New York State Teamsters Council Health & Hospital Fund
SELECT PLAN

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **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 of the policy or plan document from the Fund Office by calling 1-877-698-3863.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250 Individual / $750 Family** for out-of-network services. Deductible does not apply to in-network services.	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. $1,000 Individual / $3,000 Family combined In- and Out-of-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?	Copayments, 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 *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.excellusbcbs.com **or call 1-877-650-5840** 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 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**.

- **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	30% coinsurance after deductible, Balance billi	——————none——————
	Specialist visit	$20 copay/visit	30% coinsurance after deductible, Balance bill	——————none——————
	Other practitioner office visit (chiropractor)	$20 copay / visit	30% coinsurance after deductible, Balance bill	Chiropractic coverage is limited to 16 visits per calendar year. See Plan Document for other services.
	Preventive care/screening/immunization	No charge	30% coinsurance after deductible, Balance bill	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $30 copay, Other Diagnostic: $20 copay	30% coinsurance after deductible, Balance bill	——————none——————
	Imaging (CT/PET scans, MRIs)	$30 copay	30% coinsurance after deductible, Balance bill	——————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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$7 copay (retail)/ $2 copay (mail order)	Not Covered	Mail Order is Mandatory on all Maintenance Prescriptions. If a Brand name medication is received and a generic equivalent is available, the participant must pay the Brand name copay PLUS the difference in the cost between the generic equivalent and the Brand name medication. 30-day supply - retail / 90-day supply - mail order.
	Preferred brand drugs	$14 copay (retail) / $28 copay (mail order)	Not Covered	
	Non-preferred brand drugs	$30 copay (retail / $60 copay (mail order)	Not Covered	
	Specialty drugs	Preferred or Non-Preferred copay as stated above.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 copay	30% coinsurance after deductible, Balance bill	——————none——————
	Physician/surgeon fees	$20 copay	30% coinsurance after deductible, Balance bill	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay, waived if admitted	30% coinsurance after deductible, Balance bill	——————none——————
	Emergency medical transportation	$25 copayment	$25 copayment	——————none——————
	Urgent care	$20 copay / visit	30% coinsurance after deductible, Balance bill	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	30% coinsurance after deductible, Balance bill	Must be pre-certified.
	Physician/surgeon fee	$20 copay	30% coinsurance after deductible, Balance bill	Must be pre-certified.

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	30% coinsurance after deductible, Balance bill	——————none——————
	Mental/Behavioral health inpatient services	5% coinsurance	30% coinsurance after deductible, Balance bill	Must be pre-certified.
	Substance use disorder outpatient services	$20 copay/office visit	30% coinsurance after deductible, Balance bill	——————none——————
	Substance use disorder inpatient services	5% coinsurance	30% coinsurance after deductible, Balance bill	Must be pre-certified.
If you are pregnant	Prenatal and postnatal care	$100 copay	30% coinsurance after deductible, Balance bill	Must be pre-certified
	Delivery and all inpatient services	5% coinsurance	30% coinsurance after deductible, Balance bill	Must be pre-certified
If you need help recovering or have other special health needs	Home health care	$20 copay	30% coinsurance after deductible, Balance bill	Must be pre-certified, Maximum of 40 visits per year.
	Rehabilitation services	$20 copay / visit	30% coinsurance after deductible, Balance bill	Physical and occupational therapy limited to 24 visits per year.
	Habilitation services	$20 copay/office visit	30% coinsurance after deductible, Balance bill	——————none——————
	Skilled nursing care	5% coinsurance	30% coinsurance after deductible, Balance bill	Must be pre-certified
	Durable medical equipment	5% coinsurance	30% coinsurance after deductible, Balance bill	——————none——————
	Hospice service	No charge	30% coinsurance after deductible, Balance bill	——————none——————
If your child needs dental or eye care	Eye exam	$20 copay/office visit	30% coinsurance after deductible, Balance bill	——————none——————
	Glasses	Not covered through the medical plan		

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
	Dental check-up	Not covered through the medical plan.		

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot 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.)

- Chiropractic Care
- Hearing Aids
- Non-emergency care when traveling outside the U.S.

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 by calling 1-877-698-3863. 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:

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 Fund Office by calling 1-877-698-3863. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society, Community Health Advocates, 105 East 22nd Street, New York, NY 10010 T: (888) 614-5400 E: cha@cssny.org Website:http://www.communityhealthadvocates.org

For pharmacy 1st & 2nd Level Appeals, contact: MEDCO HEALTH SOLUTIONS 8111 ROYAL RIDGE PKWY IRVING TX, 75063-0000 Attn: Admin Reviews - URGENT APPEALS: (800) 946- 3979.

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.**

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** $6,730
- **Patient pays** $810

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	$0
Copays	$440
Coinsurance	$220
Limits or exclusions	$150
Total	**$810**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,640
- **Patient pays** $760

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	$620
Coinsurance	$60
Limits or exclusions	$80
Total	**$760**

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.