- CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND
PLAN 14 – BASE BENEFIT LEVEL "A"
SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2016

BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
Note: ***Base Benefit** ****Optional Benefit** *****See additional notes starting on page 7** **+See additional notes starting on page 7**		
MAJOR MEDICAL*	***Major Medical applies to special items and services only.	
Deductible & Out-of-pocket	Each Year	Each Year
Individual Deductible Family Maximum Deductible	$200.00 $600.00	$200.00 $600.00
Out-of-Pocket	10%, plus any balances over UCR	10%, plus any balances over UCR
Individual Out-of-Pocket Maximum+	$2,500.00 plus Deductible	$2,500.00 plus Deductible
Family Out-of-Pocket Maximum+	$5,000.00 plus Deductible	$5,000.00 plus Deductible
Fund Payment	90% plus balances over Out-of-Pocket maximum	90% plus balances over Out-of-Pocket Maximum
Lifetime Maximum Benefit	Unlimited	Unlimited
HOSPITALIZATION*		
Inpatient Hospitalization Admission	$100.00 copay Fund pays 100% of balance	$100.00 copay Subject to Major Medical deductible/out-of-pocket maximum, up to UCR.
Outpatient Surgical Procedure	$100.00 copay Fund pays 100% of balance	$100.00 copay Subject to Major Medical deductible/out-of-pocket maximum, up to UCR.
Semi-Private Room & Board	100%	Subject to Major Medical Deductible/out-of-pocket maximum, up to UCR.
HOSPITALIZATION *		

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CONTINUED….		
Intensive Care Unit	100%	Subject to Major Medical Deductible/out-of-pocket maximum, up to UCR.
Surgical	100%	Subject to Major Medical Deductible/out-of-pocket maximum, up to UCR.
Hospital Miscellaneous	100%	Subject to Major Medical Deductible/out-of-pocket maximum, up to UCR.
Emergency – Accident	$100.00 copay	$100.00 copay
Emergency – Sickness (includes ER/Dr.)	$100.00 copay	$100.00 copay
MENTAL ILLNESS/ ** SUBSTANCE ABUSE		
Outpatient	$20.00 copay Fund pays 100% of balance	$30.00 copay Fund pays lesser of UCR or billed charges
Inpatient Hospital	$100.00 copay Fund pays 100% of balance	$100.00 copay Subject to Major Medical deductible/out-of-pocket maximum, up to UCR.
Inpatient Physician	100%	Subject to Major Medical deductible/out-of-pocket maximum, up to UCR.
DIAGNOSTIC *	100%	Fund pays 90% of lesser of bill or UCR.
PHYSICIAN'S MEDICAL EXPENSES INPATIENT*	100%	Subject to Major Medical Deductible and paid as Major Medical up to UCR.

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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
MEDICAL EXPENSES PHYSICIAN'S OFFICE VISITS *		
Office visits include: General Practitioner, OB-GYN, Internist, Pediatrician and Doctors of Osteopathy	$20.00 copay Fund pays 100% of balance	$30.00 copay Fund pays lesser of UCR or balance of billed charges
Specialists	$30.00 copay Fund pays 100% of balance	$55.00 copay Fund pays lesser of UCR or billed charges
Chiropractors	$25.00 maximum per visit up to 20 visits per Benefit Year ($500.00 per person/per year)	$25.00 maximum per visit up to 20 visits per Benefit Year ($500.00 per person/per year)
FLU/PNEUMONIA * VACCINATIONS	100%	Fund pays lesser of UCR or billed charges
TRANSPLANT *	100% Cost related to transplant surgery through six weeks from date of surgery.	Subject to Major Medical Deductible and paid as Major Medical up to UCR. *Cost related to transplant surgery through six weeks from date of surgery.
AMBULANCE TRANSPORT/ LIFE FLIGHTS *	$100.00 copay Fund pays 100% of balance	$100.00 copay Subject to Major Medical Deductible and paid as Major Medical up to UCR.
IMMUNIZATIONS * (recommended by the Centers for Disease Control)		
Dependent Children through age 26	100%	100%
Participants and Spouses	100%	100%
Immunizations or injections not on the Centers for Disease Control list	$25.00 reimbursement if no Physician Office Visit	$25.00 reimbursement if no Physician's Office Visit
THERAPY SERVICES *		

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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
(Including Physical, Occupational, Speech and Work Hardening)	$20.00 copay per visit Fund pays 100% of balance. Limit-3 modalities/visit and 24 visits/person/year. Extensions reviewed.	$30.00 copay per visit. Fund pays lesser of UCR or billed charges. Limit – 3 modalities/visit and 24 visits/person/year. Extensions reviewed.
OUTPATIENT NURSING *	Subject to Major Medical up to 240 hours in the benefit year. Over 240 hours payable at 50%.	Subject to Major Medical up to 240 hours in the benefit year. Over 240 hours payable at 50%.
DURABLE MEDICAL* EQUIPMENT	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	90% of UCR after deductible until Out-of-Pocket is reached; then 100%
PRESCRIPTION DRUGS **	**Retail Pharmacy:** **A.** Copay for each 34-day supply: $5 Generic/$15 Brand Preferred/ $30 Brand Non-Preferred (see attached list) Specialty - $150 for each 30-day supply **B.** Copay for each 34-day supply: $10/Generics/$20 Brand Preferred/$40 Brand Non-Preferred (see attached list) Specialty - $150 for each 30-day supply **C.** Copay for each 34-day supply: $10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list) Specialty - $150 for each 30-day supply	Copay plus excess over PPO cost for each 34 day supply: **A.** $5 Generic/$15 Brand Preferred/ $30 Brand Non-Preferred (see attached list) Specialty - $150 for each 30-day supply **B.** Copay plus excess over PPO cost for each 34-day supply: $10/Generics/$20 Brand Preferred/$40 Brand Non-Preferred (see attached list) Specialty - $150 for each 30-day supply **C.** Copay plus excess over PPO cost for each 34-day supply: $10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list) Specialty - $150 for each 30-day supply
PRESCRIPTION DRUGS CONTINUED…**	**D**. Copay for each 34-day supply: $10 Generics/$30 Brand Preferred/$50 Brand Non-	**D**. Copay for each 34-day supply: $10 Generics/$30 Brand Preferred/$50 Brand Non-

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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
	Preferred (see attached list), **with a $100.00 deductible** Please see Additional Notes at the end **Mail-Order Program** up to a 90-day supply: **A.** $15 Generic/$30 Brand Preferred/ $60 Brand Non-Preferred Specialty - $300 for each 90-day supply **B.** $30 Generic/$40 Brand Preferred/$80 Brand Non-Preferred(see attached list) Specialty - $300 for each 90-day supply **C.** $30 Generic/$60 Brand Preferred/$100 Brand Non-Preferred (see attached list) Specialty - $300 for each 90-day supply **D**. $30 Generics/$60 Brand Preferred/$100 Brand Non-Preferred (see attached list), **with a $100.00 deductible** Please see Additional Notes at the end	Preferred (see attached list), **with a $100.00 deductible** Please see Additional Notes at the end
PRE-CERTIFICATION	Outpatient and inpatient 14 days prior to non-emergency outpatient procedures or inpatient hospitalization.	Outpatient and inpatient 14 days prior to non-emergency outpatient procedures or inpatient hospitalization.
DENTAL ** Routine	**A.**100% of contracted rate up to $1,000.00/person/year	**A.** 100% up to UCR maximum of $1,000.00/person/year
DENTAL ** **CONTINUED….**	**B.** 80% of contracted rate up to $800.00/person/year **C.** 60% of contracted rate up to $600.00/person/year	**B**. 80% up to UCR maximum of $800.00/person/year **C.** 60% up to UCR maximum of $600.00/person/year

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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
Accidental (same for all levels A, B, and C)	$1,000.00/per accident/lifetime	$1,000.00/per accident/lifetime
Orthodontic (same for all levels A, B, and C)	$3,000.00/person/lifetime No balance to Dental Benefit No adults Effective 1/1/05 – Delta Dental PPO Network available	$2,000.00/person/lifetime No balance to Dental Benefit No adults
VISION ** (same for all levels A, B, and C)	Davis Vision (see attached program description) Hearing benefits based on UCR	$45.00 exam $75.00 lenses/frames or contacts Hearing benefits based on UCR.
HEARING ** (same for all levels A, B, and C)	$1,000.00 per family per year	$1,000.00 per family per year. Hearing benefits based on UCR.
DEATH AND DISMEMBERMENT **	**A.**$35,000.00 death $35,000.00 accidental death $ 2,000.00 spouse death $ 2,000.00 child death **B.**$20,000.00 death $20,000.00 accidental death $ 2,000.00 spouse death $ 2,000.00 child death **C.**$10,000.00 death $10,000.00 accidental death $ 2,000.00 spouse death $ 2,000.00 child death	**A.**$35,000.00 death $35,000.00accidental death $ 2,000.00 spouse death $ 2,000.00 child death **B.**$20,000.00 death $20,000.00 accidental death $ 2,000.00 spouse death $ 2,000.00 child death **C.**$10,000.00 death $10,000.00 accidental death $ 2,000.00 spouse death $ 2,000.00 child death
DEATH ** AND DISMEMBERMENT CONTINUED…	**Dismemberment – Level A:** Accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia-$35,000. Paraplegia or triplegia (paralysis of three limbs)-$26,250. Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$17,500.	**Dismemberment – Level A:** Accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia-$35,000. Paraplegia or triplegia (paralysis of three limbs)-$26,250. Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$17,500.

BENEFITS	PPO NETWORK	OUT OF NETWORK
	Accidental loss of thumb and index finger of the same hand or uniplegia-$8,750 **Dismemberment – Level B:** Accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia-$20,000. Paraplegia or triplegia (paralysis of three limbs)-$15,000. Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$10,000. Accidental loss of thumb and index finger of the same hand or uniplegia-$5,000. **Dismemberment – Level C:** Accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia-$10,000. Paraplegia or triplegia (paralysis of three limbs)-$7,500. Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$5,000 Accidental loss of thumb and index finger of the same hand or uniplegia-$2,500.	Accidental loss of thumb and index finger of the same hand or uniplegia-$8,750 **Dismemberment – Level B:** Accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia-$20,000. Paraplegia or triplegia (paralysis of three limbs)-$15,000. Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$10,000. Accidental loss of thumb and index finger of the same hand or uniplegia-$5,000. **Dismemberment – Level C:** Accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia-$10,000. Paraplegia or triplegia (paralysis of three limbs)-$7,500. Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$5,000 Accidental loss of thumb and index finger of the same hand or uniplegia-$2,500.
SHORT-TERM DISABILITY **	**A.**$275.00 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted. **B.**$175.00 per week-26 weeks $100 extended – 10 weeks	**A.**$275.00 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted. **B.**$175.00 per week-26 weeks $100 extended – 10 weeks

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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
	provided required documentation submitted. **C.**$100 per week-26 weeks -no extended benefits	provided required documentation submitted. **C.**$100 per week-26 weeks -no extended benefits
RETIREE COVERAGE **	Fund requirements must be met in order to be eligible for a Retired Plan. See the below notes for Fund requirements for obtaining Retired Coverage.	Fund requirements must be met in order to be eligible for a Retired Plan. See the below notes for Fund requirements for obtaining Retired Coverage.

ADDITIONAL NOTES

PRESCRIPTIONS: Retail Drug Copayments are applicable to 15-day scripts for drugs classified as "Class II" Pain Medications by the FDA. Also, effective January 1, 2016, the copayment for all Zohydro prescriptions will be $150 per script.
Please see the attached Summary of Material Modifications concerning the Prescription Benefits

PRE-CERTIFICATION: Outpatient and inpatient 14 days prior to non-emergency outpatient procedures or inpatient hospitalization.

REQUIREMENTS FOR OBTAINING RETIRED COVERAGE:

Effective June 1, 2012, to satisfy the 15 year requirement, you must have two (2) years of continuous coverage immediately prior to your retirement and you must have had coverage for at least thirteen (13) of the prior eighteen (18) years. For purpose of meeting the thirteen (13) year requirement, participation for a twelve (12) month period will be considered participation for a year even if the months are not consecutive.

***** Special items and services include: home nursing care, oxygen, blood, orthopedic braces, artificial eyes, artificial larynx, prostheses for arms, hands and legs, durable medical equipment, orthotics, and breast prostheses.**

+ The individual and Family Out-of-Pocket Maximums are balances that the participant is responsible for with respect to benefits that are paid under the Major Medical provisions of the Plan. In addition to these amounts, the participant will be responsible for the payment of all Deductibles, all Copayment amounts, all benefits that exceed dollar limits as set forth in the Plan (for example, visit limits for physical therapy), and any amount billed in excess of the Fund's UCR where applicable.