no charge up to schedule maximum amount for covered services)	● Routine eye care (Adult) (no charge for exam in Region 1, co-pay for other Regions and for some lenses & frames)
● Bariatric surgery (to Plan limits)		
● Chiropractic care (to Plan limits)	● Hearing aids ($2,500 per ear/5 years)	
● Cosmetic surgery (to Plan limits)	● Non-emergency care when traveling outside the U.S. (to Plan limits)	● Weight loss programs (covered under bariatric benefit to Plan limits)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at your Local Plan's toll-free number or www.tricare.com. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For questions about your rights, this notice, or assistance, you can contact the plan at www.trifund.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,179
- **Patient pays** $361

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$150
Copays	$120
Coinsurance	$61
Limits or exclusions	$30
Total	**$361**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,065
- **Patient pays** $335*

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$150
Copays	$0
Coinsurance	$117
Limits or exclusions	$68
Total	**$335***

* This assumes the patient is enrolled in the Teamsters Take Charge program and that prescriptions are covered at no cost and nutritional counseling is covered at 100% up to $300 per year.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call your Local Plan's toll-free number or visit us at www.trifund.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or contact the Fund to request a copy