BENEFITS		TEAMSTERS WELFARE FUND Benefit Plan 856		TEAMSTERS WELFARE FUND Benefit Plan 737		TEAMSTERS WELFARE FUND Benefit Plan 127	
		In-Network	Out-of-Network (MAB)	In-Network	Out-of-Network (MAB)	In-Network	Out-of-Network
Annual Deductible	Single	$0	$0	$300	$600	Not Offered	
	Family	$0	$0	$900	$1,800		
Out-of-Pocket Maximum (including deductible)		$2,000 per family	$4,000 per family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family		
Lifetime Maximum		Unlimited	Unlimited	Unlimited	Unlimited		
Outpatient Primary Care Visit		$15 Copay	60% MAB	$20 Copay	60% after deductible		
Outpatient Specialist Visit		$30 Copay	60% MAB	$40 Copay	60% after deductible		
Wellness Benefit - Physical/GYN Exam		100%, Copay waived	60% MAB	100%, Copay/Ded. waived	60% after deductible		
Wellness Benefit - Pap Smear/Mammogram		100%, Copay waived	90% MAB	100%, Copay/Ded. waived	60% after deductible		
Wellness Benefit - Child Immunization		100%, Copay waived	80% MAB	100%, Copay/Ded. waived	60% after deductible		
Wellness Benefit - Adult Flu Vaccination		100%, Copay waived	80% MAB	100%, Copay/Ded. waived	60% after deductible		
Well Child Benefits Limits		Unlimited		Unlimited			
Obstetrical Office Visits (Pre & Post-Natal)		100%	90% MAB	80% after deductible	60% after deductible		
Inpatient Hospital Services		100% after $250 Copay	90% after $250 Copay	80% after deductible	60% after deductible		
Emergency Care		$75 Copay waived if admitted	$75 Copay waived if admitted	$100 Copay waived if admitted	80% after deductible		
Urgent Care Centers		$35 Copay	60% MAB	$45 Copay	60% after deductible		
Lab and X-Ray		100%	90% MAB	80% after deductible	60% after deductible		
Major Diag. (CT, PET, MRI, MRA, NM)		100%	90% MAB	80% after deductible	60% after deductible		
Outpatient Mental Health and Substance Abuse		$15 Copay Mental Health Parity	60% MAB	$20 Copay Mental Health Parity	50% MAB		
Inpatient Mental Health and Substance Abuse		100% after $250 Copay Mental Health Parity	100% MAB after $250 Copay	80% after deductible Mental Health Parity	60% after deductible		
Rx Card	Retail & Mail up to 34 days	$10/$20/$35	$10/$20/$35	$10/$20/$35	$10/$20/$35		
	Retail 90 & Mail 35 - 60 days	$20/$40/$70	$20/$40/$70	$20/$40/$70	$20/$40/$70		
	Retail 90 61 - 90 days	$30/$60/$105	$30/$60/$105	$30/$60/$105	$30/$60/$105		
	Mail 61 - 90 days	$20/$45/$80	$20/$45/$80	$20/$45/$80	$20/$45/$80		
	Diabetic Supplies	Covered under DME	Covered under DME	Covered under DME	Covered under DME		
Dental	Delta Dental PPO Network	Class I & II - 100%, Class III - 90%, Annual maximum - $2,100 Ortho - 85% up to $3,500 lifetime - Children & Adults	Class I & II - 100% MAB, Class III - 85% MAB, Annual maximum - $2,000 Ortho - 50% MAB up to $2,000 lifetime - Children only	Not a Benefit		Class I - 100%, Class II - 100% after deductible, Class III - 90% after deductible, Annual maximum - $1,600. Deductible -$50 individual or $100 family. Ortho - Not covered.	Class I - 100%, Class II - 100% after deductible, Class III - 85% after deductible, Annual maximum - $1,500. Deductible -$50 individual or $100 family. Ortho - Not covered.
	Delta Dental Premier Network	Class I & II - 100%, Class III - 85%, Annual maximum - $2,000 Ortho - 85% up to $3,500 lifetime - Children & Adults	Class I & II - 100% MAB, Class III - 85% MAB, Annual maximum - $2,000 Ortho - 50% MAB up to $2,000 lifetime - Children only			Class I - 100%, Class II - 100% after deductible, Class III - 85% after deductible, Annual maximum - $1,500. Deductible -$50 individual or $100 family. Ortho - Not covered.	Class I - 100%, Class II - 100% after deductible, Class III - 85% after deductible, Annual maximum - $1,500. Deductible -$50 individual or $100 family. Ortho - Not covered.
Vision	Benefit Period	Once per calendar year	Once per calendar year	Not a Benefit		Once per calendar year	Once per calendar year
	Exam	100%	Up to $50.00			100%	Up to $50.00
	Frames	Up to $150.00	Up to $75.00			Up to $150.00	Up to $75.00
	Basic Lenses	100%	Up to $50.00			100%	Up to $50.00
	Bifocal Lenses	100%	Up to $60.00			100%	Up to $60.00
	Trifocal Lenses	100%	Up to $70.00			100%	Up to $70.00
	Progressive Lenses	Up to $85.00	Up to $70.00			Up to $85.00	Up to $70.00
	Polycarbonate Lenses	Up to $20.00 (under age 18)	Not Covered			Up to $20.00 (under age 18)	Not Covered
	Contacts	Up to $120.00	Up to $80.00			Up to $120.00	Up to $80.00
	Uncovered Charges	20% Discount	N/A			15% Discount	N/A
	Laser Vision Correction	Up to $250.00 per eye (Lifetime)	Up to $250.00 per eye (Lifetime)			Up to $250.00 per eye (Lifetime)	Up to $250.00 per eye (Lifetime)

PRICING COMPARISON 3/30/2025 - 3/29/2026		TEAMSTERS WELFARE FUND Benefit Plan 856	TEAMSTERS WELFARE FUND Benefit Plan 737	TEAMSTERS WELFARE FUND Benefit Plan 127
Total Pricing	Single	$927.98	$726.92	$42.47
	Employee + Children	$1,855.97	$1,454.05	$85.15
	Employee + Spouse	$2,227.12	$1,744.82	$102.05
	Family	$2,783.95	$2,180.97	$127.62

CHART ONE RATES		TEAMSTERS WELFARE FUND Benefit Plan 856		TEAMSTERS WELFARE FUND Benefit Plan 737		TEAMSTERS WELFARE FUND Benefit Plan 127	
3/30/2025 - 3/29/2026		Employee (20%)	Employer (80%)	Employee (15%)	Employer (85%)	Employee	Employer (100%)
Total Pricing	Single	$186.00	$741.98	$109.00	$617.92	$0.00	$42.47
	Employee + Children	$371.00	$1,484.97	$218.00	$1,236.05	$0.00	$85.15
	Employee + Spouse	$445.00	$1,782.12	$262.00	$1,482.82	$0.00	$102.05
	Family	$557.00	$2,226.95	$327.00	$1,853.97	$0.00	$127.62

CHART TWO RATES		TEAMSTERS WELFARE FUND Benefit Plan 856		TEAMSTERS WELFARE FUND Benefit Plan 737	
3/30/2025 - 3/29/2026		Employee (50%)	Employer (50%)	Employee	Employer (50% Plan 856)
Total Pricing	Single	$464.00	$463.98	$262.94	$463.98
	Employee + Children	$928.00	$927.97	$526.08	$927.97
	Employee + Spouse	$1,114.00	$1,113.12	$631.70	$1,113.12
	Family	$1,392.00	$1,391.95	$789.02	$1,391.95

Chart One:

- All unit members regulary scheduled to work at least twenty-eight (28) hours per week.
- All unit members hired prior to July 1, 2005 and regularly scheduled to work at least fifteen (15) hours per week.
- All Transportation unit members hired on or after July 1, 2005 and prior to July 1, 2010 who are regularly scheduled to work at least twenty (20) hours per week.

Chart Two:

- All 3rd unit members hired on or after July 1, 2005 and prior to October 1, 2014 who are regularly scheduled to work between twenty (20) and twenty-seven point ninety-nine (27.99) hours per week.
- All Transportation unit members hired on or after July 1, 2010 and prior to October 1, 2014 who are regularly scheduled to work between twenty (20) and twenty-seven point ninety-nine (27.99) hours per week.