THE CONNECTION

Official Newsletter of the
Teamsters Health & Welfare
and Pension Trust Funds of Philadelphia and Vicinity

FALL 2021

2022 Open Enrollment

NOVEMBER 1, 2021 THROUGH DECEMBER 3, 2021

HEALTH & WELFARE FUND OPEN ENROLLMENT

Teamsters Health and Welfare Fund Members - it's that time of year again for open enrollment! Open enrollment is your annual opportunity to review your medical benefit plan choices. **If you wish to stay with the same coverage you currently have, you do not need to take any action.** If you want to change your coverage for 2022, you must act now.

I want to change my coverage for 2022 - now what?

If you currently have Blue Card PPO coverage and want to switch to Aetna EPO coverage, or vice versa, please call Member Services to have an open enrollment 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 3, 2021. **All changes in coverage will be effective January 1, 2022**.

Keep in mind that the level of coverage (Platinum or Gold) you will have during the 2022 coverage year depends on whether or not you, and if applicable your spouse, completed the required annual wellness screening and a preventive dental exam by October 30, 2021.

Also, enclosed in this newsletter is a Summary of Benefits & Coverages (SBC) for each medical plan option to compare plans. Please take time to review this important information. For additional open enrollment information and links to each medical plan's online provider directory, visit www.teamsterfunds.com, under the Health & Welfare tab.

Have questions?

For questions and information on open enrollment, please contact the Fund's Member Services department at 800-523-2846, option #1.

INSIDE THIS ISSUE:

IMPORTANT PLAN DOCUMENTS INCLUDED IN THIS NEWSLETTER:

- Health & Welfare Fund Summary Annual Report
- 2022 Summary of Benefits and Coverages

MAKE TIME FOR CARE

With COVID-19 still lingering in many parts of the country, staying home or distancing yourself from others can help you stay safe. But it's also important to stay healthy mentally and physically. Staying healthy matters for everyone and living your best life takes a total approach to health.

The number one concern physicians have today is the underlying progression of chronic diseases and how that may impact how long people live, or their quality of life. With this concern in mind, physicians are encouraging individuals to prioritize all their health care needs and emphasizing the importance of seeking preventive care and ongoing treatment of chronic diseases during these challenging times, even if it's virtually.

So remember to take care of yourself, stay active and keep a healthy weight. Mammograms, colonoscopies and lung cancer screenings can save lives so don't wait to get screened. Be mindful and recognize your feelings. Know the signs of depression or anxiety and talk to your doctor with concerns. Make time for those people, places and things that are the most important to you. Make time for your care, make time for self care—your life depends on it.

Effective January 1, 2022, GeniusRx Pharmacy will be the new mail order and specialty pharmacy provider through Capital Rx for the Teamsters Fund.

GENIUSRx PHARMACY:

Effective January 1, 2022, GeniusRx Pharmacy will be the new mail order and specialty pharmacy provider for the Teamsters Health and Welfare Fund through Capital Rx.

Costco Rx Specialty Pharmacy will no longer be filling mail order or the specialty prescriptions for members after 12/31/21.

Capital Rx will work directly with GeniusRx Pharmacy to transfer your prescriptions with the exception of expired prescriptions or those with zero refills remaining. Members do not need to take any action. For those members who are currently receiving specialty medications, Capital Rx will reach out to you directly by mail or phone to support a seamless transition.

For more information about your pharmacy benefits, please contact the **Capital Rx Help Desk at 844-752-2779.**

WHAT'S HAPPENING

CHANGES TO U.S. FIRST CLASS MAIL DELIVERY TO CAUSE DELAYS

Effective October 1, 2021, the United States Postal Service (USPS) has revised its service standards for certain First-Class Mail items, resulting in a delivery window of up to five days. Please note that this may delay your receipt of mail from the Fund and our receipt of mail from you. Please take this change into account when mailing items to the Fund office via US Postal Service. For more information on mail delivery delays, visit www.usps.com.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under federal legislation, annual notification of this benefit is required to all members. In 1998, the federal government enacted a law that mandates certain health coverage for breast reconstructive surgery in any health program that provides medical and surgical benefits for mastectomies. This law is know as the Women's Health and Cancer Rights Act.

If a covered person is receiving benefits in connection with a mastectomy and elects to have breast reconstruction along with that mastectomy, the policy must provide in a manner determined in consultation with the attending physician and the patient, coverage for the following:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications at all stages of the mastectomy, including lymphedema.

These benefits will be provided subject to deductibles and coinsurance to the same extent as for any other illness under your coverage. All other features and benefits of this program remain the same and are not impacted by this annual notification.

HEALTH PLANS COVERAGE AT A GLANCE

Please note that the following benefit outline is meant only to highlight key features of the medical benefit 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 annual wellness screening program. Members who do not participate in the wellness screening program will default to the Gold Plan and have higher out of pocket costs than listed below.

Please contact Member Services if you have any questions at 800-523-2846, option #1.

OVERVIEW OF 2022 HEALTH BENEFITS PLANS:

	Platinum Program BlueCard PPO		**Platinum Program Aetna EPO**
	available only to those who completed the WellTeam screening		*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)	**80%** (100% after coinsurance maximum)	**90%** (100% after coinsurance maximum)
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 copay**	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 the 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.

OVERVIEW OF HEALTH BENEFITS PLANS CONTINUED:

Non-Emergency Out Patient Laboratory and Radiology Services - Lower or no copays available on out-patient radiology and laboratory services when using Health Care Solutions (HCSC) provider networks, Quest or LabCorp.

Prescription Drug - 90-day supply at retail; $5 Generic; $15 Preferred Brand; 50% Non-preferred ($30 minimum copay, $50 maximum 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 dental service.

Vision (NVA) - One exam every 12 months; materials (contacts or frames & lenses) once every 24 months.

If you have questions about Plan coverage, please call the Member Services department at 800-523-2846, option #1.

Photo Source: Teamster.org

TEAMSTERS AND DRIVE

Source: Teamster.org

In 1959, the Teamsters recognized the need to develop comprehensive legislative and political programs within the union following the passage of the Landrum-Griffin bill and other anti-labor legislation. In November of that year, James R. Hoffa established the Department of Legislation and Political Education. Hoffa called for the department to develop a political action program with member support. D.R.I.V.E. —Democratic, Republican, Independent Voter Education—was born. Sid Zagri, D.R.I.V.E.'s first director, quickly realized that one of the best resources the union had was wives and women members, who had a long history as political organizers. He developed a partnership with Josephine Hoffa, wife of the General President, to create a women's auxiliary political action program.

Mrs. Hoffa had seen her husband and others physically beaten and subjected to unfair court battles as they tried to improve worker lives. She knew unions could only hold on against tough odds by active participation and constant vigilance. She was one of the first to see that political action was the best defense against the erosion of worker rights in the 1950s. "Labor's enemies don't stop for lunch—so neither can we," she said. Mrs. Hoffa knew taking on a task like D.R.I.V.E. was not for the faint hearted. She traveled from city to city in 1960 and early 1961 attending rallies that only a handful of people would attend. She and her family were subjected to negative editorials and nasty editorial cartoons for her actions, but she never stopped trying to create D.R.I.V.E. groups. "Labor unions were not built by men and women who got their feelings hurt or quit after the first disappointment," she said.

D.R.I.V.E. In Action

Mrs. Hoffa's most important achievement was the D.R.I.V.E. motorcades held throughout the 1960s. Between 1962 and 1968, more than 15,000 women delegates from Teamster Joint Councils, state conferences and auxiliaries—women of all races, and from different neighborhoods and states—boarded buses and traveled for hours to speak with their senators and representatives about labor and social justice issues. A 1963 Business Week magazine story quotes an anti-labor congressman as saying: "We may not like those D.R.I.V.E. women, but they are effective."

Earning Respect

At first leaders on Capitol Hill brushed off the women, but later came to respect their dedication and knowledge. Sen. Hubert Humphrey said he had never seen a more effective political action program than the Teamster women's motorcades. The women also were not shy about holding senators and representatives accountable for their campaign promises. D.R.I.V.E. quickly became one of the strongest political action groups in the country and remains so today. Teamsters still fight anti-labor legislation through D.R.I.V.E. and work hard to protect all working families. The Teamsters have honed their political skills greatly in the decades since D.R.I.V.E. was formed and have become a leading voice for workers in Washington.

Teamsters Health & Welfare and
Pension Trust Funds
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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 EPO medical programs

There are two PPO programs (Platinum and Gold) and two EPO programs (Platinum and Gold). Those who completed the WellTeam® screening program in 2021 earned participation in either one of the Platinum programs during the 2022 plan year. Those who did not complete the screening participate in the Gold programs.

The first 12 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 EPO medical programs.

Fall 2021

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, contact the Fund office by calling 1-800-523-2846, option #1. 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?	$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 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 $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 and 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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	$20/visit	Deductible, 20% coinsurance & balance billing	---none---
	Specialist visit	$30/visit	Deductible, 20% coinsurance & balance billing	---none---
	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	Lab tests (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 coverage is available at www.teamsterfunds.com	Generic drugs	$5/30-day supply	Not covered	Zohydro excluded
	Preferred brand drugs	$15/30-day supply	Not covered	Zohydro excluded
	Non-preferred brand drugs	$30-$50/30-day supply	Not covered	Zohydro excluded
	Specialty drugs	$100/30- day supply	Not covered	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 care	$100/visit	Deductible, 20% coinsurance & balance billing	Copayment waived if admitted

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

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)	
	Emergency medical transportation	Deductible & 10% coinsurance	20% of billed charges	Only covered if medically necessary
	Urgent Care	$50/visit	Deductible, 20% coinsurance & balance billing	Only covered if medically necessary
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 fees	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/visit	Deductible, 20% coinsurance & balance billing	Must be precertified by Total Care Network (TCN)
	Inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Must be precertified by TCN
If you are pregnant	Office visits	No cost	Deductible, 20% coinsurance & balance billing	Limited to care of the mother; newborn care is subject to deductible & 10% coinsurance.
	Childbirth/delivery professional services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	$30.00 co-pay is applied to the labor and delivery portion of the bill.
	Childbirth/delivery facility 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	$30 copayment	Deductible, 20% coinsurance & balance billing	---none---

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

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)	
	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 $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	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	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 • Weight loss programs (other than ACA-required programs)	• Cosmetic surgery • Hearing aids	• Long term care • Infertility treatment
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Private duty nursing	• Chiropractic care • Routine eye care	• Dental Care (adult) • 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, option #1.

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.

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$30
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, Jen would pay:

Cost Sharing	
Deductibles	$250
Copayments	$30
Coinsurance	$480
What isn't covered	
Limits or exclusions	$150
The total Jen would pay is	**$910**

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$30
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	$250
Copayments	$230
Coinsurance	$118
What isn't covered	
Limits or exclusions	$79
The total Joe would pay is	**$677**

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$30
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	$460
Coinsurance	$266
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$781**

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

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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	Zohydro excluded
	Preferred brand drugs	$15/30-day supply	Not covered	Zohydro excluded
	Non-preferred brand drugs	$30-$50/30-day supply	Not covered	Zohydro excluded
	Specialty drugs	$100/ 30- day supply	Not covered	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 care	$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

[* 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 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 copayment applies
	Childbirth/delivery facility 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	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.

[* 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 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, option #1.

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

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

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.

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.

Jen 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, Jen would pay:

Cost Sharing	
Deductibles	$100
Copayments	$25
Coinsurance	$250
What isn't covered	
Limits or exclusions	$150
The total Jen 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.

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?	$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 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 $750/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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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	$30/visit	Deductible, 20% coinsurance & balance billing	---none---
	Specialist visit	$40/visit	Deductible, 20% coinsurance & balance billing	---none---
	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	Lab tests (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 coverage is available at www.teamsterfunds.com	Generic drugs	$10/30-day supply	Not covered	Zohydro excluded
	Preferred brand drugs	$20/30-day supply	Not covered	Zohydro excluded
	Non-preferred brand drugs	$40-$60/30-day supply	Not covered	Zohydro excluded
	Specialty drugs	$150/30- day supply	Not covered	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 care	$100/visit	Deductible, 20% coinsurance & balance billing	Copayment waived if admitted

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

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
	Emergency medical transportation	Deductible & 10% coinsurance	80% of billed charges	Only covered if medically necessary
	Urgent care	$50/visit	Deductible, 20% coinsurance & balance billing	Only covered if medically necessary
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 fees	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit	Deductible, 20% coinsurance & balance billing	Must be precertified by Total Care Network (TCN)
	Inpatient services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	Must be precertified by TCN
If you are pregnant	Office visits	No cost	Deductible, 20% coinsurance & balance billing	Limited to care of the mother; newborn care is subject to deductible & 10% coinsurance.
	Childbirth/delivery professional services	Deductible & 10% coinsurance	Deductible, 20% coinsurance & balance billing	$40.00 co-pay is applicable
	Childbirth/delivery facility 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	$40 copayment	Deductible, 20% coinsurance & balance billing	---none---

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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
	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 $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	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	Children's eye exam	No charge	Balance billing over $40	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 • Weight loss programs (other than ACA-required programs)	• Cosmetic surgery • Hearing aids	• Long term care • Infertility treatment
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Private duty nursing	• Chiropractic care • Routine eye care	• Dental Care (adult) • 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,). 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, option #1.

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.

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$40
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, Jen would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$510
What isn't covered	
Limits or exclusions	$150
The total Jen would pay is	**$1230**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$40
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	$500
Copayments	$480
Coinsurance	$120
What isn't covered	
Limits or exclusions	$79
The total Joe would pay is	**$1179**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$40
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	$110
Copayments	$580
Coinsurance	$266
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$956**

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

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, option #1 to request a copy.

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 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 $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 & 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. Out of Network benefits are not available.
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	$25/visit	Not covered	---none---
	Specialist visit	$35/visit	Not covered	---none---
	Preventive care/screening/ immunization	No more than $25/visit, depending on the treatment.	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	$10/30-day supply	Not covered	Zohydro excluded
	Preferred brand drugs	$20/30-day supply	Not covered	Zohydro excluded
	Non-preferred brand drugs	$40-$60/30-day supply	Not covered	Zohydro excluded
	Specialty drugs	$150/ 30- day supply	Not covered	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 care	$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

[* 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 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	$30/visit	$1000 deductible/20% co-insurance	Must be precertified by Total Care Network (TCN)
	Inpatient services	Deductible & 10% coinsurance	$1000 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	$35.00 copayment applies
	Childbirth/delivery facility 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	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.

[* 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 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, option #1.

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.

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

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.

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

The plan's overall deductible	$350
Specialist *[cost sharing]*	$35
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, Jen would pay:

Cost Sharing	
Deductibles	$350
Copayments	$35
Coinsurance	$500
What isn't covered	
Limits or exclusions	$150
The total Jen would pay is	**$1035**

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

The plan's overall deductible	$350
Specialist *[cost sharing]*	$35
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	$350
Copayments	$385
Coinsurance	$497
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1312**

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

The plan's overall deductible	$350
Specialist *[cost sharing]*	$35
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	$150
Copayments	$105
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$405**

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

Teamsters Health & Welfare Fund

of Philadelphia and Vicinity

2500 McClellan Ave, Suite 140 • PENNSAUKEN, NJ 08109 • (856) 382-2400
TOLL-FREE 1-800-523-2846 • FAX (856) 382-2401 • www.teamsterfunds.com

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 01/01/2020 through 12/31/2020. 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 DEARBORN NATIONAL LIFE INSURANCE 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 12/31/2020 were $406,779. 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 $156,546,371 as of the end of plan year, compared to $129,040,424 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of $27,505,947. 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 $130,376,451 including employer contributions of $111,291,987 employee contributions of $1,641,875, and earnings from investments of $17,442,589. Plan expenses were $102,870,504. These expenses included $3,629,759 in administrative expenses, $4,396,321 in benefit administrative expenses (paid to carriers) and $94,844,424 in benefits paid to or on behalf of 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 2500 McCLELLAN AVE, SUITE 140, 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: 2500 McCLELLAN AVE, SUITE 140, 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