Teamsters Local 830 *Premier Medical Plan + RX 2*
Coverage Period: Beginning on or after 09/01/2017

Summary of Benefits and Coverage **Plan Type: DPOS / Keystone/Amerihealth Networks**

This is only a summary. **If you want more detail about your coverage and costs, you can get the complete terms of the plan by contacting the Local 830 Health and Welfare Fund office at 215-969-1012 (local) or 800-782-5379 (toll free)**

Important Questions	Answers	Why this Matters:
What is the deductible? & When does it apply?	For **participating providers** $0 person / $0 family. **For non-participating providers** $5,000 person / $10,000 family.	**The Out-of-Network deductible** applies to all services provided by non-participating providers.
Are there other deductibles for specific services?	**No**	Other services may be subject to copay or coinsurance. See Page 2 for the cost of other services not subject to deductible.
Is there an out-of-pocket limit on my expenses?	**Yes.** **For participating providers** $5,000 person / $10,000 family. **For non-participating providers** $50,000 person / $100,000 family	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. It includes any deductibles, copays or coinsurance. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Out-of-network balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for services.	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.**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** See **www.ibx.com/find_a_provider** or call **1-800-ASK-BLUE** for a list of participating providers, or contact Local 830 Fund office for assistance.	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**.

Important Questions	Answers	Why this Matters:
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. However, we suggest that you consult your Primary Care Physician (PCP) or GN Mobile Care Coordinator for recommendations.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. 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 where applicable as noted.
- 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. . (This is called **balance billing**.)
- This plan encourages you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use An In-Network Provider	Your Cost If You Use An Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic for treatment of an injury or illness.	Primary care visit to treat an injury or illness	PCMH / $0 Copayment, Non-PCMH / $15 Copayment	50% after deductible	If you are enrolled in a PCMH (Patient Centered Medical Home) your visit will be covered at 100%.
	Specialist visit	$30 Copayment	50% after deductible	PCP referral required to designated provider for routine x-rays, physical/occupational therapy.
	Other practitioner office visit	$30 Copayment	50% after deductible	Spinal manipulations limited to 20 visits per benefit period.
	Preventivecare/screening/immunization	No Charge	50% No deductible	Age and frequency schedules may apply.
If you have a test	Routine Radiology	$20 Copayment	50% , after deductible	PCP referral to designated provider required.
	Blood Work	No Charge	50% , after deductible	PCP referral to designated provider required.
	Complex Imaging (CT/PET scans, MRIs)	$40 Copayment	50% , after deductible	Precertification required; Imaging copay not applicable if performed in the Emergency Room or office setting
If you need drugs to treat your illness or condition	Generic drugs	$8 (retail)/$16 (mail order)	Not Covered	Note: Prescription Drug coverage provided by BeneCard. See Plan Summary for more details. Annual maximum out-of-pocket $1,250 individual/$2,500 family.
	Preferred (formulary) brand drugs	$16 (retail)/$32 (mail order)	Not Covered	
	Non-preferred (Non-formulary) brand drugs	Not Covered	Not Covered	See prescription plan for exceptions.
	Outpatient Injectables	$0 copay Standard $75 Copay Biotech/Specialty	50% , after deductible	Prior-authorization required. A complete list of drugs requiring prior- authorization is available at www.ibx.com/preapproval
If you have outpatient surgery	Facility fee (e.g., hospital outpatient facility or freestanding ambulatory surgery center)	No Charge	50% , after deductible	Outpatient surgery performed in an office setting is subject to a $30 copayment. Some outpatient surgeries require pre-authorization.
		Advance consultation with Fund's Mobile Care Coordinator strongly recommended for all elective procedures. Please call 267-567-9550.		
	Physician/Surgeon fees	No Charge	50% , after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use An In-Network Provider	Your Cost If You Use An Out-Of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 Copayment	$150 Copayment	Your costs for Emergency Room services are waived if you are admitted to the hospital.
	Emergency medical transportation	$25 Copayment	$25 Copayment	----------none----------
	Urgent care	$75 Copayment	50% , after deductible	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	50% , after deductible	Precertification required.
		Advance consultation with Fund's Mobile Care Coordinator strongly recommended for elective hospital stays. Please call 267-567-9550.		
	Physician/Surgeon fee	No Charge	50% , after deductible	Precertification required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 Copayment	50% , after deductible	----------none----------
	Mental/Behavioral health inpatient services	No Charge	50% , after deductible	Precertification required.
	Substance abuse disorder outpatient services	$30 Copayment	50% , after deductible	Precertification required.
	Substance abuse disorder inpatient services	No Charge	50% , after deductible	Precertification required.
If you are pregnant	Prenatal and postnatal care	$15 Copayment	50% , after deductible	Your cost is for first OB visit only.
	Delivery and all inpatient services	No Charge	50% , after deductible	Pre-notification requested
If you need help recovering or have other special health needs	Home health care	$15 Copayment	Not Covered	Pre-certification required
	Rehabilitation services	$30 Copayment	50% , after deductible	Speech Therapy: 20 visits per benefit period; Physical/Occupational Therapies: 30 visits combined per benefit period. PCP referral required for Physical/Occupational therapies.
	Habilitation services	$30 Copayment	50% , after deductible	Speech Therapy: 20 visits per benefit period; Physical/Occupational Therapies: 30 visits combined per benefit period. PCP referral required for Physical/Occupational therapies.
	Skilled nursing care	$150 Copayment per day; maximum of 5 copays per admission	50% , after deductible	120 day limit per benefit period for in- network services. 60 day limit for out-of-network services. Precertification required.
	Hearing Aids	Not Applicable	Up to $1000 per ear	Once every 36 months
	Durable medical equipment	15% coinsurance	50% , after deductible	Precertification required for purchases (including repairs and replacements) over $500 and all rentals
	Hospice service	No Charge	50% , after deductible	----------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.)		
• Acupuncture • Cosmetic surgery	• Weight loss programs • Dental care (Adult) • Long-term care	• Routine eye care (Adult) • Non-emergency care when travelling outside the U.S. • Routine foot care
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.)		

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 Fund office at 215-969-1012 or Toll Free 800-782-5379. 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 Grievance and Appeals Rights:

Your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements. If you are dissatisfied with a denial of coverage for claims under your plan, you may contact IBC at 1-800-ASK-BLUE. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 866-444-3272. As an alternative, the Pennsylvania Department of Insurance can also provide assistance. Please contact them at 1-877-881-6388.

Does this Plan provide Minimum Essential Coverage and meet the Minimum Value Standard?

The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage**. In addition, the Affordable Care Act establishes a minimum value standard of benefits of a health plan. **This plan meets 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.

A Hospital Confinement

- **Amount owed to providers: $7,500**
- **Plan Pays $7,500**
- **Patient Pays $0**

Sample Care Costs:

Hospital charges (Room and Board)	$3,600
Physicians Services	$1,800
Diagnostic Imaging	$1,300
Laboratory tests	$500
Prescriptions	$300
Total	**$7,500**

Patient Responsibility:

Deductibles (for facility charges)	$0
Copays	$0
Coinsurance	$0
Total	**$0**

Arthroscopic Knee Surgery

(freestanding ambulatory surgery center)

- **Amount owed to providers: $3,776**
- **Plan Pays $3,776**
- **Patient Pays $0**

Sample Care Costs:

Facility Charge	$2,037
Physicians Services	$1,241
Anesthesia	$499
Total	**$3,776**

Patient Responsibility:

Deductibles (for facility charges)	$0
Copays	$0
Coinsurance	$0
Total	**$0**

Questions and answers about the Coverage Examples

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **employee contributions of any.**
- Sample care costs are based on fair market value.
- 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, if any** 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 own care needs?

- **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 and supplemental coverage 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**.