TEAMSTERS JOINT COUNCIL 32 – EMPLOYERS HEALTH AND WELFARE FUND
3001 Metro Drive—Suite 500
Bloomington, Minnesota 55425
Bloomington Office: (952) 854-0795 or (800) 535-6373
Duluth Office: (218) 727-0824 or (800) 570-1012

SCHEDULE OF BENEFITS

These pages include a high level summary of your benefits. For a more complete explanation of your benefits, including eligibility requirements, limitations, and exclusions, You must refer to the full body of this Summary Plan Description booklet. The following summarizes the Medical, Prescription Drug, Dental, Vision, Weekly Disability, Death, and Accidental Death and Dismemberment benefits offered through the Fund. Most, but not all bargaining or participation agreements provide for these benefits. If You have questions about which benefits You are eligible for please contact the Fund Office. The Trust also offers a Health Reimbursement Arrangement (HRA) to bargaining units that provide for the benefit.

MEDICAL BENEFITS

The information below is a brief outline of your benefits. For more information, See Parts Two through Four of this booklet, beginning on page 20. Throughout Parts One through Four this booklet uses defined terms, which are capitalized. The definitions of these terms are found in the section titled "Medical Plan Definitions," which begins on page 48.

Annual Deductible Amount:

	In-Network	Out-of-Network
Individual	$500/calendar year	$500/calendar year
Family	$1,500/calendar year	$1,500/calendar year

The Deductibles for In-Network and Out-of-Network services are combined and determined annually on a calendar-year basis.

Percentage Payable:

	In-Network	Out-of-Network
General rule for medical services, except as specified below	85%, after Deductible is met	75%, after Deductible is met
Autism Treatment	85%, Deductible does not apply	75%, after Deductible is Met
Bariatric Surgery	Services covered at corresponding In-Network Benefit rates.	No coverage
Chiropractic Services	85%, after Deductible is met	No coverage
Convenience Clinics	100%, Deductible does not apply	75%, after Deductible is met

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	In-Network	Out-of-Network
Inpatient Hospital Services, including: **Facility fees** **Professional fees** *Out-of-Network professional fees will be paid at In-Network benefit level if patient admitted to In-Network facility through Emergency Room.*	85%, Deductible does not apply 85%, after Deductible is met	No coverage except in limited situations ** 75%, after Deductible is met
Inpatient Mental Health and Chemical Dependency Services, including inpatient hospital/ residential treatment facilities for adults and children and psychiatric treatment for emotionally disabled children	85%, Deductible does not apply	No coverage except in limited situations **
Medically Necessary hospitalization and anesthesia for dental care, including: **Facility fees** **Professional fees**	85%, Deductible does not apply 85%, after Deductible is met	No coverage except in limited situations ** 75%, Deductible does not apply
Newborn expenses (facility and professional fees)	85%, Deductible does not apply	75%, Deductible does not apply
Outpatient Mental Health and Chemical Dependency Services	85%, Deductible does not apply	75%, after Deductible is met

** An exception applies for services qualifying as Emergency Care, care that is considered Continuity of Care, or care received when You are residing in or traveling in an area where an In-Network Provider is not available and the inpatient services are Medically Necessary.

	In-Network	Out-of-Network
Preventive Care, including: **Routine health exams and periodic health assessments** **Child health supervision services up to age 6 and appropriate immunizations to age 18** **Routine Pre-natal and post-natal care** **Routine screening procedures for cancer** **Routine hearing exams** **Professional voluntary family planning** **Adult immunizations** **Women's preventive health** (including all FDA approved contraceptive methods prescribed by Physician) **Obesity screening and management** **Diagnostic imaging and laboratory services associated with preventive care**	100%, Deductible does not apply	No coverage
Telemedicine visits	100%, Deductible does not apply	75%, after Deductible is met
Transplant Services, including:		
Facility Fees	85%, Deductible does not apply	85%, Deductible does not apply
Professional fees	85%, after Deductible is met	75%, after Deductible is met

The Plan covers the following services, when an Participant elects to receive them from an Out-of-Network provider, at the same level of coverage the Plan provides when an Participant elects to receive the services from a network provider:

1. Voluntary family planning of the conception and bearing of children.

2. Testing and treatment of sexually transmitted diseases (other than HIV).

3. Testing for AIDS and other HIV-related conditions.

4. Medically Necessary emergency room services

For any other Out-of-Network claims, if a benefit is payable under the Plan, the Plan will calculate a benefit based on the lesser of the amount the Out-of-Network Provider's billed charges or a "Reasonable Expense" for such services, as determined in the sole discretion of the Fund. The Reasonable Expense calculation is not intended to represent a "usual, customary and reasonable charge."

For services provided outside of Minnesota, the Reasonable Expense for services from Out-of-Network Providers is commonly determined by affiliates of the Plan's PPO Network Provider. The difference between billed charges and Reasonable Expense amount can be significant and, unlike Co-payments and Co-insurance, does not apply toward the Plan's annual Out-of-Pocket maximum. Benefits are not available from Out-of-Network facilities except for care that constitutes continuity of care, or when You are traveling or residing in an area where an In-Network Provider is not available.

Medical Benefits with Separate Co-Payments

Emergency Room Facility	$200 Co-payment then 85%
Urgent Care	$25 Co-payment then 85%

Emergency room Co-payment is waived if there is an inpatient admission for the same condition within 48 hours.

Medical Benefits with Annual Visit or Dollar Limits

Chiropractic Services
Limited to 20 visits to In-Network Providers per calendar year.

Massage
Limited to 20 visits per calendar year.

Accidental Dental Services
For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the Injury. Coverage is limited to the initial course of treatment and/or initial restoration and subject to a $5,000 maximum. Services must be provided within 24 months of the date of Injury to be covered.

Wigs
Wigs for hair loss resulting from alopecia areata are subject to $350 maximum benefit per calendar year for In-Network Benefits and Out-of-Network Benefits combined.

Home Hospice Services
Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.

Annual Medical Out-of-Pocket Maximum:

	In-Network	Out-of-Network
Individual	$2,500/calendar year	$2,500/calendar year
Family	$5,000/calendar year	$5,000/calendar year

The Out-of-Pocket limits for In-Network and Out-of-Network services are combined and are determined annually on a calendar year basis.

The following don't apply to the out-of-pocket limit:

- Deductibles
- Out-of-Network Benefits above the Reasonable Expense (see Definitions beginning on page 48)
- Any reduction in benefits for failure to obtain prior authorization, as required. Inpatient Hospital, Home Health Care, Residential Behavioral Health Facility, Skilled Nursing Facility, Skilled Nursing Care, Hospice Care, certain surgeries and procedures, and certain Durable Medical Equipment require prior authorization
- Any service or treatment that is not a Covered Charge

In no event, however, will the annual Out-of-Pocket expenses for medical and prescription drug Covered Charges exceed $7,350 per individual or $14,700 per family.

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PRESCRIPTION DRUG BENEFITS

Annual Prescription Drug Out-of-Pocket Maximum:

	In-Network	Out-of-Network
Individual	$3,000/calendar year	No Coverage
Family	$7,000/calendar year	No Coverage

Prescription drug Co-payments and Co-insurance apply to the Annual Prescription Drug Out-of-Pocket Maximum; they do not apply toward the Annual Medical Out-of-Pocket Maximum.

	In-Network	Out-of-Network
Generic Drugs found on Network formulary	$10 Co-pay or 20% of Cost, whichever is greater, up to a maximum of $50	No Coverage
Brand Name Drugs found on Network formulary	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
Non-formulary Brand Drugs	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
Specialty Drugs	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
90-day Retail or Mail Order – Generic	$25 Co-pay or 15% of Cost, whichever is greater, up to a maximum of $125	No Coverage
90-day Retail or Mail Order – Brand Name Formulary	$62.50 Co-pay or 25% of Cost, whichever is greater, up to a maximum of $375	No Coverage
90-day Retail or Mail Order – Brand Name Non-Formulary	$62.50 Co-pay or 25% of Cost, whichever is greater, up to a maximum of $375	No Coverage

Step Therapy, Prior Authorization, and other cost and benefit management programs apply for certain medications.

Take Home Drugs:

Drugs dispensed by a hospital are payable under the medical portion of the Plan.

See Part Six beginning on page 55 for more information on Your prescription drug benefit.

WEEKLY DISABILITY BENEFITS (Active Employees Only, Retirees and Dependents Not Eligible)

Weekly Benefit:	$300 or 1/7th of the weekly amount if disabled less than a full week.
Maximum Disability Period:	26 weeks per illness, per Injury in a 12-month period
	When Benefits Begin
Accident/Injury	1st day of total disability
Illness or Pregnancy	8th day after date Physician first finds You to be disabled

See Part Seven beginning on page 60 for more information on Your Disability benefits.

DEATH & ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Death Benefits (Active Employees and Dependent(s) Only. Retirees and Retiree's Dependent(s) are Not Eligible)

Employee	$40,000
Spouse of Employee	$10,000
Children of Employee	Between $300 and $3,000 (depending on their age)

Accidental Death and Dismemberment (AD&D) Benefits (Active Employees Only, Retirees and Dependents Not Eligible)

Up to $80,000; the Plan will pay between $20,000 and $80,000 if You are seriously injured in an accident (depending on the severity of the accidental loss and Plan provisions). See Part Eight, beginning on page 63 for more information on Your Death and AD&D benefits.

DENTAL

Deductible Amount:

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating Dentist
Individual	$0	$25/calendar year	$25/calendar year
Family	$0	$75/calendar year	$75/calendar year

Deductible does not apply to Diagnostic and Preventative or Orthdontic Services.

Percentage Payable

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating ** Dentist
Diagnostic & Preventive Services	100%	100%	100%
Basic Service	100%	100%	100%
Endodontics	90%	80%	80%
Periodontics	90%	80%	80%
Oral Surgery	90%	80%	80%
Major Restorative Services	90%	80%	80%
Prosthetic Repairs and Adjustments	90%	80%	80%
Prosthetics	90%	80%	80%
Orthodontics	50%	50%	50%

** Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

Benefit Maximums

Annual	$2,000
Lifetime Orthodontic	$1,000
Dental treatment relating to any incident of accidental injury	$5,000

Orthodontics limited to those orthodontic treatment plans commenced on or after the eligible Dependent Child's eighth birthday and prior to the Dependent Child's nineteenth birthday.

All services (other than orthodontia) must be commenced and completed within one benefit year (January 1 – December 31).

There will be no carry-over payment from one benefit year to another.

A benefit will not be paid on a tooth replaced with an implant more than once in a lifetime.

See Section Nine beginning on page 68 for more information on Your Dental benefits.