The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [1-800-523-2846]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.teamsterfunds.com.com or call 1-800-523-2846 to request a copy.

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 services covered before you meet your deductible?	Yes.	All preventative services under the Affordable Care Act are covered with no cost share
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.
What is the out-of-pocket limit for this plan?	$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 & penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes	Network providers are contracted to accept a negotiated rate so your out of pocket would be calculated based on the negotiated rate rather than the total charges. No out of network benefits with this Plan
Do you need a referral to see a specialist?	No	This plan will pay some or all of the costs to see a **specialist** for covered services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	Not covered	---none---
	Specialist visit	$25/visit	Not covered	---none---
	Preventive care/screening/ immunization	No more than $15/visit	Not covered	One round of preventative treatment/person/year. Colonoscopy, mammography, and prostate screening coverage varies by age.
If you have a test	Lab tests (blood work)	Deductible & 10% coinsurance	Not covered	Special networks available with no cost sharing
	Imaging (CT/PET scans, MRIs)	Deductible & 10% coinsurance	Not covered	Special networks available with $20 copay
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	
	Preferred brand drugs	$15/30-day supply	Not covered	
	Non-preferred brand drugs	$30-$50/30-day supply	Not covered	
	Specialty drugs	$100/ 30- day supply	Not covered	
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---

[* For more information about limitations and exceptions, see the plan or policy document at www.teamsterfunds.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room facility charges	$100/visit	Not covered	Copayment waived if admitted
	Emergency medical transportation	Deductible & 10% coinsurance	80% of billed charges	Only covered if medically necessary
	Urgent care	$50/visit	Not covered	Only covered if medically necessary
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible & 10% coinsurance	Not covered	Precertification is required. If it is not obtained, then you may owe a $1,000 penalty.
	Physician/surgeon fees	Deductible & 10% coinsurance	Not covered	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/visit	$500 deductible & 20% co-insurance	Must be precertified by Total Care Network ("TCN")
	Inpatient services	Deductible & 10% coinsurance	$500 deductible & 20% co-insurance	Must be precertified by TCN
If you are pregnant	Office visits	No cost	Not covered	Limited to care of the mother; newborn care is subject to deductible & 10% coinsurance
	Childbirth/delivery professional services	Deductible & 10% coinsurance	Not covered	$25.00 co-pay applies
	Childbirth/delivery facility services	Deductible & 10% coinsurance	Not covered	---none---

[* For more information about limitations and exceptions, see the plan or policy document at www.teamsterfunds.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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	Limitations apply depending on the type of habilitation services needed as noted in the plan document
	Skilled nursing care	Deductible & 10% coinsurance	Not covered	Custodial nursing care is excluded.
	Durable medical equipment	Deductible & 10% coinsurance	Not covered	If it exceeds $1000, it must be precertified. If it is not precertified, then you will incur a 20% reduction in the benefits payable.
	Hospice services	Deductible & 10% coinsurance	Not covered	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	Children's eye exam	No charge	Balance billing over $40	One exam every 12 months through the Plan's Vision Program
	Children's glasses	No charge	Balance billing	Allowable charges depend on the type of glasses obtained; one pair every 24 months. Covered through the Plan's Vision Program
	Children's dental check-up	$0	Balance billing	Covered through the Plan's Dental Program

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [State of New Jersey, HHS, DOL, and/or other applicable agency.]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Member Services at 1-800-523-2846.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month

Does this plan meet the Minimum Value Standards? **Yes** If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [1-800-523-2846].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [not available].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [not available].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [not available].]

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

[* For more information about limitations and exceptions, see the plan or policy document at www.teamsterfunds.com.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$100
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$7540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$25
Coinsurance	$250
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$525**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$100
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$275
Coinsurance	$118
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$573**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$100
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2820**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$55
Copayments	$125
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$330**

The plan would be responsible for the other costs of these EXAMPLE covered services.