United Teamster Fund

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

Coverage Period: 05/01/2016-04/30/2017

Coverage for: Single, Family | **Fund Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms of the Fund at **http://utfonline.com** or by calling **718-859-1624, (732) 882-1901, (718) 842-1212**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$250 single/$500 family in-network; $3,000 single/$6,000 family out-of-network.	You must pay all the costs up to the **deductible** amount before this Fund begins to pay for covered services you use. Check your policy or Fund document to see when the **deductible** starts over (May 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?	There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this Fund covers.
Is there an out–of–pocket limit on my expenses?	Yes. $3,000 single/$6,000 family in-network; $13,000 single/$26,000 family 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 Fund for health care expenses.
What is not included in the out–of–pocket limit?	Copayments, premiums, balance-billed charges, and health care this Fund 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 Fund pays?	No.	This Fund does not have an annual limit. See the chart starting on page 2 for other *specific* coverage limits, such as limits on the number of office visits.
Does this Fund use a network of providers?	Yes. For a list of **in-network providers**, see www.mycigna.com or call 718-859-1624.	If you use an in-network doctor or other health care **provider**, this Fund 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. We use the term **in-network**, **preferred**, or **participating** to describe **providers** in the **network**. See the chart starting on page 2 for how this Fund 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 Fund.	You can see the **specialist** you choose without permission from this Fund.
Are there services this Fund doesn't cover?	Yes.	Some of the services this Fund doesn't cover are listed on page 6. See your Fund's document for additional information about **excluded services**.

Questions: Call **718-859-1624, (732) 882-1901, (718) 842-1212** or visit us at **http://utfonline.com**

If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.cciio.cms.gov.

- **Copayments (or copays)** 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 **Maximum Reimbursable Charge (or "MRC" for short)** for the service. For example, assuming you have met your deductible, if the Fund's MRC for an overnight hospital stay is $1,000, your **coinsurance** payment of 40% would be $400.
- The amount the Fund pays for covered services is based on the MRC. If an out-of-network **provider** charges more than the MRC, you are responsible for the difference. For example, if an out-of-network hospital charges $5,000 for an overnight stay and the **allowed amount** is $1,000, in addition to the deductible and co-insurance you may have to pay the $4,000 difference. (This is called **balance billing**.)
- This Fund encourages you to use **in-network providers**. By doing this you will have lower **deductibles**, **copayments** and **coinsurance**.

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	Primary care visit to treat an injury or illness	$25 copay	40% coinsurance of the Maximum Reimbursable Charge ("MRC")*.	Out-of-network benefit is subject to yearly out-of-network deductible.
	Specialist visit	$25 copay	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible.
	Other practitioner office visit	$25 copay for chiropractor	40% coinsurance of the MRC* for chiropractor.	25 day max per year for chiropractic care. Out-of-network benefit is subject to yearly out-of-network deductible.
	Preventive care/screening/immunization	No charge	40% coinsurance of the MRC* for preventive care for children through age 5; well woman care; and immunization.	Out-of-network preventive care for children age 6 and over and adult preventive care (other than well woman care) not covered. Out-of-network benefit is subject to yearly out-of-network deductible.

*Your cost may also include 100% of the amount charged in excess of the MRC.

If you have a test	Diagnostic test (x-ray, blood work)	$50 copay for x-ray, $25 copay for bloodwork at physician's office	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible.
	Imaging (CT/PET scans, MRIs)	$50 copay	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 718-859-1624.	Generic drugs	$25 copay	Not covered	——————none——————
	Brand name drugs - no generic available	$25 copay	Not covered	——————none——————
	Brand name drugs - generic available	$25 copay, plus difference in cost	Not covered	——————none——————
	Injectable medications	$50 copay	Not covered	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay per visit	40% coinsurance of the MRC*.	Pre-certification required. Out-of-network benefit is subject to yearly out-of-network deductible.
	Physician/surgeon fees	No charge	20% coinsurance of the MRC* for anesthesiologist fees; 40% coinsurance of the MRC* for other physician/surgeon fees.	Pre-certification required. Out-of-network benefit is subject to yearly out-of-network deductible, except for anesthesiologist fees. Deductible is waived for anesthesiologist fees.
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay waived if admitted. Deductible not applicable.
	Emergency medical transportation	20% coinsurance of the MRC.	20% coinsurance of the MRC*.	The in-network and out-of-network benefit are both subject to the yearly in-network deductible.
	Urgent care	$25 copay per visit	40% coinsurance of the MRC*.	Copay waived if admitted. Out-of-network benefit is subject to yearly out-of-network deductible.

*Your cost may also include 100% of the amount charged in excess of the MRC.

If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per day	40% coinsurance of the MRC*.	$100 copay is subject to a $500 Out-of-Pocket max per year. Out-of-network benefit is subject to yearly out-of-network deductible. In-network coverage limited to the negotiated rate. Out-of-network coverage for semi-private/private room limited to semi-private rate; coverage for special care units limited to the ICU/CCU daily room rate. Pre-certification required.
	Physician/surgeon fee	No charge	20% coinsurance of the MRC* for anesthesiologist fees; 40% coinsurance of the MRC* for other physician/surgeon fees.	Pre-certification required. Out-of-network benefit is subject to yearly out-of-network deductible, except for anesthesiologist fees. Deductible is waived for anesthesiologist fees.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay per visit for Office Visit.	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible.
	Mental/Behavioral health inpatient services	$100 copay per day	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible. $100 copay is subject to $500 Out-of-Pocket max per year. Pre-certification required.
	Substance use disorder outpatient services	$25 copay per visit for Office Visit.	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible.
	Substance use disorder inpatient services	$100 copay per day	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible. $100 copay is subject to $500 Out-of-Pocket max per year. Pre-certification required.

*Your cost may also include 100% of the amount charged in excess of the MRC.

If you are pregnant	Prenatal and postnatal care	$25 copay for initial prenatal visit	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible.
	Delivery and all inpatient services	$100 copay per day	20% coinsurance of the MRC* for anesthesiologist fees; 40% coinsurance of the MRC* for other fees.	Out-of-network benefit is subject to yearly out-of-network deductible, except for anesthesiologist fees. Deductible is waived for anesthesiologist fees. $100 copay is subject to $500 Out-of-Pocket max per year. Pre-certification required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance of the MRC.	40% coinsurance of the MRC*.	In-network benefit is subject to yearly in-network deductible. Out-of-network benefit is subject to yearly out-of-network deductible. 40 day max per year and 16 hour maximum per day. Pre-certification required.
	Rehabilitation services	Inpatient: $100 copay per day. Outpatient: $25 copay per visit.	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible. 60 day maximum per year for inpatient services. 60 day maximum per year for outpatient services (for all therapies combined). $100 copay is subject to $500 Out-of-Pocket max per year. Pre-certification required.
	Skilled nursing care	Inpatient: $100 copay per day.	40% coinsurance of the MRC*.	Out-of-network benefit is subject to yearly out-of-network deductible. 60 day maximum per year for inpatient services. $100 copay is subject to $500 Out-of-Pocket max per year. Pre-certification required.

*Your cost may also include 100% of the amount charged in excess of the MRC.

If you need help recovering or have other special health needs	Durable medical equipment	20% coinsurance of the MRC.	40% coinsurance of the MRC*.	In-network benefit is subject to yearly in-network deductible. Out-of-network benefit is subject to yearly out-of-network deductible. Pre-certification / prior authorization required if cost is $500 or more.
	Hospice service	20% coinsurance of the MRC.	40% coinsurance of the MRC*.	In-network benefit is subject to yearly in-network deductible. Out-of-network benefit is subject to yearly out-of-network deductible. Pre-certification required.
If your child needs dental or eye care	Eye exam	Any costs over $15	Any costs over $15	Maximum one exam per year. **This benefit is covered through Healthplex.**
	Glasses	Any costs over $65. Any costs over $100 for contact lenses.	Any costs over $65	Maximum one pair of glasses per year. **This benefit is covered through Healthplex.**
	Dental	No Charge	Not covered.	$2,000 annual maximum. $1,650 lifetime maximum for orthodontia. **This benefit is covered through Healthplex.**

*Your cost may also include 100% of the amount charged in excess of the MRC.

Excluded Services & Other Covered Services:

Services Your Fund Does NOT Cover (This isn't a complete list. Check your Fund document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or Fund document for other covered services and your costs for these services.)

- Bariatric surgery (subject to medical necessity and clinical guidelines)
- Chiropractic Care
- Dental care
- Dialysis
- Hearing aids
- Private-duty nursing (provided under Home Health Care)
- Routine eye care
- Routine foot care
- Blood when blood replacement is available (except for fees associated with the collection and/or donation of blood)

Your Rights to Continue Coverage:

If you lose coverage under the Fund, 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 what you may have been paying, if anything, while covered under the Fund. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Fund at (718) 859-1624. 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 Fund, you may be able to **appeal**. For questions about your rights, this notice, or assistance, you can contact: the Fund Administrator at (718) 859-1624. You may also contact the Department of Labor's Employee Benefits Security Administration, (EBSA), at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (718) 859-1624, (732) 882-1901, (718) 842-1212.]

To see examples of how this Fund might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this Fund 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 funds.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this Fund. 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
- **Fund pays** $7,130
- **Patient pays** $410

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	$370
Coinsurance	$40
Limits or exclusions	$0
Total	**$410**

These numbers assume the patient has given notice of her pregnancy to the Fund, is using a participating provider and had already satisfied her deductible. If you are pregnant and have not given notice of your pregnancy and are using an out-of-network provider, your costs will be higher. For more information contact the Fund at 718-859-1624, (732) 882-1901, (718) 842-1212.

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

- **Amount owed to providers:** $5,400
- **Fund pays** $4,400
- **Patient pays** $ 1,000

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	$530
Coinsurance	$170
Limits or exclusions	$300
Total	**$1,000**

Note: These numbers assume the patient is participating in our diabetes monitoring program. If you have diabetes and do not participate in the monitoring program, your costs may be higher. For more information about the diabetes please contact the Fund Administrator at (718) 859-1624, (732) 882-1901, (718) 842-1212.

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 fund.
- 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 Fund.
- 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 Fund allows.

Can I use Coverage Examples to compare Funds?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other Funds, you'll find the same Coverage Examples. When you compare Funds, check the "Patient Pays" box in each example. The smaller that number, the more coverage the Fund provides.

Are there other costs I should consider when comparing Funds?

✓ **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**. If available through your employer, 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.