PHILADELPHIA

Update

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

www.teamsterfunds.com

November 2012

Yearly Open Enrollment Begins November 1st and Ends December 7th . . .

It's Your Chance to Choose Between Blue Cross PPO or Aetna HMO Coverage

Open Enrollment is your annual opportunity to review your medical plan choices. All changes will be effective January 1, 2013. Take some time to review this Newsletter. *We have included a Summary of Benefits & Coverage (SBC) for each medical plan* — one for the PPO and one for the HMO. Also visit www.teamsterfunds.com for Open Enrollment information and links to each medical plan's online provider directory.

If you are presently enrolled in the BlueCard PPO program and don't want to make any change to your present coverage, you don't have to do a thing. If you have *PPO* coverage now and don't do anything, as of January 1, 2013 you'll still enjoy coverage under the PPO program.

If you have BlueCard PPO coverage and want to switch to the Aetna HMO coverage effective January 1, 2013, call 1-800-523-2846 to have an enrollment kit mailed to you. You must fill out the enrollment form, choose a Primary Care Physician, *AND* have the enrollment form returned to the Fund office before the open enrollment period **ends on December 7th.**

If you have Aetna HMO coverage now and want to keep that HMO coverage into next year, you don't have to do a thing. If you have HMO coverage now and don't do anything, as of January 1, 2013 you'll still enjoy coverage under the HMO program. *If you have Aetna HMO coverage and want to switch to the Blue Cross PPO coverage effective January 1, 2013, call the Fund office at 1-800-523-2846 for a coverage change form (a copy is also available on the Fund's web site).*

If you wish to change your coverage for the coming year, YOU MUST ACT NOW!

Also in this Issue . . . . .

- ***Summary Annual Report for the Health & Welfare Fund***
- ***Annual notice regarding post-mastectomy reconstructive surgery benefits***

What's Staying the Same for Plan Year 2013?

- No change in the Plan of Benefits
- Copayments, deductibles and coinsurance remain the same
- Health plan offerings remain the same
- Total Care Network continues to administer the mental health and substance abuse benefit (regardless of whether you choose the PPO or HMO medical program)
- Dental and vision coverages will remain the same for both PPO and HMO participants
- PPO participants can avoid out-of-pocket costs by using LabCorp or Quest for their outpatient laboratory needs and the ***Health Care Solutions*** network for their diabetic supplies and outpatient radiology services
- Although no changes are scheduled for the prescription drug program (the current 3 tier copay structure will remain the same), the Fund's current agreement with Express Scripts is due to expire December 31st. Whether Express Scripts will continue as the Fund's Pharmacy Benefit Manager after December 31st has not yet been determined. *If a different vendor is chosen, the preferred formulary could change (and it can change quarterly with Express Scripts as well), which could impact your copayment for brand name drugs.* Members will, of course, be notified as to any changes in the prescription drug program.

Updated Summary Plan Descriptions Scheduled for Publication in January 2013

- In late January 2013, the Fund will be mailing to each member's home a new and updated Summary Plan Description, which describes in easy-to-read terms, the valuable benefits you enjoy as a participant of the Teamsters Health & Welfare Fund. Be sure to read and save your copy for future reference.

We can't communicate with you unless you tell us where you live!

- Be sure to notify the Fund office promptly of any change in your address. Neither your employer nor your Local Union share this information with us.
- Don't assume that we have your new address just because you gave it to your employer or your Local.

We respect your privacy!

Learn more about the Fund's privacy policy by reading your Summary Plan Description or visiting the Fund's web site. The Privacy Policy is posted at: http://www.teamsterfunds.com/For%20Members/Privacy%

Attention Health & Welfare Fund Participants:

Annual Notice Regarding Post-Mastectomy Reconstructive Surgery Benefits

As required by the Women's Health and Cancer Rights Act of 1998, the Health & Welfare Fund's Plan provides (as it always has) benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedemas). For more information, contact the Fund's Member Services Department at 1-800-523-2846.

SUMMARY ANNUAL REPORT FOR 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 01/01/2011 through 12/31/2011. 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 TEAMSTERS HEALTH & WELFARE FUND OF PHILA & 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 insurance contracts with AETNA LIFE INSURANCE COMPANY & AFFILIATES and THE UNION LABOR LIFE INSURANCE COMPANY to pay certain Life insurance, ACCIDENTAL DEATH & DISMEMBERMENT claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2011 were $790,129 (an amount which includes premiums from the last 6 months of 2010).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $60,285,188 as of the end of plan year, compared to $56,412,285 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of $3,872,903. 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 $98,435,128 including employer contributions of $95,182,649, employee contributions of $2,231,424, gains/(losses) of $0 from the sale of assets, and earnings from investments of $1,819,433. Plan expenses were $94,562,225. These expenses included $6,019,385 in administrative expenses, and $88,542,840 in benefits paid to 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 office of WILLIAM J EINHORN, who is a representative of the plan administrator, at 6981 NORTH PARK DRIVE, SUITE 400, PENNSAUKEN, NJ 08109 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: 6981 NORTH PARK DRIVE, SUITE 400, 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.

William J. Einhorn, Administrator

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION ABOUT YOUR OPEN ENROLLMENT RIGHTS UNDER YOUR HEALTH AND WELFARE PLAN.

THE SUMMARY OF BENEFITS AND COVERAGE, REQUIRED BY THE AFFORDABLE CARE ACT, IS ENCLOSED WITH THIS PACKET

PLEASE TAKE THE TIME TO READ IT AND SAVE IT!

HAVE QUESTIONS? CALL OUR MEMBER SERVICES DEPARTMENT AT 1-800-523-2846 OR SEND US AN EMAIL THROUGH OUR WEB SITE . . . WWW.TEAMSTERFUNDS.COM

Find us on the World Wide Web at www.teamsterfunds.com

Teamsters Health & Welfare Fund
of Philadelphia and Vicinity
6981 N. Park Drive, Suite 400
Pennsauken, NJ 08109

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Teamsters Health & Welfare Fund

of Philadelphia and Vicinity

This packet of information contains the Summary of Benefits and Coverage for both the Blue Card PPO and Aetna HMO medical programs.

The first seven pages of this packet contain the Summary of Benefits and Coverage for the Blue Card PPO medical program.

The remaining pages relate to the Aetna HMO medical program.

Teamsters Health & Welfare Fund: Blue Card PPO

Coverage Period: 01/01/2013-12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Coverage Types | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.teamsterfunds.com or by calling 1-800-523-2846.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$225/person & $450/family in-network; $500/person & $1,000/family out-of-network; inapplicable to copays.	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 after you meet the **deductible**.
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.
Is there an out–of–pocket limit on my expenses?	Yes. $500/person for in-network & $1,500/person for out-of-network care.	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, deductibles, penalties & copays.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes. $2,000,000/person/year	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.bcbs.com and www.teamsterfunds.com or call 1-800-355-2583 or 1-800-523-2846 for a list.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use "**in-network**" or "**preferred**" **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	20% coinsurance plus balance billing	---none---
	Specialist visit	$25/visit	20% coinsurance plus balance billing	---none---
	Other practitioner office visit	$25/visit for chiropractor	20% coinsurance plus balance billing	15 manipulations per benefit period
	Preventive care/screening/ immunization	No more than $15/visit	20% coinsurance plus balance billing	One round of preventative treatment/person/year; HPV vaccinations are covered (ages 9-26) at the lesser of $175 or the billed amount; colonoscopy, mammography, and prostate screening coverage varies by age.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance plus balance billing	First $100/year covered in full; special networks available with no cost sharing
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance plus balance billing	Special networks available with $20 copay
If you need drugs to treat your illness or condition	Generic drugs	$3/prescription	Not covered	---none---
	Preferred brand drugs	$10/prescription	Not covered	Step therapy may apply
	Non-preferred brand drugs	$30 to $40/prescription	Not covered	Step therapy may apply

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at http://www.teamsterfunds.com	Specialty drugs	$10 for preferred; $30 to $40 for non-preferred per prescription	Not covered	Step therapy may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance plus balance billing	---none---
	Physician/surgeon fees	10% coinsurance	20% coinsurance plus balance billing	---none---
If you need immediate medical attention	Emergency room services	$100/visit	20% coinsurance plus balance billing	Copayment waived if admitted
	Emergency medical transportation	10% coinsurance	20% coinsurance plus balance billing	Only covered if medically necessary
	Urgent care	$50/visit	20% coinsurance plus balance billing	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance plus balance billing	Precertification is required. If it is not, then you may owe a $1,000 penalty.
	Physician/surgeon fee	10% coinsurance	20% coinsurance plus balance billing	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	20% coinsurance plus balance billing	Must be precertified by Total Care Network ("TCN"); 30 visits/year; 60 visits/year for serious mental illness
	Mental/Behavioral health inpatient services	No charge	20% coinsurance plus balance billing	Must be precertified by TCN; up to 30 days/year
	Substance use disorder outpatient services	No charge	20% coinsurance plus balance billing	Must be precertified by TCN; 4 confinements of up to 7 days per lifetime; up to 30 days residential treatment/year; 90 days/lifetime
	Substance use disorder inpatient services	No charge	20% coinsurance plus balance billing	Must be precertified by TCN; 30 visits/year; 120 visits/lifetime
If you are pregnant	Prenatal and postnatal care	$25 copayment on initial visit	20% coinsurance plus balance billing	Limited to care of the mother; newborn care is subject to 10% coinsurance

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	10% coinsurance	20% coinsurance plus balance billing	---none---
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance plus balance billing	Precertification is required; if it is not obtained then you will incur a 20% reduction in the benefits payable.
	Rehabilitation services	10% coinsurance	20% coinsurance plus balance billing	---none---
	Habilitation services	$25 copayment	20% coinsurance plus balance billing	Limitations apply depending on the type of habilitation services needed as noted in the plan document
	Skilled nursing care	10% coinsurance	20% coinsurance plus balance billing	Custodial nursing care is excluded.
	Durable medical equipment	10% coinsurance	20% coinsurance plus balance billing	If it exceeds $500, it must be precertified. If it is not precertified, then you will incur a 20% reduction in the benefits payable.
	Hospice service	10% coinsurance	20% coinsurance plus balance billing	---none---
If your child needs dental or eye care	Eye exam	No charge	Balance billing over $40	One office visit every 24 months.
	Glasses	No charge	Balance billing	Allowable charges depend on the type of glasses obtained; one pair every 24 months.
	Dental check-up	$0	Balance billing	Comprehensive exam once every 12 months; periodic exam once every 6 months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care
- Hearing aids
- Infertility treatment
- Long term care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic care
- Dental Care (adult)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-523-2846. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or http://www.ccio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: William Einhorn, Administrator, Teamsters Health and Welfare Fund of Philadelphia and Vicinity, 6981 N. Park Drive, Suite 400, Pennsauken, New Jersey 08109, 1-800-523-2846 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,660
- **Patient pays** $880

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$225
Copays	$25
Coinsurance	$480
Limits or exclusions	$150
Total	**$880**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,748
- **Patient pays** $ 652

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$225
Copays	$230
Coinsurance	$118
Limits or exclusions	$79
Total	**$652**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Teamsters Health & Welfare Fund

of Philadelphia and Vicinity

The next seven pages of this packet contain

the Summary of Benefits and Coverage

for the Aetna HMO medical program.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.teamsterfunds.com or by calling 1-800-523-2846.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
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.
Is there an out–of–pocket limit on my expenses?	Yes. $440/person/year	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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes. $2,000,000/person/year	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com and www.teamsterfunds.com or call 1-800-523-2846 for a list.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use "**in-network**" or "**preferred**" **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10/visit	Not covered	$15 for after hours visits
	Specialist visit	$20/visit	Not covered	---none---
	Other practitioner office visit	$20/visit Chiropractor	Not covered	15 manipulations per benefit period
	Preventive care/screening/immunization	No more than $10/visit, depending on the treatment.	Not covered	Each participant is limited to one round of preventative treatment each year; HPV vaccinations are covered (ages 9-26) at $35 copay per injection; colonoscopy, mammogram, and prostate screening coverage varies by age.
If you have a test	Diagnostic test (x-ray, blood work)	$0	Not covered	Referral required
	Imaging (CT/PET scans, MRIs)	$0	Not covered	Referral required
If you need drugs to treat your illness or condition	Generic drugs	$3/prescription	Not covered	---none---
	Preferred brand drugs	$10/prescription	Not covered	Step therapy may apply
	Non-preferred brand drugs	$30 to $40/prescription	Not covered	Step therapy may apply

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at http://www.teamsterfunds.com	Specialty drugs	$10 for preferred; $30 to $40 for non-preferred per prescription	Not covered	Step therapy may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	Not covered	---none---
	Physician/surgeon fees	$0	Not covered	---none---
If you need immediate medical attention	Emergency room services	$100/visit	Not covered	Copayment waived if admitted; non-emergency use of the ER is not covered.
	Emergency medical transportation	$0	20% coinsurance plus balance billing	Only covered if medically necessary
	Urgent care	$50/visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$0	Not covered	Must be authorized by Aetna
	Physician/surgeon fee	$0	Not covered	Must be authorized by Aetna
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	20% coinsurance plus balance billing	Must be precertified by Total Care Network ("TCN"); 30 visits/year; 60 visits/year for serious mental illness
	Mental/Behavioral health inpatient services	No charge	20% coinsurance plus balance billing	Must be precertified by TCN; up to 30 days/year
	Substance use disorder outpatient services	No charge	20% coinsurance plus balance billing	Must be precertified by TCN; 4 confinements of up to 7 days per lifetime; up to 30 days residential treatment/year; 90 days/lifetime
	Substance use disorder inpatient services	No charge	20% coinsurance plus balance billing	Must be precertified by TCN; 30 visits/year; 120 visits/lifetime
If you are pregnant	Prenatal and postnatal care	$20/visit	Not covered	For prenatal treatment, only the first office visit requires a copayment.
	Delivery and all inpatient services	$0	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
you need help recovering or have other special health needs	Home health care	$0	Not covered	Precertification is required; if it is not obtained then you will incur a 20% reduction in the benefits payable.
	Rehabilitation services	$0	Not covered	Covered for 60 calendar days per condition
	Habilitation services	$0	Not covered	Covered for 60 calendar days per condition
	Skilled nursing care	$0	Not covered	Covered up to 180 days per calendar year
	Durable medical equipment	$0	Not covered	Must be authorized by PCP and Aetna
	Hospice service	$0	Not covered	Must be authorized by PCP and Aetna
If your child needs dental or eye care	Eye exam	None	Balance billing over $40	One office visit every 24 months.
	Glasses	None	Balance billing	Allowable charges depend on the type of glasses obtained; one pair every 24 months.
	Dental check-up	$0	Balance billing	Comprehensive exam once every 12 months; periodic exam once every 6 months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care
- Hearing aids
- Infertility treatment
- Long term care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic care
- Dental Care (adult)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-523-2846. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or http://www.ccio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: William Einhorn, Administrator, Teamsters Health and Welfare Fund of Philadelphia and Vicinity, 6981 N. Park Drive, Suite 400, Pennsauken, New Jersey 08109, 1-800-523-2846 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,360
- **Patient pays** $180

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$30
Coinsurance	$0
Limits or exclusions	$150
Total	**$180**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,100
- **Patient pays** $ 300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$220
Coinsurance	$0
Limits or exclusions	$80
Total	**$300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.