PHILADELPHIA Update

Official Publication of the
Teamsters Health & Welfare Fund
of Philadelphia and Vicinity

www.teamsterfunds.com

Fall 2016

Yearly Open Enrollment Begins Nov. 1st and Ends Dec. 2nd . . .

It's Your Chance to Choose Between Blue Cross PPO or Aetna HMO Coverage

Open Enrollment is your annual opportunity to review your medical plan choices. All changes will be effective January 1, 2017. Take some time to review this Newsletter. Also visit www.teamsterfunds.com for Open Enrollment information and links to each medical plan's online provider directory.

If you have *PPO* coverage now and don't do anything, as of January 1, 2017 you'll still enjoy coverage under the PPO program. However, the level of coverage you will enjoy during 2017 (Platinum level or Gold level) depends upon whether you completed your required wellness screening by October 31, 2016.

If you have BlueCard PPO coverage and want to switch to the Aetna HMO coverage effective January 1, 2017, call 1-800-523-2846 to have an enrollment kit mailed to you. You must fill out the enrollment form, choose a Primary Care Physician, ***AND*** have the enrollment form returned to the Fund office before the open enrollment period **ends on December 2nd.**

If you have HMO coverage now and don't do anything, as of January 1, 2017 you'll still enjoy coverage under the HMO program. However, the level of coverage you will enjoy during 2017 (Platinum level or Gold level) depends upon whether you completed your required wellness screening by October 31, 2016.

If you have Aetna HMO coverage and want to switch to the Blue Cross PPO coverage effective January 1, 2017, call the Fund office at 1-800-523-2846 for a coverage change form (a copy is also available on the Fund's web site).

If you wish to change your coverage for the coming year, YOU MUST ACT NOW!

Please read and review the enclosed Summary of Benefits and Coverages pull-out section for each of the plans

What's Changing for Plan Year 2017? What's Staying the Same?

- A Lot!!! If you completed your WellTeam® Wellness screening, you earned participation in the Fund's "Platinum" PPO or HMO benefit programs; if you didn't, then your benefits for the 2017 plan year are those detailed in the "Gold" PPO or HMO benefit programs. Summaries of each are set forth in the special pull-out section.
- To earn participation in the "Platinum" benefit program for 2018, you will need to complete the wellness screening in 2017 AND have at least one preventive dental exam by September 30, 2017.
- Whether you enjoy benefits under the Platinum or Gold plan(s):
  - Total Care Network continues to administer the mental health and substance abuse benefit (regardless of whether you choose the PPO or HMO medical program)
  - Dental and vision coverages will remain the same for both PPO and HMO participants
  - PPO participants can avoid out-of-pocket costs by using LabCorp or Quest for their outpatient laboratory needs and the ***Health Care Solutions*** network for their diabetic supplies and out-patient radiology services
- You can continue to save time and money, without sacrificing care, by visiting Urgent Care Centers, rather than hospital emergency rooms, for non-life threatening, but nonetheless urgent medical conditions

Health Plan Terminology

– Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage (for example, 30% of the allowed amount). You pay coinsurance plus any deductibles. Applies to health care services until the maximum out-of-pocket is reached.

– Copayment (or copay): A fixed amount you pay for a covered health care service, usually when you receive service.

– Deductible: The amount you owe for health care services under the PPO or HMO before the plan begins to pay. The deductible applies to all services **except** preventive care, office visits and outpatient therapy copayments, emergency room and urgent care copayments and labs done at a Quest Diagnostics or LabCorp location.

– Maximum Out-of-Pocket: The most you would pay in a year. After the maximum out-of-pocket is reached, the plan pays at 100% of the allowed amount. This includes both deductible and co-pays.

– Network (In-Network): The facilities, providers and suppliers your health plan has contracted with to provide health care services.

– Out-of-Network (or Non-Network): The facilities, providers and suppliers that do not contract with your health plan. For PPO members, you have an out-of- network benefit but it is subject to a deductible and coinsurance. Those members enrolled in the HMO have no coverage if you visit a provider who is not in the HMO's network.

We can't communicate with you unless you tell us where you live!

- Be sure to notify the Fund office promptly of any change in your address. Neither your employer nor your Local Union share this information with us.
- Don't assume that we have your new address just because you gave it to your employer or your Local.
- Be one of the first to learn about new developments at the Fund and your benefits. Register your email address with the Fund.

We respect your privacy!

Learn more about the Fund's privacy policy by reading your Summary Plan Description or visiting the Fund's web site. The Privacy Policy is posted at: http://www.teamsterfunds.com/For%20Members/Privacy%20Policy.htm.

Sprain your Ankle? Sore Throat? Think twice about where you get your care.

You may think of the emergency room first when you have a medical event, but that might not be your best choice. If you want quicker non-emergency care, you may be wiser to skip the ER and go to your nearest urgent care center. Urgent care centers often have extended evening and weekend hours to make it convenient for you. That's because ERs are busy, crowded places. If your situation is not a true emergency, you can end up waiting for hours for the care you need. Generally, you'll want to visit your primary care physician or nearest urgent care center for non-life threatening health events such as the flu, a cold, a rash, sore throat, ear ache, a minor cut, vomiting, diarrhea, sprain, or even a broken bone. Of course, it's a good idea to plan ahead. Don't wait until an event happens before you locate an urgent care center convenient to your home.

Best of all . . .the copay at urgent care is $50, not $100 as is the case for an ER visit!

And coming January 1st . . .coverage at CVS' MinuteClinic® with only a $10 copay!

Attention Health & Welfare Fund Participants: Annual Notice Regarding Post-Mastectomy Reconstructive Surgery Benefits

As required by the Women's Health and Cancer Rights Act of 1998, the Health & Welfare Fund's Plan provides (as it always has) benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedemas). For more information, contact the Fund's Member Services Department at 1-800 -523-2846.

Teamsters Health & Welfare Fund

of Philadelphia and Vicinity

This packet of information contains the

Summary of Benefits and Coverages for the

Blue Card PPO and Aetna HMO medical programs

There are two PPO programs (Platinum and Gold) and two HMO programs (Platinum and Gold). Those who completed the WellTeam® screening program in 2016 earned participation in either one of the Platinum programs during the 2017 plan year. Those who did not complete the screening participate in the Gold programs.

The first 14 pages of this packet contain the Summary of Benefits and Coverages for the Platinum and Gold PPO benefit programs. The remaining pages relate to the HMO medical programs.

Fall 2016

Teamsters Health & Welfare Fund: Blue Card PPO Platinum Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Coverage Types | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.teamsterfunds.com or by calling 1-800-523-2846.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$250/person & $500/family in-network; $500/person & $1,000/family out-of-network. The deductible does not apply to services which require a co-payment or for which no cost sharing is permitted.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services in addition to the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $5,000/person; $10,000/family for medical, of which $500/person (in-network) & $1,500/person (out-of-network) applies to coinsurance; remainder applies to copayments. Pharmacy copayments are capped at $1,500/person & $3,000/family. **(Previously, there was no limit on any copayments.)**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, health care this plan doesn't cover & penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.bcbs.com and www.teamsterfunds.com or call 800-523-2846 for a list.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your plan document for additional information about **excluded services.**

Questions: Call 1-800-523-2846 or visit us at www.teamsterfunds.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-523-2846 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use "**in-network**" or "**preferred**" **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	Deductible, 20% coinsurance & balance billing	---none---
	Specialist visit	$30/visit	Deductible, 20% coinsurance & balance billing	---none---
	Other practitioner office visit	$30/visit for chiropractor	Deductible, 20% coinsurance & balance billing	15 manipulations per benefit period
	Preventive care/screening/ immunization	No more than $20/visit	Deductible, 20% coinsurance & balance billing	One round of preventative treatment/person/year. Colonoscopy, mammography, and prostate screening coverage varies by age.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Special networks available with no cost sharing
	Imaging (CT/PET scans, MRIs)	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Special networks available with $20 copay
If you need drugs to treat your illness or condition More information about	Generic drugs	$5/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
	Preferred brand drugs	$15/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
	Non-preferred brand drugs	$30-$50/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded

prescription drug coverage is available at www.teamsterfunds.com	Specialty drugs	$100/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
	Physician/surgeon fees	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
If you need immediate medical attention	Emergency room services	$100/visit	Deductible, 20% coinsurance & balance billing	Copayment waived if admitted
	Emergency medical transportation	Deductible & 10% coinsurance	80% of billed charges	Only covered if medically necessary
	Urgent care	$50/visit	Deductible, 20% coinsurance & balance billing	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Precertification is required. If it is not obtained, then you may owe a $1,000 penalty.
	Physician/surgeon fee	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Deductible, 20% coinsurance & balance billing	Must be precertified by Total Care Network ("TCN")
	Mental/Behavioral health inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Must be precertified by TCN
	Substance use disorder outpatient services	$20/visit	Deductible, 20% coinsurance & balance billing	Must be precertified by TCN
	Substance use disorder inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Must be precertified by TCN
If you are pregnant	Prenatal and postnatal care	$30 copayment on initial visit	Deductible, 20% coinsurance & balance billing	Limited to care of the mother; newborn care is subject to deductible & 10% coinsurance

	Delivery and all inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
If you need help recovering or have other special health needs	Home health care	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Precertification is required; if it is not obtained then you will incur a 20% reduction in the benefits payable.
	Rehabilitation services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
	Habilitation services	$30 copayment	Deductible, 20% coinsurance & balance billing	Limitations apply depending on the type of habilitation services needed as noted in the plan document
	Skilled nursing care	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Custodial nursing care is excluded.
	Durable medical equipment	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	If it exceeds $500, it must be precertified. If it is not precertified, then you will incur a 20% reduction in the benefits payable.
	Hospice service	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Precertification is required; if it is not obtained then you will incur a 20% reduction in the benefits payable.
If your child needs dental or eye care	Eye exam	No charge	Balance billing over $40	One office visit every 24 months.
	Glasses	No charge	Balance billing	Allowable charges depend on the type of glasses obtained; one pair every 24 months.
	Dental check-up	$0	Balance billing	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Long term care
- Custodial care
- Weight loss programs (other than ACA-required programs)
- Hearing aids
- Infertility treatment

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic care
- Dental Care (adult)
- Private duty nursing
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-523-2846. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Administrator, Teamsters Health and Welfare Fund of Philadelphia and Vicinity, 6981 N. Park Drive, Suite 400, Pennsauken, New Jersey 08109, 1-800-523-2846 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-523-2846.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,630
- **Patient pays** $ 910

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$30
Coinsurance	$480
Limits or exclusions	$150
Total	**$910**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,723
- **Patient pays** $ 677

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$230
Coinsurance	$118
Limits or exclusions	$79
Total	**$677**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Teamsters Health & Welfare Fund: Blue Card PPO Gold

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Coverage Types | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.teamsterfunds.com or by calling 1-800-523-2846.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500/person & $1,000/family in-network; $1,000/person & $2,000/family out-of-network. The deductible does not apply to services which require a co-payment or for which no cost sharing is permitted.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services in addition to the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $5,000/person; $10,000/family for medical, of which $750/person (in-network) & $2,250/person (out-of-network) applies to coinsurance; remainder applies to copayments. Pharmacy copayments are capped at $1,500/person & $3,000/family. **(Previously, there was no limit on any copayments.)**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, health care this plan doesn't cover & penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.bcbs.com and www.teamsterfunds.com or call 800-523-2846 for a list.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your plan document for additional information about **excluded services.**

Questions: Call 1-800-523-2846 or visit us at www.teamsterfunds.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-523-2846 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use "**in-network**" or "**preferred**" **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	Deductible, 20% coinsurance & balance billing	---none---
	Specialist visit	$40/visit	Deductible, 20% coinsurance & balance billing	---none---
	Other practitioner office visit	$40/visit for chiropractor	Deductible, 20% coinsurance & balance billing	15 manipulations per benefit period
	Preventive care/screening/ immunization	No more than $30/visit	Deductible, 20% coinsurance & balance billing	One round of preventative treatment/person/year. Colonoscopy, mammography, and prostate screening coverage varies by age.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Special networks available with no cost sharing
	Imaging (CT/PET scans, MRIs)	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Special networks available with $20 copay
If you need drugs to treat your illness or condition More information about **prescription drug**	Generic drugs	$10/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
	Preferred brand drugs	$20/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
	Non-preferred brand drugs	$60/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded

coverage is available at www.teamsterfunds.com	Specialty drugs	$150/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
	Physician/surgeon fees	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
If you need immediate medical attention	Emergency room services	$100/visit	Deductible, 20% coinsurance & balance billing	Copayment waived if admitted
	Emergency medical transportation	Deductible & 10% coinsurance	80% of billed charges	Only covered if medically necessary
	Urgent care	$50/visit	Deductible, 20% coinsurance & balance billing	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Precertification is required. If it is not obtained, then you may owe a $1,000 penalty.
	Physician/surgeon fee	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30/visit	Deductible, 20% coinsurance & balance billing	Must be precertified by Total Care Network ("TCN")
	Mental/Behavioral health inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Must be precertified by TCN
	Substance use disorder outpatient services	$30/visit	Deductible, 20% coinsurance & balance billing	Must be precertified by TCN
	Substance use disorder inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Must be precertified by TCN
If you are pregnant	Prenatal and postnatal care	$40 copayment on initial visit	Deductible, 20% coinsurance & balance billing	Limited to care of the mother; newborn care is subject to deductible & 10% coinsurance
	Delivery and all inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---

If you need help recovering or have other special health needs	Home health care	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Precertification is required; if it is not obtained then you will incur a 20% reduction in the benefits payable.
	Rehabilitation services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
	Habilitation services	$40 copayment	Deductible, 20% coinsurance & balance billing	Limitations apply depending on the type of habilitation services needed as noted in the plan document
	Skilled nursing care	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Custodial nursing care is excluded.
	Durable medical equipment	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	If it exceeds $500, it must be precertified. If it is not precertified, then you will incur a 20% reduction in the benefits payable.
	Hospice service	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Precertification is required; if it is not obtained then you will incur a 20% reduction in the benefits payable.
If your child needs dental or eye care	Eye exam	No charge	Balance billing over $40	One office visit every 24 months.
	Glasses	No charge	Balance billing	Allowable charges depend on the type of glasses obtained; one pair every 24 months.
	Dental check-up	$0	Balance billing	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Long term care
- Custodial care
- Weight loss programs (other than ACA-required programs)
- Hearing aids
- Infertility treatment

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic care
- Dental Care (adult)
- Private duty nursing
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-523-2846. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Administrator, Teamsters Health and Welfare Fund of Philadelphia and Vicinity, 6981 N. Park Drive, Suite 400, Pennsauken, New Jersey 08109, 1-800-523-2846 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-523-2846.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,340
- **Patient pays** $1,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$40
Coinsurance	$510
Limits or exclusions	$150
Total	**$1,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,461
- **Patient pays** $ 939

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$240
Coinsurance	$120
Limits or exclusions	$79
Total	**$939**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Teamsters Health & Welfare Fund: Aetna HMO Platinum

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: All Coverage Types | Plan Type: HMO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.teamsterfunds.com or by calling 1-800-523-2846.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$** 100/person; **$** 200/family. The deductible does not apply to services which require a co-payment or for which no cost sharing is permitted.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services in addition to the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$**5,000/person; **$**10,000/family for medical, of which **$**250/person (in-network) applies to coinsurance; remainder applies to copayments. Pharmacy copayments are capped at **$**1,500/person & **$**3,000/family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com and www.teamsterfunds.com or call 1-800-523-2846 for a list.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-523-2846 or visit us at www.teamsterfunds.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-523-2846 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use "**in-network**" or "**preferred**" **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	Not covered	$20 for after hours visits
	Specialist visit	$25/visit	Not covered	---none---
	Other practitioner office visit	$25/visit Chiropractor	Not covered	15 manipulations per benefit period
	Preventive care/screening/ immunization	No more than $15/visit, depending on the treatment.	Not covered	Each participant is limited to one round of preventative treatment each year; colonoscopy, mammogram, and prostate screening coverage varies by age.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible & 10% coinsurance	Not covered	Referral required
	Imaging (CT/PET scans, MRIs)	Deductible & 10% coinsurance	Not covered	Referral required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.teamsterfunds.com.	Generic drugs	$5/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
	Preferred brand drugs	$15/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
	Non-preferred brand drugs	$30 to $50/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded

	Specialty drugs	$100 /30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible & 10% coinsurance	Not covered	---none---
	Physician/surgeon fees	Deductible & 10% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	$100/visit	Not covered	Copayment waived if admitted; non-emergency use of the ER is not covered.
	Emergency medical transportation	Deductible & 10% coinsurance	Deductible, 20% coinsurance plus balance billing	Only covered if medically necessary
	Urgent care	$50/visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible & 10% coinsurance	Not covered	Must be authorized by Aetna
	Physician/surgeon fee	Deductible & 10% coinsurance	Not covered	Must be authorized by Aetna
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Deductible, 20% coinsurance plus balance billing	Must be precertified by Total Care Network ("TCN")
	Mental/Behavioral health inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance plus balance billing	Must be precertified by TCN
	Substance use disorder outpatient services	$20/visit	Deductible, 20% coinsurance plus balance billing	Must be precertified by TCN
	Substance use disorder inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance plus balance billing	Must be precertified by TCN
If you are pregnant	Prenatal and postnatal care	$25/visit	Not covered	For prenatal treatment, only the first office visit requires a copayment.
	Delivery and all inpatient services	Deductible & 10% coinsurance	Not covered	---none---

If you need help recovering or have other special health needs	Home health care	Deductible & 10% coinsurance	Not covered	Precertification is required; if it is not obtained then you will incur a 20% reduction in the benefits payable.
	Rehabilitation services	Deductible & 10% coinsurance	Not covered	---none---
	Habilitation services	Deductible & 10% coinsurance	Not covered	---none---
	Skilled nursing care	Deductible & 10% coinsurance	Not covered	Covered up to 180 days per calendar year
	Durable medical equipment	Deductible & 10% coinsurance	Not covered	Must be authorized by PCP and Aetna
	Hospice service	Deductible & 10% coinsurance	Not covered	Must be authorized by PCP and Aetna
If your child needs dental or eye care	Eye exam	None	Balance billing over $40	One office visit every 24 months.
	Glasses	None	Balance billing	Allowable charges depend on the type of glasses obtained; one pair every 24 months.
	Dental check-up	$0	Balance billing	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture • Weight loss programs (other than ACA-required programs)	• Cosmetic surgery	• Custodial care	• Hearing aids	• Infertility treatment	• Long term care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

• Bariatric Surgery • Routine eye care	• Chiropractic care • Routine foot care	• Dental Care (adult)	• Private duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-523-2846.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,020
- **Patient pays** $520

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$100
Copays	$20
Coinsurance	$250
Limits or exclusions	$150
Total	**$520**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,000
- **Patient pays** $400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$220
Coinsurance	$118
Limits or exclusions	$80
Total	**$400**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Teamsters Health & Welfare Fund: Aetna HMO Gold

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Coverage Types | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.teamsterfunds.com or by calling 1-800-523-2846.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 350/person; $ 700/family. The deductible does not apply to services which require a co-payment or for which no cost sharing is permitted.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services in addition to the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $5,000/person; $10,000/family for medical, of which $500/person (in-network) applies to coinsurance; remainder applies to copayments. Pharmacy copayments are capped at $1,500/person & $3,000/family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com and www.teamsterfunds.com or call 1-800-523-2846 for a list.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-523-2846 or visit us at www.teamsterfunds.com.
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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use "**in-network**" or "**preferred**" **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit	Not covered	$20 for after hours visits
	Specialist visit	$35/visit	Not covered	---none---
	Other practitioner office visit	$35/visit Chiropractor	Not covered	15 manipulations per benefit period
	Preventive care/screening/ immunization	No more than $25/visit, depending on the treatment.	Not covered	Each participant is limited to one round of preventative treatment each year; colonoscopy, mammogram, and prostate screening coverage varies by age.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible & 10% coinsurance	Not covered	Referral required
	Imaging (CT/PET scans, MRIs)	Deductible & 10% coinsurance	Not covered	Referral required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.teamsterfunds.com.	Generic drugs	$10/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
	Preferred brand drugs	$20/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
	Non-preferred brand drugs	$60/30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded

	Specialty drugs	$150 /30-day supply	Not covered	Suboxone & Bunavail 3 months/life; Zohydro excluded
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible & 10% coinsurance	Not covered	---none---
	Physician/surgeon fees	Deductible & 10% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	$100/visit	Not covered	Copayment waived if admitted; non-emergency use of the ER is not covered.
	Emergency medical transportation	Deductible & 10% coinsurance	Deductible, 20% coinsurance plus balance billing	Only covered if medically necessary
	Urgent care	$50/visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible & 10% coinsurance	Not covered	Must be authorized by Aetna
	Physician/surgeon fee	Deductible & 10% coinsurance	Not covered	Must be authorized by Aetna
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30/visit	Deductible, 20% coinsurance plus balance billing	Must be precertified by Total Care Network ("TCN")
	Mental/Behavioral health inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance plus balance billing	Must be precertified by TCN
	Substance use disorder outpatient services	$30/visit	Deductible, 20% coinsurance plus balance billing	Must be precertified by TCN
	Substance use disorder inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance plus balance billing	Must be precertified by TCN
If you are pregnant	Prenatal and postnatal care	$35/visit	Not covered	For prenatal treatment, only the first office visit requires a copayment.
	Delivery and all inpatient services	Deductible & 10% coinsurance	Not covered	---none---

If you need help recovering or have other special health needs	Home health care	Deductible & 10% coinsurance	Not covered	Precertification is required; if it is not obtained then you will incur a 20% reduction in the benefits payable.
	Rehabilitation services	Deductible & 10% coinsurance	Not covered	---none---
	Habilitation services	Deductible & 10% coinsurance	Not covered	---none---
	Skilled nursing care	Deductible & 10% coinsurance	Not covered	Covered up to 180 days per calendar year
	Durable medical equipment	Deductible & 10% coinsurance	Not covered	Must be authorized by PCP and Aetna
	Hospice service	Deductible & 10% coinsurance	Not covered	Must be authorized by PCP and Aetna
If your child needs dental or eye care	Eye exam	None	Balance billing over $40	One office visit every 24 months.
	Glasses	None	Balance billing	Allowable charges depend on the type of glasses obtained; one pair every 24 months.
	Dental check-up	$0	Balance billing	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture • Weight loss programs (other than ACA-required programs)	• Cosmetic surgery	• Custodial care	• Hearing aids	• Infertility treatment	• Long term care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

• Bariatric Surgery • Routine eye care	• Chiropractic care • Routine foot care	• Dental Care (adult)	• Private duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

Questions: Call 1-800-523-2846 or visit us at www.teamsterfunds.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-523-2846 to request a copy.

For more information on your rights to continue coverage, contact the plan at 1-800-523-2846. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Administrator, Teamsters Health and Welfare Fund of Philadelphia and Vicinity, 6981 N. Park Drive, Suite 400, Pennsauken, New Jersey 08109, 1-800-523-2846 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-523-2846.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,405
- **Patient pays** $1,035

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$350
Copays	$35
Coinsurance	$500
Limits or exclusions	$150
Total	**$1,035**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,253
- **Patient pays** $1,147

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$350
Copays	$220
Coinsurance	$497
Limits or exclusions	$80
Total	**$1,147**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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SUMMARY ANNUAL REPORT FOR THE TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA AND VICINITY

This is a summary of the Annual Report of the TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA & VICINITY, a health, dental, vision, temporary disability and death benefits plan (Employer Identification Number 23-1392600), for the plan year 01/01/2015 through 12/31/2015. The Annual Report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

THE BOARD OF TRUSTEES OF THE TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA & VICINITY has committed itself to pay certain dental, prescription, vision, medical and disability claims incurred under the terms of the plan.

Insurance Information

The plan has an insurance contract with MUTUAL OF OMAHA INSURANCE COMPANY to pay certain Life Insurance, Accidental Death & Dismemberment claims incurred under the terms of the plan and a group policy. The total premiums paid for the plan year ending 12/31/2015 were $355,345. All other benefits are self-insured and paid directly from the Trust Fund.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $67,645,088 as of the end of plan year, compared to $71,927,690 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of -$4,282,602. This change includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $112,276,029 including employer contributions of $111,705,277 employee contributions of $1,199,290, and earnings from investments of -$628,538. Plan expenses were $116,558,631. These expenses included $7,835,023 in administrative expenses, and $108,723,608 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full Annual Report, or any part thereof, on request. The items listed below are included in that report: 1. An accountant's report; 2. Financial information and information on payments to service providers; 3. Assets held for investment; 4. Transactions in excess of 5 percent of the plan assets; and 5. Insurance information, including sales commissions paid by insurance carriers. To obtain a copy of the full Annual Report, or any part thereof, write or call the Fund office at 6981 NORTH PARK DRIVE, SUITE 400, PENNSAUKEN, NJ 08109, Attention: Plan Administrator, and phone number, 856-382-2400. The charge to cover copying costs will be $5.00 for the full Annual Report, or $0.10 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full Annual Report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the Annual Report at the main office of the plan: 6981 NORTH PARK DRIVE, SUITE 400, PENNSAUKEN, NJ 08109, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

-Board of Trustees

Important Note: The Fund May Suspend or Cancel Your Coverage for Fraud or Intentional Misrepresentation

If you intentionally provide false or misleading information about eligibility for coverage under the Benefit Plan (or about a claim), your coverage may be suspended or canceled. This may occur, for example, if you file a false claim, fail to notify us promptly of a divorce or fail to submit timely proof of birth or adoption that verifies your relationship with a new child whom you have added as a dependent.

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION ABOUT YOUR OPEN ENROLLMENT RIGHTS UNDER YOUR HEALTH AND WELFARE PLAN.

PLEASE TAKE THE TIME TO READ IT AND SAVE IT!

HAVE QUESTIONS? CALL OUR MEMBER SERVICES DEPARTMENT AT 1-800-523-2846 OR SEND US AN EMAIL THROUGH OUR WEB SITE . . .WWW.TEAMSTERFUNDS.COM

In this Issue . . . . .

Teamsters Health & Welfare Fund
of Philadelphia and Vicinity
6981 N. Park Drive, Suite 400
Pennsauken, NJ 08109

RETURN SERVICE REQUESTED

Stay in touch at www.teamsterfunds.com