SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS

NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND
MEDICAL BENEFITS PLAN

(Plan No.: 501; I.D. No.: 15-0551885)

August 19, 2022

Dear Participant:

The following is a notice describing recent changes to the Schedules of Benefits attached as Exhibit A to the Medical Benefits Plan booklet of the Summary Plan Description ("SPD") for the New York State Teamsters Council Health & Hospital Fund ("Fund" or "Plan"). These changes, shown in bold/italics below, became effective July 1, 2022. You should keep this notice with your SPD for permanent reference. If you have any questions, please contact the Fund Office at 877.698.3863, option 1.

Supreme Benefits

INPATIENT HOSPITAL SERVICES			
PLAN BENEFIT GUIDE	**IN NETWORK BENEFITS YOU PAY**	**OUT OF NETWORK BENEFITS YOU PAY**	**PAGE # MEDICAL PLAN**
Physician Visits in the Hospital	***Covered in Full***	***Covered in Full***	***20***
Inpatient Consultation	***Covered in Full***	***Covered in Full***	23
OTHER SERVICES			
Autism Assistive Communication Device	***Covered in Full***	***$100 Individual Deductible $250 Family Deductible then processed at 80% and Balance up to Charge***	25

Select Benefits

PLAN BENEFIT GUIDE	IN NETWORK BENEFITS YOU PAY	OUT OF NETWORK BENEFITS YOU PAY	PAGE # MEDICAL PLAN
INPATIENT HOSPITAL SERVICES			
Physician Visits in the Hospital	***5% Coinsurance***	Deductible / Coinsurance Balance after Allowable Amount	***20***
EMERGENCY CARE			
Emergency Room Care – waived if Admitted	$100 Copayment	***$100 Copayment***	4/29
Physician Visit in Emergency Room	$20 Copayment	***$20 Copayment***	29
Observation Stay – Up to 23 hours and in lieu of Inpatient Admission	***5% Coinsurance***	Deductible / ***30%*** Coinsurance	13
OTHER SERVICES			
Autism Assistive Communication Device	***Covered in Full***	***Deductible / Coinsurance Balance after Allowable Amount***	***SMM***

Classic Benefits

PLAN BENEFIT GUIDE	IN NETWORK BENEFITS YOU PAY	OUT OF NETWORK BENEFITS YOU PAY	PAGE # MEDICAL PLAN
INPATIENT HOSPITAL SERVICES			
Physician Visits in the Hospital	***Deductible/Coinsurance***	***Deductible/Coinsurance***	***20***
Anesthesia	Deductible/Coinsurance	***$250*** Deductible/Coinsurance	19/20
Inpatient Consultation	***Deductible/Coinsurance***	***Deductible/Coinsurance***	23
OUTPATIENT HOSPITAL SERVICES			
Anesthesia	Deductible/Coinsurance	***$250*** Deductible/Coinsurance	19

EMERGENCY CARE			
Emergency Room Care – Waived if Admitted	$125 Copayment	***$125 Copayment***	4/29
Physician Visit in Emergency Room	$25 Copayment	***$25 Copayment***	29
Observation Stay – up to 23 hours and in lieu of Inpatient Admission	***Deductible / Coinsurance***	***Deductible / Coinsurance***	13
Ambulance – Ground ***& Water***	***$125 Copayment***	***$125 Copayment***	27/28
Ambulance – Air Medical Necessity Applies	***$125 Copayment***	***$125 Copayment***	27/28
OTHER SERVICES			
Autism Assistive Communication Device	***Covered in Full***	***Deductible / Coinsurance Balance after Allowable Amount***	25

Sincerely,

BOARD OF TRUSTEES
NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND