Kingston Trust Fund Benefits At A Glance – 01/01/2025 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 Part A & B once the primary member is retired and 65 or disabled.)	www.ktftrustfund.com	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.
KTF Appeals and Compliance KTF PPO Network	**844-KTF-FUND**	Medical necessity appeals and all other appeals must be filed within 180-days (of payment or denial) with the Compliance Office.
MagnaCare Medical Claims and Medical Prior Authorizations	**800-352-6465**	See Plan for details and "Prior Authorization" section below.
MagnaCare PPO Network (Medical and Behavioral Health)	www.magnacare.com **800-352-6465**	MagnaCare PPO Network for Medical and Behavioral Health.
First Health PPO Network	www.firsthealth.com	First Health is an alternative network for use outside of the state of New York.
Four Corners (Pharmacy Benefit Manager)	**866-443-9331**	Contact for any prescription related problems or Rx authorizations.
Manifest Pharmacy (Mail Order Rx)	**888-770-4009**	Contact for any mail order prescription.
CVS Caremark Specialty Pharmacy	**800-237-2767**	For specialty drugs that are mail order only.
CanaRx	**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.

Prior Authorization

Refer to the Plan, Part A, for complete prior authorization rules. All inpatient confinement, outpatient visits in excess of 6 with the same provider, diagnostic tests over $2,500, all genetic testing, any physical therapy, or infertility treatment, and any other claims over $2,500 must be preauthorized.

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. First Health Network providers are available outside of the state of New York.

Benefit	PPO	NPPO	Explanations or Comments
Deductible Single/Family	No Deductible	$1,800/$4,800	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 limits include 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 limits.
Coinsurance	10%	30%	
Office Visit (OV)	$30	Ded. + Coins.	Office visits with charges over $500 have a $100 copay. All outpatient office visits with the same provider must be preauthorized after 6 visits. NPPO providers are subject to NPPO deductible and coinsurance.
Hospital Copay	$50/day up to $250	$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 visits; 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)	Prior authorization 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 preauthorized 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 of $100 (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	20 visits for enrolled diabetic/10 visits 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 prior authorization 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) 01/01/2025 Changes in RED			
Benefit	**Retail (30-days)**	**Mail Order (90-days)**	**Explanations or Comments**
Generic Drugs	$15	$20	Copays doubled for failure to use mail order after 3rd refill; copays plus cost difference between brand and generic for failure to use generics unless medical necessity override is
Preferred Brand Drugs	$25	$50	

Non-Preferred Brand Drugs	$60	$120	approved. Step Therapy rules may apply. Nursing home patients must submit request for Rx to be filled locally at long term care pharmacy.
Specialty Drugs (31-days) (Mail Order Only)	20% up to OOP		Most specialty drugs are available through mail order only. **Subject to prior authorization and must be ordered through the Specialty Pharmacy** (applies to chemotherapy and/or radiation or other specialty drugs.)
Rx Out-of-Pocket (OOP) Limit	$4,000 (non-Medicare); $2,000 (Medicare) 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 preauthorized 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 is subject to prior authorization for medical necessity. Covered same as any other test if approved.
Cardiac Rehab	OV Copay	D/C	Maximum of 40 visits.
Acupuncture	OV Copay	D/C	The maximum benefit for acupuncture is limited to $100/PPO and $75/NPPO per visit. Combined PPO/NPPO benefits for acupuncture, chiropractic, and massage therapy are limited to $2,500 per benefit year.
Chiropractic	OV Copay	D/C	The maximum benefit for chiropractic is limited to $75 per visit. Combined PPO/NPPO benefits for acupuncture, chiropractic, and massage therapy are limited to $2,500 per benefit year.
Massage Therapy	OV Copay	OV Copay	PPO maximum benefit is limited to $70 for 1-hour visit or $35 for ½ hour visit. NPPO 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/massage $2,500 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 $300/year.
Hearing Aids	100%	Deductible Waived	Limited to $1,500 (single) or $3,000 (pair) of hearing aids every five (5) benefit years. The 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 Therapy, Occupational, Speech & Cognitive Therapy	OV Copay	D/C	Subject to prior authorization, 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	NPPO outpatient copay will apply for approved urgent care visits. Contact prior authorization 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	$50/day up to $250	$500 copay + 30% Coinsurance	Hospital copays are included in the OOP limit: $1,500 Individual/ $3,000 Family for PPO and $2,700 Individual/ $5,200 Family for NPPO.
Surgical Copay	$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 the 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 Preauthorize Benefits Prior to Treatment: Benefits will be reduced for failure to preauthorize 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, halfway houses, and transportation (if not preauthorized 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, unless otherwise noted under the specific benefit, 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.