Teamsters Local 728 Movie Industry Plan Comparison

A comparison of the EPO Plan 60 can be found at MyTeamCare.org/Movies728	**Flex Plan** **Anthem Premier EPO Plan 80**		TEAMCARE®
Network	**Blue Cross Blue Shield National PPO Network**		**Blue Cross Blue Shield National PPO Network**
Annual Deductibles			
Individual	$1,250		$500
Family	$3,125		$1,000
Annual Out-of-Pocket			
Individual	$4,000		$4,000
Family	$10,000		$8,000
Office Visit Co-Pay			
Primary Care	$30		$30
Specialist	$50		$30
Urgent Care	$30		$30 If Billed as an Office Visit
Key Medical Benefits	**Coinsurance Applies After Deductible is Met**		
Preventive Care	Covered in Full		Covered in Full - No Cost to the Member
TELADOC Telemedicine	$15 Copay		Covered in Full - No Cost to the Member
minute clinic CVS Minute Clinic	N/A		Covered in Full - No Cost to the Member
Urgent Care	$30 Copay or If billed as an outpatient 20%		If Billed as an Outpatient Visit: 25%
Emergency Room	$200 Copay / 20%		$150 Copay / 25%
Coinsurance (Inpatient, Outpatient, Surgical, Ambulance)	20%		25%
QuestSelect™ Formerly Lab Corp® Outpatient Lab Services	$30 Copay		Covered in Full - No Cost to the Member: Quest
USIN Outpatient Imaging (MRI, CT)	20%		Covered in Full - No Cost to the Member: USIN
Chiropractic Benefit	20% Copay (Max 24 Visits)		50% Up to $500 Per Person, Per Year
Outpatient Behavioral Health	$30 Copay		$30 Copay
Inpatient Behavioral Health	20%		25%
Prescription Benefits			CVS caremark®
Retail (up to 30 day supply)	Tier 1: $10 Copay Tier 2: $100/$200 Deductible, Then $25 Copay	Tier 3: $50 Copay Tier 4: 30%, Max $150	No Deductible, 25% Coinsurance
Maintenance (up to 90 day supply)	Tier 1: $10 Copay Tier 2: $100/$200 Deductible, Then $50 Copay	Tier 3: $50 Copay Tier 4: 30%, Max $150	No Deductible, 20% Coinsurance
Dental Benefits	**Delta Dental**		Humana. Dental
Dental Deductible	$50/$150		No Deductible
Dental Annual Max	$1,000 Per Person, Per Year		$1,500 Per Person, Per Year
Orthodontia Max	$1,000 Per Person		$1,500 Per Child
Vision Benefits	**VSP**		eyemed
Vision (In-Network)	$10 (Every 12 Months)		$10 (Every 12 Months)
Lenses	Included (Every 12 Months)		Included (Every 12 Months)
Frame Allowance	$150 Allowance (Every 24 Months)		$150 Allowance (Every 12 Months)
Contact Lenses	$150 Allowance (Every 12 Months)		$120 Allowance (Every 12 Months)
Short-Term Disability	Available		To Be Determined
Life Insurance (Member)	$20,000		To Be Determined
Family Protection Benefit	Not Available		TeamCare Provides up to Five Years of Free Health Coverage for Covered Dependents in the Event of the Member's Death.

If there is a discrepancy in this comparison, the Plan Document shall govern.
Visit MyTeamCare.org for more information.

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

Corrected Version May 24, 2022