Kingston Trust Fund Benefits At A Glance - 2019 Changes are in RED
To access the entire plan, various schedules, forms, PPO providers and other important information, go to www.ktftrustfund.com.

Important Information/Contacts		
KTF Enrollment (Enrollment is required in Medicare A&B once Primary Member is retired and 65 or disabled.)	**Go to** www.ktftrustfund.com **for forms**	You must enroll within 30-days of your hire or rehire date. Any family status change (divorce, legal separation, marriage) affecting eligibility for coverage or any change in other coverage, including Medicare eligibility, must be reported within 60-days of the change.
Kingston Trust Fund Office	**1-845-338-5422**	Located at 307 Wall St Suite 6, Kingston, NY 12401.
KTF Claims/Appeals/Compliance KTF PPO Network	**1-844-KTF-FUND**	Medical necessity appeal must be filed within 4-months of the initial denial. All other appeals must be filed within 180-days (of payment or denial) with the Compliance Office.
Pre-certification	**1-844-KTF-FUND**	See Plan for details and Pre-certification Section below.
MagnaCare PPO Network for Medical and Behavioral Health	**1-800-235-7330**	MagnaCare PPO Network for Medical and Behavioral Health.
Multiplan PPO Network	**1-888-342-7427**	Multiplan is an alternative network when a provider is not available in the MagnaCare or KTF PPO.
ProAct Customer Service (Rx)	**1-877-635-9545**	Contact for any prescription related problems or Rx authorizations.
Noble Customer Service (Specialty Rx)	**1-888-843-2040**	For Specialty Drugs; mail order only.
CanaRx	**1-866-893-6337**	Brand name drugs only.

Disclaimer: This summary is a "brief" summary of the plan benefits for the Trust. For complete information, please refer to your Plan or Summary Plan Description (SPD), which can be found at www.ktftrustfund.com. Hard copies of any document will be provided upon request. For benefit questions contact the Compliance Office.

Pre-certification

Refer to the Plan Part A for complete pre-certification rules. All inpatient confinement, outpatient visits in excess of 6 with same provider, diagnostic tests over $2,500, any physical therapy, massage therapy or infertility treatment, and any other claims over $1,500 must be pre-certified.

Basic Deductible, Copays, Coinsurance and Out of Pocket Limits In-Network (PPO) and Out-of-Network (NPPO)

MagnaCare and KTF PPO are the Primary PPO Networks; MultiPlan Providers are available when a provider is not available through MagnaCare or KTF PPO, otherwise Multiplan is considered NPPO.

Benefit	PPO	NPPO	Explanations or Comments
Deductible Single/Family	No deductible	$1,800/$4,500	NPPO deductible applies to outpatient services only. See hospital copays below. NPPO Deductible is separate from the PPO limits.
Out of Pocket (OOP) Single/Family	$1,500/$3,000	$2,700/$5,200	OOP limit includes ALL copays, including Hospital copays, coinsurance, and deductibles. NPPO OOP is separate from PPO OOP. Limited benefits (infertility, hearing aids, vision, wellness benefits, etc.) and excess charges are not credited to the OOP limit.
Coinsurance	10%	30%	
Office Visit (OV) KTF/MagnaCare	$30	Ded. + Coins.	All outpatient office visits with the same provider must be precertified after six visits. NPPO providers are subject to NPPO deductible and coinsurance.
Hospital Copay/MultiPlan	$50/day up to $250 $100/day up to $500	$500 copay + 30% coinsurance up to OOP Limit.	

Preventive Benefits Covered at 100% Under Health Care Reform with PPO Providers Only (Deductible and Copays Waived)
Excess preventive or wellness visits are not covered

Annual adult physical; well child care; bone density or osteoporosis exam, after age 50; cholesterol screen; colonoscopy, endoscopy, sigmoidoscopy, every 5 years after age 45; immunizations and vaccinations per ACA guidelines for children and adults; mammogram; nutrition counseling; pap smear, prostate exam.

Other PPO Preventive and First Dollar Benefits Paid at 100% with no copay or deductible.	
Benefit	**Explanation**
Allergy Injections	Only when not part of an office visit.
Annual Adult Physical	Two preventive exams (age 19 and older), including well woman care. Excess preventive benefits not covered.
Breast Cancer Screening	Limited to once per year or as medically necessary.
Breast Feeding	Includes counseling, supplies, and equipment. See Part C Notice on Preventive Benefits and coverage.
Birth Control	Includes pills, diaphragm, IUD (OV copay for insertion) and patch. Excluding brand pills - subject to normal copays.
Assistant Surgeon	Limited to 25% of primary surgeon's allowed charges.
Bone Density or Osteoporosis Exam	Limited to one per year after age 50.
Chemotherapy/Radiation/Infusion Therapy	Copays for Rx may apply. Office visit copays are waived.
Cholesterol Screen with No Office Visit	Limited to 4 times per year.
Colonoscopy, Endoscopy, Sigmoidoscopy	Covered every 5 years after age 45. All others shall be subject to normal diagnostic exam copay and related copays.
Diabetic Program (MUST ENROLL)	Special diabetic benefits, including supplies and insulin paid at 100%. See Plan & Rx Plan for details.
Dialysis	Including home dialysis.
Durable Medical Equipment (DME)	Pre-certification required if expected to cost over $500.
FTS (Downs Syndrome Test)	Limited to one test during the first trimester only.
Genetic (Level II) Obstetrical Ultrasound	Limited to one test per pregnancy. All other genetic testing must be pre-certified and is covered as Any Other Benefit.
Hearing Screening	Covered for all newborns.
Hospice (limited to 210 days)	More than 180-days must elapse between each hospice confinement.
Injections (non-insulin)	OV copay applies if office visit is billed.
Lab Tests – OV copay applies when done by outside lab (not billed with office visit)	$30 Copay applies to all lab tests (other than preventive tests) billed by an independent lab. Complex lab and diagnostic tests are subject to Complex Test Copay (see Complex X-ray/Diagnostic).
Mammogram	One per year after age 40.
Nursery Care	Routine nursery care is paid at 100% if enrolled in Healthy Beginnings Pre-Natal Program. Non-routine nursery care is paid under baby's own claim (hospital copay applies).
Nutritional/Training	15 hours for enrolled diabetic/10 hours for non-enrolled diabetic by certified diabetic or nutritional trainer.
Physical Therapy (Inpatient)	Limited to 30 visits per therapy while confined. Extended treatment may be approved.
Pre-natal Ultrasound	Limited to once per pregnancy unless medically necessary.
Pre-natal Visits	Covered under Well Woman Care as set out by Health and Human Services (HHS) guidelines.
Vaccines/Immunizations (including catch-up vaccines)	Based on ACIP (Advisory Committee on Immunization Practices) schedules available at www.ktftrustfund.com. Other vaccines required for school, work or travel are not covered. Vaccines are subject to OV copay.
Weight Loss Incentive Program	Enrollment required. See Plan or call Pre-certification for details.
Well Child Care to 19	Well care visits are covered, limited to 7 visits to age 1, then 6 visits per year ages 1 to 19. Non-routine well care or diagnostic visits are subject to OV copay.
Wellness/Fitness Benefit	Reimbursement of $100 for single/$150 for member and spouse for membership. See Plan for details.

Prescription Drug (Rx) Coverage When KTF is PRIMARY Plan (Network Only Coverage) 1/1/2019 Changes in RED			
Benefit	**Retail**	**Mail Order**	**Explanations or Comments**
Generic Drugs (30-days)	$10	$15	Copays doubled for failure to use mail order after 3rd refill; copays doubled for failure to use generics, unless medical necessity override is approved. Step Therapy rules may apply. Nursing Home Patients must submit request for Rx to be filled locally at long term care pharmacy.
Brand Drugs (90-days) – [Medicare Primary Copay]	$35 [$20]	$55	

Specialty Drugs (30-days) (Mail Order Only)	20% up to OOP	Most specialty drugs are available through mail order only. **Subject to pre-certification and must be ordered through Noble** – applies to chemotherapy and/or radiation or other specialty drugs.
Rx Out of Pocket (OOP) Limit	$2,550 combined Rx copays limited	The Rx OOP limit is separate from the Medical OOP limit and applies to copays for retail and mail order drugs, excluding any penalty copays and all major-medical Rx.
Major Medical Drugs	Paid at 80%, subject to medical Out of Pocket (OOP).	If KTF is secondary plan, copays in excess of deminis copays ($10) must be submitted for reimbursement within 90-days or when you reach maximum Rx benefits under your Primary Plan.
Diabetics Supplies (Enrollment Required)	Insulin, tests strips, Glucophage and Metformin are covered at 100% for enrolled diabetics. Medicare Part B is primary for test strips and insulin (if on insulin pump) for Medicare primary members. Special rules apply if Medicare is Primary. See Plan.	

In-Network PPO and NPPO Outpatient Benefits (All NPPO Benefits are subject to Deductible and Coinsurance (D/C) unless noted)

Benefit	PPO	NPPO *	Explanations or Comments
Any Other Benefit	90%	80%	Medically necessary benefits pre-certified before treatment.
Alternative Providers	OV Copay	D/C	Combined benefit is limited to $500 for PPO and NPPO providers.
Allergy Testing	OV Copay	D/C	Excludes allergy injections.
Genetic/Infertility Test	OV Copay	D/C	Genetic testing subject to pre-certification for medical necessity. Covered same as any other test if approved.
Cardiac Rehab	OV Copay	D/C	Maximum of 40 visits.
Acupuncture/Chiropractic	OV Copay	D/C	Maximum benefit for acupuncture and chiropractic is limited to $75 per visit. Combined PPO/NPPO benefits for chiropractic, acupuncture and massage therapy are limited to $2,500 per benefit year.
Massage Therapy	OV Copay	D/Paid at 50%	Maximum benefit is limited to $50 for 1-hour visit or $25 for ½ hour visit. Limited to 15 visits annually. Included & subject to Acupuncture/Chiropractic Annual Limit. Member responsible for excess charges.
Eye Exam	OV Copay	OV Copay	One routine eye exam is covered annually, deductible is waived. This Plan is secondary to any standalone vision exam. Glasses and contacts are covered at 50% up to $250/year.
Hearing Aids	100%	Deductible Waived	Limited to $1,000 (single) or $3,000 (pair) of hearing aids every five (5) benefit years. Batteries are not covered. NPPO deductible waived and paid same as PPO.
Home Health Care	OV Copay	D/C	Limited to 200 visits per calendar year and 4 hours equals one visit. Custodial care is not covered.
Orthotics	OV Copay	D/C	Maximum benefit limited to $500 per year.
Physical, Occupational, Speech & Cognitive Therapy	OV Copay	D/C	Subject to pre-certification, medical necessity, appropriateness of care and measurable improvement for continued care based on a stated treatment plan, as prescribed by a doctor.
Podiatry	OV Copay	D/C	Includes injections and non-routine foot care. Routine foot care is not covered.

Emergency Care, Ambulance, Lab, Diagnostic and X-Ray

Benefit	PPO	Out of Network (NPPO)	Explanations or Comments
Emergency Room	$100	$100 (deductible waived)	Paid at 50% for non-emergency, medically necessary transfers paid at 90%.
Ambulance	100%	100% (deductible waived)	$250 copay for air ambulance.
X-ray/Diagnostic (<$2,500)	OV Copay	Deductible/Coinsurance	Includes Complex CT Scans, MRI, CAT Scans and other complex testing performed on an outpatient basis that is not part of any preadmission x-ray or testing. Copay applies to all tests combined on daily basis for same provider.
X-ray/Diagnostic (>$2,500)	$100	Deductible/Coinsurance	
Urgent Care	OV Copay	Deductible/Coinsurance	Non KTF/MagnaCare PPO Outpatient copay will apply for approved Urgent Care visits. Contact Pre-certification for authorization while traveling.

Inpatient Hospital and Surgical Benefits (PPO and NPPO)			
Benefit	**In Network (PPO)**	**Out of Network (NPPO)**	**Explanations or Comments**
Hospital Copay – KTF/MagnaCare PPO Hospital or Multiplan Hospital	$50/day up to $250 $100/day up to $500	$500 copay + 30% Coinsurance	Hospital copays are included in the OOP limit: $1,500 Individual/ $3,000 Family for PPO and $2,000 Individual/ $3,500 Family for NPPO.
Surgical Copay – KTF/MagnaCare PPO	$100	Deductible + $250 + 30% Coinsurance	Applies to primary surgeon. Assistant surgeon charges limited to 25% of Primary surgeon. Benefits reduced for 2nd/3rd procedure.
Anesthesia	100%	100% up to allowed charge	Members are responsible for excess charges for NPPO providers.
Skilled Nursing	Hospital Copay	Deductible + Coinsurance	Limited to maximum of 100-days for PPO and NPPO combined.
Surgical Center/Facility	100%	Deductible + Coinsurance	Facility charges are paid 100%.
Transplant	100% if Center of Excellence used	Deductible + Coinsurance	Copays and deductibles apply to other transplant facilities. See Part A Plan document for detailed transplant benefits.
Maternity (enrolled in Healthy Beginnings Program)	**	N/A	**Must enroll during first 14 weeks or within 60-days of coverage. Paid at 100% after first OV copay. Hospital/Surgical copays are waived. Copays and deductible apply if you fail to timely enroll.

PENALTIES AND EXCLUSIONS (Partial List – See Plan for Additional Information)

Penalties for Late Filed Claims and Failure to Pre-certify Benefits Prior to Treatment: Benefits will be reduced for failure to pre-certify required benefits and/or failure to file claims within 90-days of service. Benefits are also reduced by 50% if you fail to complete an approved treatment program.

Non-Covered Treatment: Court Ordered Treatment; Educational Services/Treatment; Treatment for chronic conditions that cannot be favorably changed by a specific treatment plan; experimental treatment; nursing homes, custodial care, half way houses, and transportation (if not pre-certified as Medically Necessary).

NPPO (Out of Network) Outpatient Benefits

All NPPO providers are subject to the NPPO deductible and coinsurance. The NPPO limits (copays, coinsurance and deductible) are separate and in addition to the PPO limit. Members are responsible for excess charges if a NPPO Provider is used. Members are responsible for verifying the status of their provider PRIOR to service.

Foreign Travel	Limited to emergency services only and is subject to separate $250 copay in addition to emergency copay of $100 and then NPPO deductible and coinsurance apply. Travel insurance is recommended for foreign travel. This Plan is always secondary to Travel insurance. See Plan for details.
Limited Benefits	Limited benefits are paid the same for both PPO and NPPO providers, but these benefits are not subject to the Plan's out of pocket limits nor is the member's coinsurance credited towards the out of pocket limit. Limited benefits include alternative providers, acupuncture, chiropractic, holistic medicine, Lasik benefits, eye care, hearing aids, limited dental, infertility benefits, weight loss, wellness benefits, and massage therapy.