Teamsters Local No. 377 Health & Welfare Fund

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

Coverage Period: 09/01/2013 – 08/31/2014

Coverage for: Single or 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.yourunionbenefits.com or by calling 330-744-3148.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500**/single,**$1,000**/family Network **$1,000**/single, **$2,000**/family Non-Network Doesn't apply to co-insurance, copays, and network preventive care	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 other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes**. $5,000**/single, **$10,000**/family Network **$5,000**/single, **10,000**/family Non-Network	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?	Copays, deductibles, premiums, balance-billed charges, and health care 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.	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 **MedMutual.com/SBC or call 1-800-426-6158** for a list of participating providers.	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 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 later in the document. 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 an overnight hospital stay is $1,000, your **coinsurance** 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 **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% coinsurance	————————none————————
	Specialist visit	$40 copay/visit	40% coinsurance	————————none————————
	Other practitioner office visit (Chiropractic) (Acupuncture)	20% coinsurance Not Covered	40% coinsurance Not Covered	10 visits per benefit period, then Medical Review; combined with Physical and Occupational Therapies Excluded Service
	Preventive care/screening/immunization	No charge	40% coinsurance	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	No charge at Physician; 20% co-insurance for all other places	40% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No charge at Physician; 20% co-insurance for all other places	40% coinsurance	————————none————————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-scripts.com.	Generic drugs	$15 copay/ prescription retail $30 copay/ prescription mail order	Not Covered	Retail: 30-day supply Mail Order: 90-day supply Step Therapy program and Generic Preferred program apply. Generic oral contraception is subject to $0 co-pay. Certain OTC generic products are subject to $0 co-pay with a physician prescription. Prescriptions filled at Wal-Mart, Walgreens, and Marc's pharmacies are not covered.
	Brand Formulary drugs	$30 copay/ prescription retail $60 copay/ prescription mail order	Not Covered	
	Brand Non-Formulary drugs	$60 copay/ prescription retail $120 copay/ prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	————————none————————
	Physician/surgeon fees (Outpatient)	20% coinsurance	40% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	$100 copay/visit, deductible, 20% coinsurance		————————none————————
	Emergency medical transportation	20% coinsurance	40% coinsurance	————————none————————
	Urgent care	$20 copay/visit	40% coinsurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	————————none————————
	Physician/surgeon fee (inpatient)	20% coinsurance	40% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/office visit	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	——————none——————
	Substance use disorder outpatient services	$20 copay/office visit	40% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Covered for subscriber and spouse only
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Covered for subscriber and spouse only
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	10 visits, then Medical Review – Professional; unlimited – Institutional; combined with Occupational Therapy and Chiropractic Therapy
	Habilitation services (Occupational Therapy and Speech Therapy)	20% coinsurance	40% coinsurance	10 visits, then Medical Review – Professional; unlimited – Institutional
	Skilled nursing care	20% coinsurance	40% coinsurance	730 days with 90 day renewal – Institutional; unlimited - Professional
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice service	20% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	20% coinsurance		Eye exam also available under Medical benefit; 100% Network; 40% coinsurance Non-Network. Dental and Vision benefits are subject to a combined maximum of $1,000 per family per calendar year. Annual limit does not apply to dependents under age 19.
	Glasses	20% coinsurance		
	Dental check-up	20% coinsurance		

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
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling 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.)**

- Bariatric Surgery (subject to review by Medical Mutual)
- Chiropractic Care
- Dental Care (Adult & Child)
- Glasses
- Hearing Aids (one per ear every 36 rolling months; $1,500 maximum per appliance per year)
- Private Duty Nursing
- Routine Eye Care (Adult & Child)
- Weight Loss Programs (Medical Mutual Weight Watchers)

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 330.744.3148. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 X61565 or www.cciiocms.gov

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 the plan at 330.744.3148. You may also contact the Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3273) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Para obtener asistencia en Español, llame al 800.426.6158.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800.426.6158.

如果需要中文的帮助，**请拨打这个号码** 800.426.6158.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800.426.6158.

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** $5,620
- **Patient pays** $1,920

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
Copays	$20
Coinsurance	$1,200
Limits or exclusions	$200
Total	**$1,920**

These numbers assume that the patient does not Use an HRA or FSA. If you participate in an HRA or FSA and use to pay for out-of-pocket expenses, then your costs may be lower. For more information about your HRA of FSA, please contact the Fund Office.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

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	$0
Copays	$800
Coinsurance	$0
Limits or exclusions	$100
Total	**$900**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 800.426.6158.

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.