




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 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--- |

[* 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 |
|---|---|------------------------------|---|--|
| | 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 .) | | |
|---|--|---|
| <ul style="list-style-type: none">• Acupuncture• Weight loss programs (other than ACA-required programs) | <ul style="list-style-type: none">• Cosmetic surgery• Hearing aids | <ul style="list-style-type: none">• 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.) | | |
| <ul style="list-style-type: none">• Bariatric Surgery• Private duty nursing | <ul style="list-style-type: none">• Chiropractic care• Routine eye care | <ul style="list-style-type: none">• 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, kwijigo 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 | \$500 |
| ■ Specialist [<i>cost sharing</i>] | \$40 |
| ■ Hospital (facility) [<i>cost sharing</i>] | 10% |
| ■ Other [<i>cost sharing</i>] | 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|---------------|
| Deductibles | \$500 |
| Copayments | \$40 |
| Coinsurance | \$510 |
| <i>What isn't covered</i> | |
| 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 [<i>cost sharing</i>] | \$40 |
| ■ Hospital (facility) [<i>cost sharing</i>] | 10% |
| ■ Other [<i>cost sharing</i>] | 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|---------------|
| Deductibles | \$500 |
| Copayments | \$480 |
| Coinsurance | \$120 |
| <i>What isn't covered</i> | |
| 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 [<i>cost sharing</i>] | \$40 |
| ■ Hospital (facility) [<i>cost sharing</i>] | 10% |
| ■ Other [<i>cost sharing</i>] | 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$110 |
| Copayments | \$580 |
| Coinsurance | \$266 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$956 |