FALL 2019

THE CONNECTION

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

It's Open Enrollment for the Health & Welfare Fund

November 4 through December 7, 2019

Open enrollment is your annual opportunity to review your medical plan choices. If you want to change your coverage for 2020, you must act now. If you wish to stay with the same coverage you currently have, you do not need to take any action.

FOR EXAMPLE: If you currently have Blue Card PPO coverage and want to switch to Aetna EPO coverage, or vice versa, please call Member Services at 800-523-2846 to have an open enrollment kit, including a Medical Benefit Option Change form, mailed to you. If you choose to change your coverage you must complete this form and return it to the Fund office before the open enrollment period ends on December 7, 2019. **All changes in coverage will be effective January 1, 2020.**

Please keep in mind that the level of coverage (Platinum or Gold) you will have during the 2020 coverage year depends on whether or not you, and if applicable your spouse, completed the required annual wellness screening and preventive dental exam by October 31, 2019.

Take time to review the important medical plan information included in this newsletter. Also, we have enclosed a Summary of Benefits & Coverage (SBC) for each medical plan option. For additional open enrollment information and links to each medical plan's online provider directory, visit the Fund's website at www.teamsterfunds.com, under the Health & Welfare tab.

Plan Coverage at a Glance

Overview of 2020 Health Benefit Plans

	Platinum BlueCard PPO Program *(available only to those who completed the WellTeam ® screening)*		**Platinum Aetna EPO Program** *(available only to those who completed the WellTeam ® screening)*
	In Network	Out of Network*	In Network Only
Deductible (Individual/Family)	$250 / $500	$500 / $1,000	$100 / $200
Coinsurance - Plan Pays	90% (100% after Coinsurance Maximum is reached)	80% (100% after Coinsurance Maximum is reached	90% (100% after Coinsurance Maximum is reached)
Coinsurance Maximum	$500	$1,500	$250
Primary Care Office Visit Copay	$20, No deductible	80%, after deductible	$15, No deductible
Specialist Office Visit Copay	$30, No deductible	80%, after deductible	$25, No deductible
Inpatient Hospital Services	90%, after deductible **	80%, after deductible	90%, after deductible **
Out-Patient Surgery	90%, after deductible **	80%, after deductible	90%, after deductible **
Emergency Room (Facility charges only, Copay waived if admitted)	$100 copay	$100 copay	$100 copay
Urgent Care Office Visit Copay	$50 copay	$50 copay	$50 copay
Skilled Nursing Facility	90%, after deductible **	80%, after deductible	90%, after deductible **
Out-Patient Radiology & Laboratory	90%, after deductible **	80%, after deductible	90%, after deductible **
Physical, Speech, Occupational Therapy	$30 co-pay	80%, after deductible	90%, after deductible **
Durable Medical Equipment and Prosthetics	90%, after deductible **	80%, after deductible	90%, after deductible **
NOTE: *Out-of Network, non-participating providers may bill you for differences between the Plan allowance and the provider's actual charge. This amount may be significant. **Plan pays 100% of the allowable charges after coinsurance maximum is met.			
Lower or no copays available when using the Healthcare Solutions provider network for outpatient lab (LabCorp or Quest) and outpatient radiology services.			
Prescription Drug	30 day supply at retail: $5 generic; $15 preferred brand; 50% non-preferred ($30 min. copay, $50 max copay); $100 specialty drug; maintenance drugs - 90 day supply = a single copay.		
Dental	**$2000 maximum per year, per patient plus separate lifetime orthodontic allowance for children 10-18 years; copays may apply for orthodontic, periodontic, oral surgery, denture, crown, and fixed bridge services; subject to Fund allowances for each dental service.**		
Vision (National Vision Administrators)	**One exam every 12 months; materials (contacts or frames & lenses) once every 24 months.**		

PLEASE NOTE THAT THE ABOVE BENEFIT OUTLINE IS MEANT ONLY TO HIGHLIGHT KEY FEATURES OF THE PLANS. PRE-AUTHORIZATION MAY BE REQUIRED FOR MANY OF THE SERVICES PROVIDED. REFER TO THE SUMMARY PLAN DESCRIPTION FOR MORE DETAILS ABOUT THE MEDICAL BENEFIT PROGRAM, AS WELL AS EXCLUSIONS AND LIMITATIONS. PLATINUM PLAN BENEFITS ARE ONLY AVAILABLE TO THOSE MEMBERS AND SPOUSES WHO PARTICIPATE IN THE WELLTEAM SCREENING PROGRAM. MEMBERS WHO DO NOT PARTICIPATE IN THE WELLNESS PROGRAM WILL DEFAULT TO THE GOLD PLAN AND HAVE HIGHER OUT OF POCKET COSTS THAN LISTED ABOVE.

“Participate” vs. “Accept” - That is the question.

Have you called a doctor’s office to make an appointment and they told you that the doctor you want to see “accepts” your insurance? Does this mean that this physician is a participating provider with your insurance plan? - Maybe not.

If a doctor or provider’s office says that they “accept” your insurance, double check on the Fund’s website under the **Health & Welfare** tab, click on **Schedule of Benefits** and select your medical plan’s **Provider Lookup** link to make sure they are a participating provider under your plan. Participating providers are physicians or other health care providers that have an agreement with a particular insurance plan. These health care providers are considered in-network. If a provider has no contract with your health plan, they're considered out-of-network and they can balance bill you for service fees. Please note, for Aetna EPO plan participants there are no out-of-network benefits.

What is balance billing? Balance billing is when a provider bills the patient for the difference between the provider’s charge and the allowed amount for covered services under the insurance plan. For example, if the provider’s charge is $100 and the allowed amount under the plan is $70, the provider may bill you for the remaining $30.

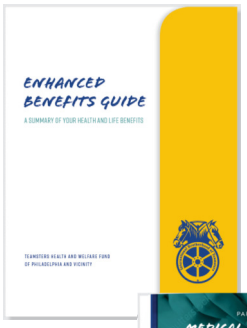
Insurance plans require that the patient be responsible for some portion of their medical bills, except for no cost share medical services under the ACA. This patient responsibility is usually represented by a deductible, copayment, and coinsurance. However, if you receive care from a non-participating, out-of-network provider you could be responsible for the balance bill in addition to your deductible, co-pay and coinsurance. Be an informed patient and avoid unexpected medical bills by knowing who is a participating provider under your health plan and how the plan works.

MEMBER WELCOME KIT

Beginning in November all eligible members will receive, by mail, a newly redesigned member welcome kit. This new kit includes:

- Summary Plan Description
- Enhanced Benefits Guide
- Dental Provider Booklet
- Dental Fee Schedule
- Member Identification Card

This Enhanced Benefits Guide provides program descriptions and contact information on all of the Fund’s carved out benefits and services members and eligible dependents have access to through their medical benefits plan. When you receive your member welcome kit, please take the time to review the important health and life benefits information enclosed. Keep this kit easily accessible and use it as a point of reference. This information is extremely valuable and can help you save money on your medical expenses. If you still have questions about your benefits, please contact Member Services at 800-523-2846.



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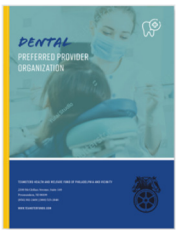
Dental Provider Booklet



Program Descriptions

Carved Out Benefits ID Cards

SPD

Teamsters Health & Welfare Fund
of Philadelphia and Vicinity
2500 McClellan Ave., Suite 140
Pennsauken, NJ 08109

Address Correction Requested

THIS DOCUMENT CONTAINS TIME SENSITIVE OPEN ENROLLMENT INFORMATION AND THE SUMMARY OF BENEFITS AND COVERAGES REQUIRED BY THE AFFORDABLE CARE ACT.

PLEASE READ THIS INFORMATION AND SAVE IT. THESE ARE IMPORTANT HEALTH BENEFITS DOCUMENTS.

Have questions? Contact the Fund's Member Services Department at 800-523-2846.