Teamsters Miscellaneous Indemnity Medical Plan A2

Coverage Period: 06/01/2016 – 05/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Tiered or Composite | 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 by contacting the Teamsters Miscellaneous Security Trust Fund ("Plan") at its Administrative office: Northwest Administrators, Inc. at 225 So. Lake Ave., Ste. 110, Pasadena, CA 91101, 1-877-214-8928 or **www.nwadmin.com.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** Individual /**$1500** Family Deductible does not apply to Wellness, Chiropractic, Acupuncture, Podiatry or Managed Transplant benefits.	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. For PPO providers **$3500** Individual/**$10,500** Family For prescription drug PPO pharmacies **$1200**/Family. However, your out-of-pocket will be more if you use out-of-network Providers.	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?	Penalties for failure to obtain prior authorization, premiums, balance billed charges and health care services and supplies this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	**No annual dollar limit on Essential Health Benefits (EHB)**	The chart starting on page 2 describes any limits and what the plan will pay for *specific* covered services, such as office visits.

Does this plan use a network of providers?	Yes. For Medical PPO providers: contact Anthem Blue Cross at www.anthem.com/ca. or call 1-800-810-2583. For Mental Health/Substance Abuse care, contact HMC at 1-866-269-7391. For Podiatry, you must call PPOC at 1-800-367-7762 and for Chiropractic and Acupuncture, you must call ASHN at 1-800-848-3555	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. 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 don't need a referral to see a specialist.	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 5. See your policy or plan document for additional information about excluded services.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance 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 an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use an Preferred Provider (PPO)	Your cost if you use an Non-Preferred Provider (Non-PPO)	Limitations & Exceptions
If you visit a health care provider's office	Primary care visit to treat an injury or illness	25% co-insurance	50% co-insurance	After deductible has been met.
	Specialist visit	25% co-insurance	50% co-insurance	After deductible has been met

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or clinic	Other practitioner office visit	25% co-insurance	50% co-insurance	After deductible has been met. Necessary care any combination of Chiropractic Care and Acupuncture limited to 40 visits per calendar year. Outpatient physical therapy prescribed in writing by a medical doctor is limited to 40 visits per calendar year.
	Preventive care/screening/immunization	0% co-insurance	100% co-insurance	Annual physicals from Non-PPO provider are not covered
If you have a test	Diagnostic test (x-ray, blood work)	25% co-insurance	50% co-insurance	Covered when medically necessary.
	Imaging (CT/PET scans, MRIs)	25% co-insurance	50% co-insurance	Covered when medically necessary.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at (800) 797-9791	Generic drugs	$10 co-pay retail $10 co-pay mail	10% after co-pay	Covered when dispensed through the Fund's Prescription Program. Up to a 30-day supply retail; 90-day supply mail order. Maintenance drugs must be filled by mail order after 2 refills at retail, not to exceed a total of a 90-day supply.
	Formulary drugs	$15 co-pay retail $20 co-pay mail	10% after co-pay	
	Non-Formulary brand drugs	$15 co-pay retail $35 co-pay mail	10% after co-pay	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% co-insurance	Up to $2500	For Non-PPO Out Patient Surgery Centers, plan will pay up to $2500 per outpatient admission at outpatient surgical facility.
	Physician/surgeon fees	25% co-insurance	50% co-insurance	
If you need immediate medical attention	Emergency room services	25% co-insurance	25% co-insurance	----------none----------
	Emergency medical transportation	25% co-insurance	25% co-insurance	Covered when medically necessary.
	Urgent care	25% co-insurance	50% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	25% co-insurance	50% co-insurance	Prior Authorization is required.
	Physician/surgeon fee	25% co-insurance	50% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% co-insurance	50% co-insurance	Call HMC 1-866-269-7391. Pre-Authorization required for all impatient treatment.
	Mental/Behavioral health inpatient services	25% co-insurance	50% co-insurance	
	Substance use disorder outpatient services	25% co-insurance	50% co-insurance	
	Substance use disorder inpatient services	25% co-insurance	50% co-insurance	
If you are pregnant	Prenatal and postnatal care	25% co-insurance	50% co-insurance	----------none----------
	Delivery and all inpatient services	25% co-insurance	50% co-insurance	----------none----------
If you need help recovering or have other special health needs	Home health care	25% co-insurance	25% co-insurance	----------none----------
	Rehabilitation services	25% co-insurance	25% co-insurance	----------none----------
	Habilitation services	25% co-insurance	25% co-insurance	----------none----------
	Skilled nursing care	25% co-insurance	25% co-insurance	----------none----------
	Durable medical equipment	25% co-insurance	25% co-insurance	----------none----------
	Hospice service	25% co-insurance	25% co-insurance	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

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.)

- Cosmetic surgery
- Dental care
- Hearing Aids
- Long-term care
- Routine eye care
- Weight loss programs

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 (you must use an American Specialty Health Network Provider or you will receive no benefits)
- Chiropractic care (you must use an American Specialty Health Network Provider or you will receive no benefits)
- Private Duty Nursing (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Bariatric Surgery (limitations apply)
- Routine foot care (you must use the Podiatry Plan Organization of California Provider or you will receive no benefits)
- Infertility Treatment (IVF lifetime maximum of $15,000; limitations apply)

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 1-877-214-8928. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Your Grievance and 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** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your Plan at 1-877-214-8928, or the Department of Labor's Employee Benefit 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 or policy 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.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-214-8928.

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** $5,180
- **Patient pays** $2,360

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	$500
Co-pays	$20
Co-insurance	$1,690
Limits or exclusions	$150
Total	**$2,360**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $2,640
- **Patient pays** $1,460

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$500
Co-pays	$400
Co-insurance	$480
Limits or exclusions	$80
Total	**$1,460**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.