THE CONNECTION

Newsletter of The Teamsters Health & Welfare Fund
of Philadelphia & Vicinity

It's that time of year! Open Enrollment is now open, and this is your opportunity to review and update your health, welfare, and pension benefits. Whether you're making changes or confirming your current selections, please take a moment to ensure that your benefits best meet your needs.

WINTER NEWSLETTER 2024

NOTICE

Aetna, Inc. Termination of Services Effective January 1, 2025

Effective January 1, 2025, the Teamsters Health and Welfare Fund will no longer be providing coverage through Aetna, Inc. Instead, all members will now be covered solely by Horizon Blue Cross/Blue Shield of New Jersey (Horizon BCBSNJ). Please see attached benefit detail for more info.

Guardian Nurses Termination of Services Effective February 1, 2025

Effective February 1, 2025, Teamsters Health and Welfare Fund will no longer participate with the Guardian Nurses Program. Guardian Nurses has played an important role in guiding our members toward appropriate diabetic care. Moving forward, members will be directed to contact Horizon Blue Cross/Blue Shield for questions or concerns related to provider access, treatments, and other diabetes-related services.

We appreciate your patience as we manage this transition. Our commitment to providing excellent care to our members remains unchanged.

This is your yearly opportunity to review and update your medical plan

- Keeping Your Current Coverage? No action is needed.
- Switching Plans? Please call Member Services at 800-523-2846 to request a Medical Benefit Option Change Form. Complete and return the form by December 6, 2025.
- Aetna, Inc. will no longer be a vendor partner with this Fund Effective January 1, 2025. All currently enrolled Aetna members will be automatically enrolled in a new plan with Horizon Blue Cross and Blue Shield of New Jersey called Horizon PPO "In-Network Only". This Plan includes both Platinum and Gold tiers. Please See the enclosed Summary of Benefits

Coverage changes will take effect on January 1, 2025.

2025 Coverage Reminder: Your level of coverage (Platinum or Gold) in 2025 depends on the completion of your annual wellness screening by October 31, 2024. The preventive dental exam requirement for members and spouses has been waived for the 2025 plan year.

Please review the medical plan details in this newsletter. You'll also find a Summary of Benefits & Coverage (SBC) to help compare options. The Platinum plan has lower out-of-pocket costs than the Gold plan. For additional enrollment details, links to provider directories, and more, visit our website at www.teamsterfunds.com (Health & Welfare tab).

Have questions? Call Member Services at 800-523-2846, option 1.

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 01/01/2023 through 12/31/2023. 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 TEAMSTER 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 12/31/2023 were $448,147. 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 $148,505,730 as of the end of plan year, compared to $141,474,796 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of $7,030,934. 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 $128,279,347 including employer contributions of $114,624,008, employee contributions of $607,484, and earnings from investments of $13,047,855. Plan expenses were $121,248,413. These expenses included $4,779,728 in administrative expenses, $4,996,906 in benefit administrative expenses (paid to carriers) and $111,471,779 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

Teamsters Health & Welfare Fund

of Philadelphia and Vicinity

This packet of information contains the

Summary of Benefits and Coverages for the

Horizon Blue PPO and Horizon Blue PPO "In-Network Only" medical programs

There are two PPO programs (Platinum and Gold) and two PPO "In-Network Only" programs (Platinum and Gold). Those who completed the WellTeam® screening program in 2024 earned participation in either one of the Platinum programs for the 2024 plan year. Those who did not complete the screening will 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 PPO "In-Network Only" medical programs.

Fall 2024

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?	$200/person & $400/family in-network; $450/person & $900/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	$200
Copayments	$30
Coinsurance	$480
What isn't covered	
Limits or exclusions	$150
The total Jen would pay is	**$860**

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	$200
Copayments	$230
Coinsurance	$118
What isn't covered	
Limits or exclusions	$79
The total Joe would pay is	**$627**

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.

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?	$450/person & $900/family in-network; $/person & $950/ person & $1,900/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.)		
• 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	$450
Copayments	$40
Coinsurance	$510
What isn't covered	
Limits or exclusions	$150
The total Jen would pay is	**$1150**

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	$450
Copayments	$480
Coinsurance	$120
What isn't covered	
Limits or exclusions	$79
The total Joe would pay is	**$1129**

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?	$50/person; $100/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, 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.

[* 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	$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	$50
Copayments	$25
Coinsurance	$250
What isn't covered	
Limits or exclusions	$150
The total Jen would pay is	**$475**

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	$50
Copayments	$275
Coinsurance	$118
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$523**

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, option #1 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/person; $600/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	$300
Copayments	$35
Coinsurance	$500
What isn't covered	
Limits or exclusions	$150
The total Jen would pay is	**$985**

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	$300
Copayments	$385
Coinsurance	$497
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1262**

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.

2024 Notification

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 known 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; and
- 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.

(continued)

Getting information about your health benefits

Horizon is committed to helping you understand your health benefits. Visit HorizonBlue.com to learn more about:

Getting care, including:

- How to get primary care, specialty care and hospital and behavioral health services
- How to get care after hours
- How and when to get emergency care or call **911** or your local emergency response system
- How and when to change from a pediatric doctor to an adult-care doctor

Your benefits and coverage, including:

- How to find which services are included in your plan
- How to find information about getting care outside of your plan's coverage area
- Where to find your copayment, deductible and coinsurance information
- How to submit a claim for covered services
- How to submit a complaint or an appeal

Horizon programs, including:

- Our pharmaceutical management procedures
- How Horizon evaluates new medical technology for inclusion as a covered benefit
- Our Chronic Care and Case Management programs, and how to enroll
- How to contact our Utilization Management department, including after-hours contact information; how coverage decisions are made and the availability of external review rights
- Our Quality Improvement program and how we work to improve the quality of care and services provided to our members

Your member rights, including:

- Your rights and responsibilities as a Horizon member
- How to get help in another language

If you do not have access to the internet, you can call Member Services at the number on the back of your member ID card to get a free copy of this information.

Horizon.

HorizonBlue.com

ECN0022317 (0924)

color | American Cancer Society

Virtual Cancer Clinic®

Take control *of* cancer.

INTERCEPT CANCER EARLY AND ENTER FOR A CHANCE TO WIN A

SAQUON BARKLEY JERSEY

TO PARTICIPATE VISIT WWW.COLOR.COM/TEAMSTERS AND COMPLETE YOUR CANCER RISK ASSESMENT BY NOVEMBER 30, 2024. THIS BENEFIT IS AVAILABLE TO ALL TEAMSTER MEMBERS AND THEIR SPOUSES AT NO COST. IF YOU'VE ALREADY COMPLETED YOUR CANCER RISK ASSESMENT, YOU WILL BE AUTOMATICALLY ENTERED IN A CHANCE TO WIN.

Important news about your dental benefits!

Did you know the Trustee's enriched your Dental Benefits??

We are pleased to inform you that starting August 1, 2024, The Teamsters Health & Welfare Fund will be adding partial coverage for 3 dental procedures currently excluded from your coverage under your dental plan. This addition is part of our ongoing commitment to provide you with enhanced benefits and help you maintain optimal oral health.

[D0364 Dental Cone Beam CT scan]

A dental cone beam CT scan is a specialized X-ray which produces 3D images of your teeth & jaw. These images can be used to help your dentist determine a course of treatment.

[D6057 Custom Fabricated Abutment]

An abutment is an integral part of a dental implant procedure which connects the dental implant and the prosthetic tooth.

[D6059 Abutment supported implant crown]

An abutment supported implant crown is a crown that is attached to the custom fabricated abutment and implant. This is your new prosthetic tooth.

Details about the New Coverage:

- **Eligibility**: The procedure will be partially reimbursed when deemed medically necessary and subject to normal eligibility guidelines.
- **Benefit Coverage**: Whether services are rendered by an in-network or out of network dental office, you may be charged for the full cost of the procedure. At the end of the benefit year, after all your dental claims have been processed you may request reimbursement from the Fund not to exceed the balance of your Annual Dental Maximum of $3000.00. Simply request an itemized receipt from your dental provider and submit it to the Fund office for reimbursement. For example, if you have used $2500.00 of your annual dental maximum of $3000.00, you can be reimbursed up to $500.00, not to exceed what the service cost.

Horizon.

Exercise regularly and get rewarded!

At home, the gym or walking anywhere

How to earn rewards

HorizonbFit is Horizon's fitness incentive program for covered members 18 years of age and older. Track your activity to earn a $20 reward each month:

- Work out at home 12 or more days a month, and record and submit your workout using the ActiveFit@Home™ feature on the ActiveFit® app; or
- Walk 10,000 steps a day for at least 12 days a month; or
- Complete any combination of the above activities for at least 12 days a month
- Visit one of the nation's 30K+ fitness facilities tracked through advanced geo-location technology

You can earn up to $240 per year in rewards!

Tracking your steps and activity

HorizonbFit has a free mobile app[1] called ActiveFit, which makes it easy to report trips to the gym. When the app is open, it uses GPS and Bluetooth services to detect when you enter a participating gym. ActiveFit will automatically log the visit toward your monthly incentive — there's no additional tracking!

You can also use ActiveFit to:

- Find participating facilities
- View which facilities you've visited and when
- Access incentive payment information
- Track your steps and receive motivational messaging to keep your workouts on track

You can download ActiveFit for free from the App Store℠ or Google Play™.

Staying fit from home

The ActiveFit@Home feature provides a simple way for you to report your at-home workouts. To validate your at-home activity, submit your post-workout selfie by following these easy steps:

- Locate the ActiveFit@Home option in the main menu in ActiveFit.
- Tap the *Get Started* button to open your camera and take a post-workout selfie.
- Once you preview your photo, click *Upload*.

The photo, along with a geo-location time stamp, allows your activity to be reviewed and approved. Please allow 24 to 48 hours for your activity to be accepted.

Note: Photos submitted for a date other than the day the photo was taken will be placed in a pending status and may not be accepted. Please ensure that you have downloaded and installed the latest version of the ActiveFit app.

How to enroll

Enrolling is free and easy at HorizonbFit.com — just use your Horizon member ID number to set up your account. If your fitness facility does not participate with HorizonbFit, you can nominate it for inclusion. If you have questions about the HorizonbFit program or ActiveFit@Home, call **1-201-351-7850**, option **1**.

[1]There is no charge to download the app, but rates from your wireless provider may apply.

HorizonbFit.com

ECN038197 (0324)

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

PRSRT STD
US Postage PAID
Lehigh Valley, PA
Permit No. 460