Central Pennsylvania Teamsters Health and Welfare Fund

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CENTRAL PENNSYLVANIA TEAMSTERS HEALTH & WELFARE FUND

Summary of Material Modification
January 1, 2020

IF YOU RECEIVE TREATMENT OR SERVICES FROM NON-NETWORK PROVIDERS, YOUR FINANCIAL RESPONSIBILITY WILL INCREASE SIGNIFICANTLY EFFECTIVE JANUARY 1, 2020.

The Trustees of the Central Pennsylvania Teamsters Health & Welfare Fund ("Fund") have changed the Benefits available when you or a family member receives certain Treatment or Services from a **Non-Network** Provider, as described further below. **Network** Providers are those in the Aetna Choice POS II (open Access) Network.*

Important Note: *The vast majority of services being utilized by Fund participants are In-Network and will not be impacted by the changes described below.*

Effective January 1, 2020, the out-of-pocket costs to individuals who receive certain Treatment or Services from **Non-Network** Providers will be determined as follows:

	NON-NETWORK
Deductible	Single: $3,000 Family: $6,000
Coinsurance	30%
Out-of-Pocket Maximum	Maximum Not Capped

What Non-Network Treatment and Services are subject to the new Deductible and Coinsurance? *Keep in mind that the chart below is a summary of the changes. If you have any questions about whether a Non-Network Treatment or Service is subject to the new Deductible or Coinsurance, please contact the Fund Office before you have the Treatment or Service.*

*You can learn whether a Provider is a Network Provider through the Fund's website at https://www.centralpateamsters.com/health-welfare-fund/Providers or by calling the Fund Office at 610-320-5500.

Service or Treatment	Deductible	Coinsurance
Physician Office Visits (including Mental Health & Substance Use Disorder); Physical Therapy Visits; Chiropractic Visits	No	No
Physician Visits While in Hospital	Yes	Yes
ACA "Preventive Care" Services (unless provided by a Network Provider)	Yes	Yes
Hospital and Hospital Services (including Mental Health & Substance Use Disorder)	Yes	Yes
Emergency Services (Hospital, Physician, Transportation)	No	No
Surgical Services	Yes	Yes
Outpatient Diagnostic Services	No	Yes
Transplant Services	Yes	Yes
Visiting Nurses	Yes	Yes
Dental, Vision, and Hearing	No	No

EXAMPLE: On January 2, 2020, James Monroe elects to be hospitalized for non-Emergency Treatment at a Non-Network Hospital. Mr. Monroe has not yet met any of his Deductible for 2020. The bill for these Services is $60,000.00. The UCR for this Treatment is $45,000.00. Mr. Smith must pay the Hospital Copayment of $100.00, and a Deductible of $3,000, leaving a balance of $41,900.00. Thereafter, Mr. Monroe is responsible for Coinsurance (30%) of $12,570.00 ($41,900.00 x 30%). The Fund will then pay Benefits of $29,330.00 ($45,000.00 - $3,100.00 - $12,570.00). In addition, the Non-Network Provider can balance bill Mr. Monroe for $15,000.00, the difference between the billed charge and the Fund's UCR. Mr. Monroe has financial responsibility for the hospitalization in the Non-Network Hospital of $30,670.00. (If Mr. Monroe elected instead to be treated at a Network Hospital, his financial responsibility would have been significantly lower.)

These terms are important in understanding the information in this Summary of Material Modification:

- **Deductible**: A charge for Services for which a Participant or Dependent is responsible, and that is deducted from Benefits paid by the Fund after the Services have been rendered.

- **Coinsurance**: The percentage of costs of a covered health care Service you pay (30% for certain Non-Network Treatment or Services) after you've paid your Deductible.

- **Out of Pocket Maximum**: The Out-of-pocket maximum is the most you have to pay for covered Services in a plan year. The out-of-pocket costs for Non-Network Providers are not capped.

- **UCR (Usual, Customary and Reasonable Rate):** The UCR is the rate that the Trustees may determine, in their sole discretion, is the appropriate compensation for various Services provided under the Plan. Unless otherwise indicated in the Active Plan Document ("APD"), the percentile is 85%. The database is obtained from organizations that compile data on the fees that are paid for specific medical Services throughout the country. Currently, the Fund uses a database complied by Fair Health. If there is no UCR for the particular Service rendered, the Plan will pay Benefits to Non-Network Providers a percentage of billed charges.