Teamsters Miscellaneous Indemnity Medical Plan A2

Coverage Period: 06/01/2018 – 05/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Tiered or Composite | Plan Type: PPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the Teamsters Miscellaneous Security Trust Fund's ("Plan") Administrative Office: Northwest Administrators, Inc. 225 So. Lake Ave., Ste. 1200, Pasadena, CA 91101, (877) 214-8928. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.nwadmin.com or call 1-877-214-8928 to request a copy.

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.	If you have other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the **deductible** before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	For PPO providers **$3500** Individual/**$10,500** Family For prescription drug PPO pharmacies **$1200**/Family. There is no out-of-pocket limit for out-of-network providers.	The **out-of-pocket limit** is the most you could pay for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of- pocket limit has been met.
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.**
Will you pay less if you use a network provider?	Yes. For Medical PPO providers: contact Anthem Blue	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might

	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	receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get 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 you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	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
	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 www.nwadmin.com	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.
	Preferred brand drugs	$15 co-pay retail $20 co-pay mail	10% after co-pay	
	Non-preferred brand drugs	$15 co-pay retail $35 co-pay mail	10% after co-pay	
	Specialty drugs			No Charge for initial fill up to a 30 day supply at a Retail pharmacy; thereafter all subsequent fills must be filled at an OptumRx Specialty Pharmacy & copayment for each 30 day supply will be $0.
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 care	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 fees	25% co-insurance	50% co-insurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% co-insurance	50% co-insurance	Call HMC 1-866-269-7391. Pre-Authorization required for all impatient treatment.
	Inpatient services	25% co-insurance	50% co-insurance	
If you are pregnant	Office visits	25% co-insurance	50% co-insurance	----------none----------
	Childbirth/delivery professional services	25% co-insurance	50% co-insurance	----------none----------
	Childbirth/delivery facility 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 services	25% co-insurance	25% co-insurance	----------none----------
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	----------none----------
	Children's glasses	Not Covered	Not Covered	----------none----------
	Children's dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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

* For more information about limitations and exceptions, see the plan or policy document at www.nwadmin.com.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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 plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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 section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$500
■ Specialist *[Coinsurance]*	25%
■ Hospital (facility) *[Coinsurance]*	25%
■ Other *[Coinsurance]*	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$9,171**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$500
■ Specialist *[Coinsurance]*	25%
■ Hospital (facility) *[Coinsurance]*	25%
■ Other *[Coinsurance]*	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$4,408**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$505
Coinsurance	$732
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,992**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$500
■ Specialist *[Coinsurance]*	25%
■ Hospital (facility) *[Coinsurance]*	25%
■ Other *[Coinsurance]*	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$944**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$481
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$981**

The plan would be responsible for the other costs of these EXAMPLE covered services.