Teamsters Western Region & Local 177 Retiree Health Care Plan

New Level of Benefits Under Your Retiree Plan

Overview of Changes

The Teamsters Western Region & Local 177 Retiree Health Care Plan is designed to provide affordable coverage for retired Teamster members and their families and easy access to a wide range of health care services. The Retiree Plan is now offering some of the same Level of Benefits options provided by the Active Plan.

This Power Point will offer an understanding of:

- The new Level of Benefits option
- A comparison of the benefits between the Active and Retiree Plans
- Examples of different coverage circumstances under the two Level of Benefits options

The New Level of Benefits Option for the Retiree Plan

Traditional Option (Current Plan): You have the option to continue paying the same amount you do now for the same level of benefits; or

Enhanced Option: For an additional $75 per month for individual ($150 per month for family), you can receive the enhanced level of benefits that match the level of benefits currently in the Active Plan.

Remember both Options have a $1,000 annual out-of-pocket maximum. After meeting the out-of-pocket maximum, the Plan pays 100%.

What does this mean for you?

You can do nothing and your current level of benefits will remain the same under the Traditional Option

OR

You can pay an additional $75 per month for individual ($150 per month for family) for the Enhanced Option:

- Only the amount you pay and the amount the Plan pays for services will change.
- Your current benefits will NOT change. All current benefits, exclusions, and limitations will remain the same.

NOTE:

You get only **ONE** opportunity to select which level of benefits you want to be in. Once you select a level, you are locked in.

MONTHLY SELF-PAYMENT AMOUNTS

Traditional Level of Benefits			Enhanced Level of Benefits		
Retirees Non-Medicare Eligible (Pre-Age 65) Single/Family	Retirees Non-Medicare Eligible (Pre-Age 65) One Non-Medicare/One Medicare	Retirees Medicare Eligible (Post-Age 65) Single/Family	Retirees Non-Medicare Eligible (Pre-Age 65) Single/Family	Retirees Non-Medicare Eligible (Pre-Age 65) One Non-Medicare/One Medicare	Retirees Medicare Eligible (Post-Age 65) Single/Family
$150/$300	**$200**	**$50/100**	**$225/$450**	**$350**	**$125/$250**

We will review some examples of the two Level of Benefits options…

- But first, here are some key benefit differences between the Retiree Plan and the Active Plan (remember, these will not change!) and some important information on how coordination of benefits (COB) works with Medicare…

Comparison of Benefits

BENEFIT	RETIREE PLAN	ACTIVE PLAN
Infertility Treatment	Excluded except for coverage of diagnosis/treatment of underlying cause/disease	Generally covered up to a lifetime limit of 25K $
Dietitian Services	Covered for only obesity	Covered for both obesity and behavioral health conditions
Certain Genetic Testing	Coverage of testing only for diagnosis of underlying condition	A broader scope of genetic testing is covered consistent with the Plan Document description
Routine Costs in Clinical Trials	No coverage	Coverage for costs associated with an individual's participation in an "approved clinical trial" related to cancer or other life-threatening illnesses

What are the benefits of paying an additional amount for the Enhanced Option?

There are benefits to both the Traditional Option and the Enhanced Option, based on your circumstances.

There are cost saving opportunities under both options depending on how often you and your family go to the doctor or pay for prescriptions.

Let’s look at some examples…

No Deductible

Currently, in the Retiree Plan you have a $200 individual and $400 family deductible. Under the new Enhanced Level of Benefits Option, you will have **no deductible**.

What could this mean for you?

- ***With the Traditional Option:*** You must meet your $200 individual deductible before the Plan starts covering costs. If a visit costs $150, you pay the full amount until the deductible is met.
- ***With the Enhanced Option:*** There's no deductible, so you immediately pay only a copay if applicable (e.g., $10) instead of the full amount.
- ***With the Traditional Option***: Your family must pay $400 out-of-pocket for the family deductible before the Plan pays.
- ***With the Enhanced Option***: There is no deductible, so every family member gets payment coverage from day one. If a family has multiple doctor visits, prescriptions, or unexpected medical needs, they avoid paying $400 upfront before payment coverage kicks in.

Prescription Medication

Enhanced Level of Benefits Option

- Retail Prescription (up to 30-day supply): $5 copay for generic medication.
- Specialty drugs: $0 copay for generic medication.
- Mail Order Maintenance Choice (up to 90-day supply): $0 copay for generic medication.

Traditional Level of Benefits Option

- Retail Prescription (up to 30-day supply): the Plan pays 80% after the deductible is met.
- Specialty drugs (up to 30-day supply): the Plan pays 80% after the deductible is met
- Mail Order Maintenance Choice (up to 90-day supply): the Plan pays 80% after the deductible is met

Both the Traditional Level of Benefits and the Enhanced Level of Benefits require you fill a generic equivalent or be responsible for the cost difference between the price of the brand name drug and the generic drug.

Prescription Medication Examples

Example 1: Generic Prescription

- Jim needs an antibiotic for an infection.
- Under the Traditional Option: Jim needs a generic medication that costs $40. Since Jim hasn't met his $200 deductible, he pays the full $40 out-of-pocket.
- Under the Enhanced Option: Jim immediately pays only a $5 copay, without needing to meet a deductible.

Prescription Medication Examples

Example 2: Mail Order Maintenance Medication

- Stanley takes a daily medication for cholesterol, costing $120 per 90-day supply.
- Under the Traditional Option: Stanley must meet his $200 deductible first. After that, the Plan covers 80% of the cost, leaving Stanley to pay $24 for the remaining 90-day refills.
- Under the Enhanced Option: Since Stanley's medication has a generic version, Stanely pays $0 for a 90-day supply through mail order.

Prescription Medication Examples

Example 3: Humira – Used for Rheumatoid Arthritis & Other Conditions
Retail price: $7,000 per month ($21,000 for a 90-day supply)

Enhanced Level of Benefits Option

- Specialty Drug Cost: $0 copay for generic (Brand name if no generic equivalent).
- Humira has no generic equivalent, so it is covered at $0 copay.
- Total Cost to Member: $0 per month

Traditional Level of Benefits Option

- Specialty Drug Cost: Plan pays 80% after deductible is met.
- Step 1: Meet the $200 Individual Deductible
  - Patient pays first $200 out-of-pocket.
- Step 2: After Deductible
  - Plan pays 80% of remaining $6,800 = $5,440
  - Patient pays 20% of remaining $6,800 = $1,360 up to the annual out-of-pocket maximum ($800).
- Total Annual Cost to Member: $1,000 ($200 deductible + $800 coinsurance)

Prescription Medication Key Takeaways

The Enhanced Option generally has a $0 to $5 copay.

The Traditional Option covers 80% of the cost, until the annual out-of-pocket maximum is met. For the remainder of the year the Traditional Option covers 100%.

Carefully consider your prescription expenses to determine which option is best for you and your family.

Physician & Other Health Care Practitioner Services

Under the Enhanced Level of Benefits Option:

- The Plan pays 100% for in-network visits (*note that there is a $10 co-pay for office visits)
- The Plan pays 80% for office visits that are out-of-network up to the Allowed Amount, not to billed charges

Under the Traditional Level of Benefits Option:

- After your deductible is met, the Plan pays 80% if the service is in-network
- The Plan pays 70% if the service is out-of-network up to the Allowed Amount, not to billed charges

Physician & Other Health Care Practitioner Benefit & Cost Share Examples

Example 1: Routine Doctor's Visit (In-Network)

- Pam schedules a routine check-up with her primary care doctor. Total visit cost: $150
- Under the Enhanced Option: Pam pays only a $10 copay. The Plan covers the remaining $140 (100%).
  - Total cost to Pam: $10
- Under the Traditional Option: Pam must first meet her $200 deductible before the Plan starts covering costs. If she has met the deductible, the Plan pays 80%, so she is responsible for $30. If she has not met her deductible, she pays the full $150.
  - Total cost to Pam: $30 after deductible, up to $150 if deductible is not met.

Physician & Other Health Care Practitioner Benefit & Cost Share Examples

Example 2: Specialist Visit (In-Network)

- Michael sees a cardiologist for a follow-up appointment. Total visit cost: $250
- Under the Enhanced Option: Michael pays only $10. The Plan covers the remaining $240.
  - Total cost to Michael: $10
- Under the Traditional Option: If he has met his deductible, the Plan pays 80% of the cost, leaving Michael with $50. If he has not met his deductible, he pays $200 out of pocket, then the Plan pays 80% = $40.
  - Total cost to Michael: $50 after deductible, up to $210 if deductible is not met.

Physician & Other Health Care Practitioner Benefit and Cost Share Examples

Example 3: Out-of-Network Visit (Remember Out-of-Network providers leave you subject to Balance Billing!)

- Phyllis visits an out-of-network physician who billed $900.
- Total visit Allowed Amount: $300
- Under the Enhanced Option: The Plan pays 80% of the visit cost. Phyllis is responsible for 20% = $60.
  - Total cost to Phyllis: $60
  - Potential Balance Billing:
- Under the Traditional Option: If she has met her deductible, the Plan pays 70%, leaving Phyllis with $90. If she has not met her deductible, she pays $200, then the Plan pays 70% = $70.
  - Total cost to Phyllis: $90 after deductible, $230 if deductible is not met.
  - Potential Balance Billing:

The Out-of-Pocket Maximum

Both the Traditional Option and the Enhanced Option include the same Out-of-Pocket Maximum:

- $1,000 per person
- $2,000 per family

This is the most you'll have to pay for certain covered medical expenses in a plan year before the Plan starts covering 100% of the costs.

The next couple of slides will illustrate how the cost differences between the Traditional Level of Benefits Option and the Enhanced Level of Benefits Option might affect whether you reach the Out-of-Pocket Maximum.

Out-of-Pocket Maximum Example

Example: High-Cost Specialty Drug User (Over 6 Months): Angela has a chronic condition and requires a specialty medication costing $5,000 per month. She also has occasional doctor visits and a few generic prescriptions.

Enhanced Level of Benefits Option

- Specialty Drug: $0 copay for generic (Brand name if no generic equivalent)
- Doctor Visits: $10 copay per visit
- Retail Generic Prescriptions: $5 per refill
- Angela's Monthly Costs:
  - Specialty drug (generic available): $0
  - 2 doctor visits/month: $20
  - 3 generic prescriptions/month: $15
  - Total monthly out-of-pocket: $35
- Time to Reach $1,000 Out-of-Pocket Maximum:
  - $35 per month
  - Angela will likely never reach the $1,000 Out-of-Pocket Maximum

Traditional Level of Benefits Option

- Specialty Drug: 80% after deductible ($200 deductible must be met first)
- Doctor Visits: 80% after deductible
- Retail Generic Prescriptions: 80% after deductible
- Angela's First Month Costs:
- Specialty drug: First, she must pay the $200 deductible. After that, the plan covers 80%, leaving Angela responsible for $1,000 (20% of $5,000, but capped at $800 due to out-of-pocket maximum).
- 2 doctor visits ($150 each): After the deductible is met, she pays $30 per visit (20%) = $60.
- 3 generic prescriptions ($30 total before coverage): After deductible, she pays $6 (20%).
- Total first-month out-of-pocket: $1,266 (capped at $1,000 out-of-pocket max, so the Plan covers the rest)
- Time to Reach $1,000 Out-of-Pocket Maximum: Angela reaches the maximum in the first month. After that, all eligible in-network medical expenses are covered 100% for the rest of the year.

THE ENHANCED OPTION COULD KEEP COSTS LOWER THROUGHOUT THE YEAR, WHICH WOULD MAKE IT MORE DIFFICULT TO HIT THE OUT-OF-POCKET MAX.

THE TRADITIONAL OPTION GENERALLY RESULTS IN LARGER UP-FRONT EXPENSES BUT QUICKLY REACHES THE MAX FOR HIGH-COST USERS.

FOR PEOPLE NEEDING EXPENSIVE SPECIALTY DRUGS, THE ENHANCED OPTION IS HELPFUL DUE TO $0 COPAYS ON GENERICS.

FOR THOSE WITH HIGH NON-DRUG MEDICAL EXPENSES, THE TRADITIONAL OPTION MAY HIT THE OUT-OF-POCKET MAXIMUM FASTER.

Out-of-Pocket Maximum Key Takeaways

Emergency Room & Urgent Care Services

Enhanced Level of Benefits Option

- Urgent Care Services: Plan pays 100% after $10 copay for in-network; Plan pays 80% for out-of-network
- Non-Emergency Use of Emergency Room: Plan pays 100% after a $100 copay
- Emergency Use of Emergency Room Services: Plan pays 100% (copay waived) for ER visit if admitted to the Hospital, or if you seek treatment at the emergency room within 24 hours of an accident,
- 100% after $25 copay for ER visit, (if not admitted to the Hospital).

Traditional Level of Benefits Option

- Urgent Care Services: Plan pays 80% after deductible met for in-network and 70% after deductible met for out-of-network
- Non-Emergency Use of Emergency Room: Plan pays 80% after deductible met for in-network and 70% after deductible met for out-of-network
- Emergency Use of Emergency Room Services: Plan pays 80% after deductible met

Emergency Room & Urgent Care Services Example

Example 1: Urgent Care Visit for a Sinus Infection

- Toby wakes up with severe sinus pain, congestion, and a fever. He decides to visit an urgent care center.
- Urgent Care Visit Cost (In-Network): $150
- Under the Enhanced Option:
  - Toby pays a $10 copay.
  - The Plan covers the rest ($140).
  - Total Out-of-Pocket: $10
- Under the Traditional Option:
  - Toby has not met his $200 deductible yet, so he pays the full $150 out-of-pocket.
  - If he had met his deductible, he would pay 20% of $150 = $30.
  - Total Out-of-Pocket: $150 (if deductible not met) or $30 (if deductible met).

Emergency Room & Urgent Care Services Example Continued

Example 2: Toddler Falls and Gets Stitches at the ER (Emergency Use of ER)

- Meredith's 3-year-old son, Jake, falls and cuts his forehead while playing. He is taken to the ER for stitches within 24 hours.
- ER Visit Cost: $1,500
- Under the Enhanced Option:
  - Because this is an emergency, and within 24 hours of the injury, Meredith pays $0 for Jake.
  - The Plan covers the full $1,500.
  - Total Out-of-Pocket: $0
- Under the Traditional Option:
  - If Jake has not yet met his $200 deductible, Meredith pays $200 first for Jake.
  - After that, the Plan covers 80% of the remaining $1,300 = $1,040, and Jake is responsible for $260.
  - Total Out-of-Pocket: $460 if deductible not met, or $300 if deductible met prior to ER Visit.

Emergency Room & Urgent Care Services Example Continued

Example 3: Non-Emergency ER Visit for Back Pain

- Creed has had chronic back pain for months but decides to visit the ER instead of scheduling a doctor's appointment. The ER deems it a non-emergency.
  - ER Visit Cost: $2,000
- Under the Enhanced Option:
  - Since it's a non-emergency ER visit, Creed pays a $100 copay.
  - The Plan covers the rest ($1,900).
  - Total Out-of-Pocket: $100
- Under the Traditional Option:
  - Creed must meet his $200 deductible first, so he pays $200.
  - After that, the Plan covers 80% of the remaining $1,800 = $1,440, leaving Creed to pay $360.
  - Total Out-of-Pocket: $560 if deductible not met, or $400 if deductible met prior to ER Visit.

Let's Talk About Medicare…

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage. It is your responsibility to determine if you are eligible for Medicare!

If you or your spouse become eligible for Medicare, it is **critical** that you enroll in **both** Medicare Part A and Part B—and submit proof of enrollment.

Failing to do so will result in suspension of your retiree health coverage under the Plan starting the first of the month after you become eligible for Medicare, with the possibility of permanently losing your retiree coverage.

Act now: Enroll in Medicare Part A and Part B as soon as you're eligible and send your proof to the Plan's Administrative Office to avoid losing the health coverage you've earned.

Medicare Coordination of Benefits (COB)

If you are eligible for Medicare Parts A and B, this Plan is your secondary coverage, here's how it works:

- The Plan will pay benefits like it does for retirees who don't have Medicare, but it will subtract any amount already paid by Medicare and by you.

Let’s look at some examples…

Medicare COB Examples

Example 1: Office Visit

- Chris has an office visit scheduled to treat his cough, priced at $200.
- Under the Traditional Option: Let's assume Chris has met his $200 deductible already. Medicare covers 80% of the cost ($160), leaving Chris to pay 20% of the cost ($40). Since the Plan would pay the same amount Medicare pays (80%), the Plan would pay $0.
- Under the Enhanced Option: Chris has no initial deductible. He will be charged a $10 copay for the office visit; Medicare would cover 80% of the cost of the visit ($160). The Plan would pay the balance ($30).

Example 2: Hospital Stay

- Victor has a procedure and stay at the hospital. The total hospital visit is priced at $10,000.
- Under the Traditional Option: Medicare covers 80% of the cost ($8,000). Leaving Victor responsible to pay his $200 deductible and $800 of the remaining $2,000. Since he has now met his annual out of pocket maximum ($1000), the Plan would then cover the additional $1,000.
- Under the Enhanced Option: Victor has no initial deductible. Medicare would cover 80% of the cost of the visit ($8,000) and the Plan would pay balance of $2,000. Victor would pay $0.

Takeaways

- The Enhanced Level of Benefits Option provides more predictable costs for frequent healthcare needs. No deductible, lower copays, and full coverage for high-cost prescriptions (including specialty drugs) make this plan beneficial for individuals or families who visit doctors regularly or require expensive medications.
- The Traditional Level of Benefits Option may be more cost-effective for those with minimal healthcare needs. Lower monthly premiums mean lower upfront costs, but higher out-of-pocket expenses for doctor visits, prescriptions, and emergency services. High-cost medical events can quickly reach the out-of-pocket maximum under the Traditional Option.
- Expensive prescriptions or emergency room visits can lead to high initial costs under the Traditional Level of Benefits Option until the out-of-pocket maximum is reached, whereas the Enhanced Level of Benefits Option minimizes these financial surprises with set copays and full coverage for specialty drugs.
- It is important that you carefully consider your individual needs and circumstances prior to selecting an option.