


# Washington Teamsters Welfare Trust: Plan A

Coverage Period: 01/01/2020 – 12/31/2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Family | 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, visit [www.wateamsters.com](http://www.wateamsters.com) or call 1-800-458-3053. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-458-3053 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<b>\$200</b> individual / <b>\$600</b> family. Goes to \$100 individual / \$300 family if you complete the Health Assessment, \$300 individual / \$900 family if you don't.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. The deductible does not apply to in-network <u>preventive care</u> , <u>office visits</u> , <u>prescription drugs</u> , <u>obesity programs</u> .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$75</b> for outpatient emergency room visits.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<b>\$1,500</b> individual / <b>\$3,000</b> family shared in and out-of-network medical coinsurance limit. In addition, an ACA mandated limit for in-network prescription drugs of <b>\$3,150</b> individual / <b>\$6,300</b> family and in-network medical of <b>\$5,000</b> individual / <b>\$10,000</b> family.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Not included in the medical <b>\$1,500</b> individual / <b>\$3,000</b> family coinsurance limit are premiums, deductibles, co-pays, non-covered charges and obesity care. Not included in the ACA mandated limit for in-network prescriptions and in-network medical are premiums, out-of-network and non-covered charges and obesity care.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

For more information about limitations and exceptions, see the plan or policy document at [www.wateamsters.com](http://www.wateamsters.com) or call 1-800-458-3053.

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Important Questions	Answers	Why This Matters:
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.wateamsters.com">www.wateamsters.com</a> and select Premera BlueCard Network Directory <b>or call 1-800-810-2583</b> for a list of participating providers. Be sure to reference the alpha prefix <b>TMP</b> . For prescription drugs see <a href="http://www.medimpact.com">www.medimpact.com</a> <b>or call 1-800-788-2949</b> .	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 3 for how this plan pays different kinds of <b>providers</b> .
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.

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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay/visit	\$20 co-pay/visit	Applies to charge for the office visit only not other professional fees.
	<u>Specialist</u> visit	\$20 co-pay/visit	\$20 co-pay/visit	Applies to charge for the office visit only not other professional fees.
	<u>Preventive care/screening/immunization</u>	No charge	30% co-insurance after deductible and \$20 co-pay	None
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% co-insurance	30% co-insurance	None
	Imaging (CT/PET scans, MRIs)	10% co-insurance	30% co-insurance	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.medimpact.com">www.medimpact.com</a>	Generic drugs	Retail: 10% or 15% co-pay/prescription; Mail order: 10% co-pay/prescription to maximum \$15	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Preferred brand drugs	Retail: 30% or 35% co-pay/prescription; Mail order: 30% co-pay/prescription to maximum \$90	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Non-preferred brand drugs	Retail: 40% or 45% co-pay/prescription; Mail order: 40% co-pay/prescription to maximum \$130	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	<u>Specialty drugs</u>	Mail Order only: 30% co-pay/prescription to maximum \$90	Not covered except for a medical emergency	Mail Order only. Covers up to 100-day supply for mail order.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	30% co-insurance	None
	Physician/surgeon fees	10% co-insurance	30% co-insurance	None
If you need immediate medical attention	<u>Emergency room care</u>	After \$75 deductible, 10% co-insurance	After \$75 deductible, 10% co-insurance	Notify Plan within 24 hours of admission
	<u>Emergency medical transportation</u>	10% co-insurance	30% co-insurance	None
	<u>Urgent care</u>	10% co-insurance	30% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	30% co-insurance	Prior Authorization Required
	Physician/surgeon fees	10% co-insurance	30% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 co-pay/session	\$10 co-pay/session	None
	Inpatient services	10% co-insurance	30% co-insurance	Prior Authorization Required
If you are pregnant	Office visits	10% co-insurance	30% co-insurance	Child's pregnancy is not covered.
	Childbirth/delivery professional services	10% co-insurance	30% co-insurance	Child's pregnancy is not covered.
	Childbirth/delivery facility services	10% co-insurance	30% co-insurance	Child's pregnancy is not covered.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% co-insurance	30% co-insurance	Limited to 130 visits per year
	<u>Rehabilitation services</u>	10% co-insurance inpatient	30% co-insurance inpatient	None - inpatient
		\$20 co-pay/visit outpatient	\$20 co-pay/visit outpatient	Limited to 24-48 visits per year for outpatient
	<u>Habilitation services</u>	10% co-insurance inpatient	30% co-insurance inpatient	None - inpatient
		\$20 co-pay/visit outpatient	\$20 co-pay/visit outpatient	Limited to 24-48 visits per year for outpatient
	<u>Skilled nursing care</u>	10% co-insurance	30% co-insurance	Limited to 180 days per condition
<u>Durable medical equipment</u>	10% co-insurance	30% co-insurance	None	
<u>Hospice services</u>	10% co-insurance	30% co-insurance	Limited to 60 visits	

For more information about limitations and exceptions, see the plan or policy document at [www.wateamsters.com](http://www.wateamsters.com) or call 1-800-458-3053.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	10% co-insurance	30% co-insurance	Medical conditions of eye only. See vision plan for routine exam for visual acuity or eyewear.
	Children's glasses	Not Covered	Not Covered	Covered by separate vision plan.
	Children's dental check-up	Not Covered	Not Covered	Covered by separate dental plan.

## 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      | • Long-term care                                     | • Routine eye care (Adult) |
| • Dental care (Adult)   | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Infertility treatment | • Private-duty nursing                               |                            |

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

- |  |                                       |   |
|--|---------------------------------------|---|
| • Acupuncture (limited benefit)                | • Chiropractic care (limited benefit) | • Weight loss programs (if meeting plan criteria) |
| • Bariatric surgery (if meeting plan criteria) | • Hearing aids (limited benefit)      |   |

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov). 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](http://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: Northwest Administrators at 1-800-458-3053 or [www.nwadmin.com](http://www.nwadmin.com). 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](http://www.dol.gov/ebsa/healthreform).

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## 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 1-800-458-3053.]

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300*
■ <a href="#">Specialist [cost sharing]</a>	\$20
■ Hospital (facility) <a href="#">[cost sharing]</a>	10%
■ Other <a href="#">[cost sharing]</a>	10%

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$300
Copayments	\$10
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,570</b>

\*Assumes the Health Assessment is not taken

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300*
■ <a href="#">Specialist [cost sharing]</a>	\$20
■ Hospital (facility) <a href="#">[cost sharing]</a>	10%
■ Other <a href="#">[cost sharing]</a>	10%

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$100
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,260</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300*
■ <a href="#">Specialist [cost sharing]</a>	\$20
■ Hospital (facility) <a href="#">[cost sharing]</a>	10%
■ Other <a href="#">[cost sharing]</a>	10%

**This EXAMPLE event includes services like:**

Emergency room care  
*(including medical supplies)*  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$300
Copayments	\$100
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>