Teamsters Local 1932 Health and Welfare Trust

June 2025

Dear Member:

The Teamsters 1932 Health & Welfare Trust was recently notified by Blue Shield of California of another unnecessary significant rate increase effective July 26, 2025. Since collaborating with Blue Shield of California in 2020, this Trust has been asking for Blue Shield's partnership with Wellness initiatives for our membership and we have received very little cooperation. As your access to care with Bue Shield has struggled, we are trying to find creative paths for a healthier you, and Blue Shield does not want to invest in its most important asset, You! In addition, Blue Shield continues year-over-year to impose significant rate increases when services deteriorate vs improving overall.

In an effort to maintain the highest quality medical benefits for you and your family; and, at the same time achieve affordable pricing, the Board of Trustees has elected to replace the Blue Shield of California HMO medical plan with the Aetna PPO Health Plan.

Effective July 26, 2025, the Aetna PPO Health Plan will replace the Blue Shield of California Plan.

Zenith American Solutions – Fund Administrative Office
PO Box 571
San Bernardino, CA 92402-0571

(909) 494-2916 or (866) 484-1337 Fax: (909) 789-1311

https://teamsters1932.zenith-american.com

Effective July 26, 2025, the Aetna PPO Health Plan

will replace the Blue Shield of California Plan.

Enclosed please find information regarding the Aetna PPO Health Plan. We believe you will find this to be a very good health plan option. Members and Dependents will not require a referral to schedule an appointment with a specialist. The summary of benefits and coverage mirror the County of San Bernardino Plans. Referring to the attached Aetna PPO Benefit Summary, you will notice the Trust offers an Acupuncture benefit - 20 visits/plan year for disease benefit, injury & chronic pain combined with Chiropractic care. The Aetna Platinum Plan and Aetna Gold Plan are designed to closely duplicate the previous Blue Shield Platinum Plan and Blue Shield Gold Plan, with noted exceptions:

1. You have a choice between In-Network and Out-of-Network services; however, it is to your advantage to seek medical treatment from In-Network providers.
2. Blue Shield doctors and facilities **participate** in the Aetna Choice POS II. In order to receive In-Network PPO benefits, it will be necessary to find an Aetna network provider. You can access Aetna provider information online at www.aetnaresource.com/p/teamsters1932.com or by calling (844) 989-6864.

Whether you are currently covered by the Blue Shield Platinum Plan or the Blue Shield Gold Plan and Blue Shield Needles/ Non-Needles Plan, you have a choice to enroll in the Aetna Platinum PPO Plan or Aetna PPO Gold effective July 26, 2025.

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NEW PRESCRIPTION DRUG PLAN - EFFECIVE JUY 26, 2025

Effective July 26, 2025, the Trust is pleased to announce that CVS Health is the funds new Pharmacy Benefit Manager (PBM) replacing your current prescription drug plan. If you utilize In-Network Providers you will pay the least: Copay/prescription, deductible doesn't apply: $5 for 30-day supply, $10 for 60-day supply, $15 for 90-day supply (retail); $10 for 31–90-day supply (mail order).

NEXT STEPS

IF YOU DO NOT SUBMIT A COMPLETED ENROLLMENT FORM, YOU WILL BE DEFAULTED INTO THE AETNA PPO HEALTH PLAN.

If you elect to switch to the Aetna PPO Health Plan you have a few options:

1. The Teamsters Local 1932 Health and Welfare Trust offers an easy use online enrollment module at: https://Teamsters1932.Zenith-American.com
2. You also have the option to fill out a paper enrollment form which can be found at: https://Teamsters1932.Zenith-American.com
3. You can return via email, fax, mail, or by uploading it to the Trust website.

   Email the completed form to: Teamsters1932Eligibility@zenith-american.com

   Fax the completed form to: 909-789-1311

   Mail the completed form to:

   Teamsters Local 1932 Health & Welfare Trust

   P O Box 571 San Bernardino CA 92402-0571

If you do nothing, you will automatically be enrolled in the Aetna PPO Health Plan.

Should you have questions or need assistance, we're here to walk you through it step-by-step, so you will feel confident about enrolling in a new plan or switching coverage.

Call your dedicated Customer Service team at (909) 494-2916 or (866) 484-1337. Customer Service is available Monday through Friday, 8 am to 5 pm PST.

Sincerely,

Board of Trustees
Teamsters 1932 Health & Welfare Trust

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San Bernardino, CA 92402-0571

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OPEN ENROLLMENT FORM

TEAMSTERS LOCAL 1932 HEALTH AND WELFARE TRUST

___ Vision Only

Teamsters Trust Fund Administrative Office:
421 N. Sierra Way, San Bernardino, CA 92419-4831 P
909-494-2916 | P 866-484-1337 | Fax 909-789-1311

Mailing Address:
P.O. Box 571
San Bernardino, CA 92402-0571

SECTION 1: EMPLOYEE INFORMATION

Employee ID	Last Name, First Name, Middle Initial	☐ Male ☐ Female	Date of Birth / /	Social Security Number
Home Address	**City**	**State**	**Zip Code**	**Telephone** ( )
Mailing Address ☐ Same as Home Address	**City**	**State**	**Zip Code**	
County of San Bernardino - Department	**Email Address**			

SECTION 2: ENROLLMENT DECISION - TEAMSTERS LOCAL 1932 HEALTH PLAN (Select only ONE of the following options)

☐ **I "Elect to Enroll" in Teamsters Local 1932 Health and Welfare Trust.**

☐ **I "Decline to Enroll" in Teamsters Local 1932 Health and Welfare Trust.**

In electing to "Decline to Enroll", I understand that I will be enrolled in the County of San Bernardino Employer Plan. **Go directly to the Section 10.**

SECTION 3: ELECT TO CONTINUE WITH COUNTY-ENROLLED COVERAGES (Select only ONE of the following options)

☐ **Continue with the Same Health & Dental Coverages with No Dependent Enrollment Changes Go directly to the Section 10.**

☐ **Change Health or Dental Coverage; Add or Delete Dependent(s)**
Complete All Sections including Employee Signature Sections.

SECTION 4: ELECT MEDICAL COVERAGE | SELECT ONE : ☐ Pre-Tax or ☐ Post-Tax

AETNA PPO PLANS	OPT-OUT/WAIVER
☐ **Platinum Plan $10 copay** $0/admit; no charge Individual $1,500/ Family$3,000 copay max Cal-yr	☐ **Medical Opt-Out/Waiver**
☐ **Gold Plan $25 copay** $100/admit; plus 20%Individual $3,500/Family$7,000 copay max Cal-yr	

Additional information available on the website at teamsters1932.zenith-american.com, or
e-mail your dedicated Customer Service Team at teamsters1932eligibility@zenith-american.com

SECTION 5: ELECT DENTAL COVERAGE | SELECT ONE : ☐ Pre-Tax or ☐ Post-Tax

DELTA DENTAL	OPT-OUT/WAIVER
☐ Delta DHMO* ☐ Delta PPO	☐ Dental Opt-Out/Waiver**

***Delta DHMO enrollees will continue with your current Delta-assigned Dentist. Contact Delta Dental to change Dentist.**

***Employees selecting to Opt-Out/Waiver of Medical and/or Dental Coverage are required to submit a completed & signed "Opt-Out/Waiver" Form; the Opt-Out/Waiver Form must be submitted, with all required documents as listed on the Form, to the Trust Administrative Office for Review and Approval/Deny Decision.*

SECTION 6: EMPLOYEE ENROLLMENT | SELECT ONE: ☐ Medical & Dental ☐ Medical-Only ☐ Dental-Only

Last Name, First Name, Middle Initial	Marital Status ☐ Single ☐ Married ☐ Domestic Partner

SECTION 7: DEPENDENT ENROLLMENT

List all dependents to be covered; dependent verification documentation is required for all dependents. *Provide the Social Security Number of each dependent you enroll. Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS.*

SPOUSE/DOMESTIC PARTNER: Important! Medical and Dental coverage-selection required to enroll Spouse/D. Ptnr

<u>Enrolling in all products selected by subscriber</u> ☐ Yes ☐ No
If <u>no</u>, Enroll in: Medical ☐ Yes ☐ No | Dental ☐ Yes ☐ No

Relationship	Last Name, First Name, Middle Initial		Date of Birth	Social Security Number
☐ Spouse ☐ D.Ptnr		☐ Male ☐ Female	/ /	

CHILD(REN) / STEPCHILD(REN): Important! Medical and Dental coverage-selection required to enroll Child/Stepchild.

<u>Enrolling in all products selected by subscriber</u> ☐ Yes ☐ No
If <u>no</u>, Enroll in: Medical ☐ Yes ☐ No | Dental ☐ Yes ☐ No

Relationship	Last Name, First Name, Middle Initial		Date of Birth	Social Security Number
☐ Child ☐ Stepchild		☐ Male ☐ Female	/ /	

<u>Enrolling in all products selected by subscriber</u> ☐ Yes ☐ No
If <u>no</u>, Enroll in: Medical ☐ Yes ☐ No | Dental ☐ Yes ☐ No

Relationship	Last Name, First Name, Middle Initial		Date of Birth	Social Security Number
☐ Child ☐ Stepchild		☐ Male ☐ Female	/ /	

<u>Enrolling in all products selected by subscriber</u> ☐ Yes ☐ No
If <u>no</u>, Enroll in: Medical ☐ Yes ☐ No | Dental ☐ Yes ☐ No

Relationship	Last Name, First Name, Middle Initial		Date of Birth	Social Security Number
☐ Child ☐ Stepchild		☐ Male ☐ Female	/ /	

INITIAL HERE ______

SECTION 8: DEPENDENT ENROLLMENT (Continued)

CHILD(REN) / STEPCHILD(REN):

Enrolling in all products selected by subscriber ☐ Yes ☐ No
If no, Enroll in: Medical ☐ **Yes** ☐ **No | Dental** ☐ **Yes** ☐ **No**

Relationship	Last Name, First Name, Middle Initial		Date of Birth	Social Security Number
☐ Child ☐ Stepchild		☐ Male ☐ Female	/ /	

Enrolling in all products selected by subscriber ☐ Yes ☐ No
If no, Enroll in: Medical ☐ **Yes** ☐ **No | Dental** ☐ **Yes** ☐ **No**

Relationship	Last Name, First Name, Middle Initial		Date of Birth	Social Security Number
☐ Child ☐ Stepchild		☐ Male ☐ Female	/ /	

Enrolling in all products selected by subscriber ☐ Yes ☐ No
If no, Enroll in: Medical ☐ **Yes** ☐ **No | Dental** ☐ **Yes** ☐ **No**

Relationship	Last Name, First Name, Middle Initial		Date of Birth	Social Security Number
☐ Child ☐ Stepchild		☐ Male ☐ Female	/ /	

If you have more dependents to enroll, print out additional copy(ies) of **page 2** and attach to your form.

SECTION 9: NEEDLES PLAN ENROLLMENT - COUNTY OF SAN BERNARDINO, NEEDLES SUBSIDY ELIGIBLE

I understand that Needles Plan Enrollment Eligibility and the County of San Bernardino "Needles Subsidy" are entirely contingent on my work-assignment to Needles, Trona, or Baker as my work location. I understand that it is my responsibility to notify both the Trust Administrator and the County Human Resources Department - Employee Benefits and Services Division (HR-EBSD) should my assigned work-location change to an area other than Needles, Trona, or Baker.

I further understand that should it be discovered that the Needles Subsidy has been paid to me in error, the Employer (County of San Bernardino) may collect, through payroll deduction, any amount of subsidy for which I received and was not eligible.

SECTION 10: ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan and Dental Plan selected above, any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration.

I have read and made the appropriate corrections and changes to the information on file with the Teamsters Local 1932 Health and Welfare Trust Administrative Office.

Employee Signature	Date
	/ /