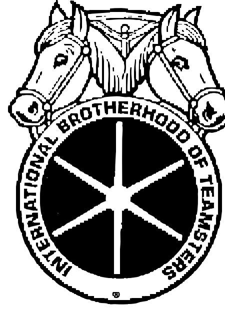
TEAMStar®

MEDICARE PART D

Prescription Drug Program (PDP)



2019 SUMMARY OF BENEFITS

JANUARY 1, 2019 – DECEMBER 31, 2019

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TEAM*Star*® MEDICARE PART D PRESCRIPTION DRUG PROGRAM (PDP)

(a Medicare Prescription Drug plan (PDP) offered by the International Brotherhood of Teamsters Voluntary Employee Benefits Trust)

Enrollment in **TEAM*Star*® Medicare Part D (PDP)** depends on Contract renewal.

SUMMARY OF BENEFITS

January 1, 2019 - December 31, 2019

This booklet gives you a summary of what we cover and what you pay. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments may change on January 1 of each year. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare prescription drug benefits

- One choice is to get prescription drug coverage through a Medicare Prescription Drug Plan, like the **TEAM*Star*® Medicare Part D (PDP)**.
- Another choice is to get your prescription drug coverage through a Medicare Advantage Plan (like an HMO or PPO) or another Medicare health plan that offers Medicare prescription drug coverage. You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **TEAM*Star*® Medicare Part D (PDP)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **TEAM*Star*® Medicare Part D (PDP)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at (866)-524-4173 (TTY/TDD 711).

Este documento puede ser disponible en otros idiomas distintos del inglés. Para informacion adicional, llame a servicio al cliente al numero de telefono mencionado arriba.

Things to Know About TEAM*Star*® Medicare Part D (PDP)

Hours of Operation

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. in your local time zone.

TEAM*Star*® Medicare Part D (PDP) Phone Numbers and Website

- Current members, call toll-free (866)-524-4173, (TTY/TDD 711).
- Prospective members, call toll-free (866)-524-4173, (TTY/TDD 711).
- Our website: http://www.teamstarpartd.com

Who can join?

To join **TEAM*Star*® Medicare Part D (PDP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. You must be an IBT Retiree, spouse or dependent of an IBT Retiree. Our service area includes the following: **All states of the United States, the District of Columbia and all U.S. territories**.

Which drugs are covered?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website (http://www.teamstarpartd.com). Or, call us and we will send you a copy of the formulary. The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Union-Designated retail pharmacies will fill certain Tier 1 Generic drugs ("Low Cost Generics") at a low copay of $5 for a one month supply. Deductibles do not apply to these drugs filled at these retail pharmacies. Please refer to your formulary and pharmacy directory.

Which pharmacies can I use?

We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's pharmacy directory at our website (http://www.teamstarpartd.com). Or, call us and we will send you a copy of the pharmacy directory.

If you have any questions about this plan's benefits or cost, please contact **TEAM*Star*® Medicare Part D (PDP)** for details.

TEAM*Star*® MEDICARE PART D

Prescription Drug Program (PDP) Premium Table

BRONZE – All 50 States, D.C. and all U.S. territories

Monthly Premium: $46.80[1] **Deductible: $415[2]**

Until your total calendar year drug costs equal $3,820, you will pay the following copayments:

UNION-DESIGNATED PHARMACY[2]

Low Cost Generics

Deductible does not apply

$5 Retail copay for a 30-day supply

OTHER NETWORK PHARMACIES

Copay/Coinsurance

Tier 1: Preferred Generics

$8 Retail copay for a 30-day supply

$16 Mail copay for a 90-day supply

Tier 2: Generics

$11 Retail copay for a 30-day supply

$22 Mail copay for a 90-day supply

Tier 3: Preferred Brands

$45 Retail copay for a 30-day supply

$90 Mail copay for a 90-day supply

Tier 4: Non-Preferred Brands & Tier 5: Specialty

25% Retail copay for a 30-day supply

25% Mail copay for a 90-day supply

[1]Monthly premiums will be reduced to $45.80 for the Bronze Plan if you elect to pay premiums by monthly bank draft.

Note: Monthly premiums shown do not reflect any Medicare imposed penalties for late enrollment or extra Part D amount based on your income. You must continue to pay your Medicare Part B premium.

[2]Union-Designated retail pharmacies will fill Tier 1 Generic drugs at a low copay of $5 for a one month supply. Deductibles do not apply to these drugs filled at Union-Designated pharmacies. Please refer to your formulary and pharmacy directory for more specifics.

TEAM*Star*® MEDICARE PART D

Prescription Drug Program (PDP)

SILVER – All 50 States, D.C. and all U.S. territories

Monthly Premium: $96.25[1] **Deductible: $100**

Until your total calendar year drug costs equal $3,820, you will pay the following copayments:

UNION-DESIGNATED PHARMACY[2]

Low Cost Generics

Deductible does not apply

$5 Retail copay for a 30-day supply

OTHER NETWORK PHARMACIES

Copay/Coinsurance

Tier 1: Preferred Generics

$8 Retail copay for a 30-day supply

$16 Mail copay for a 90-day supply

Tier 2: Generics

$11 Retail copay for a 30-day supply

$22 Mail copay for a 90-day supply

Tier 3: Preferred Brands

$45 Retail copay for a 30-day supply

$90 Mail copay for a 90-day supply

Tier 4: Non-Preferred Brands & Tier 5: Specialty

$70 Retail copay for a 30-day supply

$140 Mail copay for a 90-day supply

[1]Monthly premiums will be reduced to $95.25 for the Silver Plan if you elect to pay premiums by monthly bank draft.

Note: Monthly premiums shown do not reflect any Medicare imposed penalties for late enrollment or extra Part D amount based on your income. You must continue to pay your Medicare Part B premium.

[2]Union-Designated retail pharmacies will fill Tier 1 Generic drugs at a low copay of $5 for a one month supply. Deductibles do not apply to these drugs filled at Union-Designated pharmacies. Please refer to your formulary and pharmacy directory for more specifics.

TEAM*Star*® MEDICARE PART D
Prescription Drug Program (PDP)

PLATINUM – All 50 States, D.C. and all U.S. territories

Monthly Premium: $165.60[1] **Deductible: $0**

Until your total calendar year drug costs equal $3,820, you will pay the following copayments:

UNION-DESIGNATED PHARMACY[2]

Low Cost Generics
Deductible does not apply
$5 Retail copay for a 30-day supply

OTHER NETWORK PHARMACIES
Copay/Coinsurance

Tier 1: Preferred Generics
$8 Retail copay for a 30-day supply
$16 Mail copay for a 90-day supply

Tier 2: Generics
$11 Retail copay for a 30-day supply
$22 Mail copay for a 90-day supply

Tier 3: Preferred Brands
$35 Retail copay for a 30-day supply
$70 Mail copay for a 90-day supply

Tier 4: Non-Preferred Brands & Tier 5: Specialty
$55 Retail copay for a 30-day supply
$110 Mail copay for a 90-day supply

[1]Monthly premiums will be reduced to $164.50 for the Platinum Plan if you elect to pay premiums by monthly bank draft.

Note: Monthly premiums shown do not reflect any Medicare imposed penalties for late enrollment or extra Part D amount based on your income. You must continue to pay your Medicare Part B premium.

[2]Union-Designated retail pharmacies will fill Tier 1 Generic drugs at a low copay of $5 for a one month supply. Deductibles do not apply to these drugs filled at Union-Designated pharmacies. Please refer to your formulary and pharmacy directory for more specifics.

Long-Term Care: If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820.

After you enter the coverage gap, you pay 25% of the plan's cost for brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Platinum Plan members will pay no more than $8 for a 30-day supply of Tier 1 generics and $11 for Tier 2 generics while you are in the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of:

- 5% of the cost, or
- $3.40 copay for generic (including brand drugs treated as generic) and an $8.50 copayment for all other drugs.

However, you will pay no more than $100 per prescription after your TrOOP (True Out-of-pocket) costs reaches $5,100.

Please Read This Important Information

Are you a member of an employer or union retiree group? If you are, please check with the benefits administrator of your employer or union retiree group before you change your plan. This is important because you may lose benefits you currently receive under your employer or retiree group coverage if you switch plans, or you may already receive benefits similar to those provided by this plan.

TEAM*Star*® Medicare Part D (PDP) complies with applicable Federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

TEAM*Star*® Medicare Part D (PDP) does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.