CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND
PLAN 14 – BASE BENEFIT LEVEL "B"
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

BASE BENEFITS AT LEVEL B:

Deductible & Out-of-pocket	Each Year	Each Year
Individual Deductible	$500.00	$1,000.00
Family Maximum Deductible	$1,000.00	$2,000.00
Out-of-Pocket (excludes deductibles and copays)	10% plus any balances over UCR	20%, plus any balances over UCR
Individual Out-of-Pocket Maximum+	$1,000 plus deductible	$2,000 plus deductible
Family Out-of-Pocket Maximum+	$2,000 plus deductible	$4,000 plus deductible
Lifetime Maximum Benefit	Unlimited	Unlimited
HOSPITALIZATION*		
Inpatient Hospitalization Admission	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR after deductible until Out-of-Pocket is reached; then 100%
Outpatient Surgical Procedure	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR after deductible until Out-of-Pocket is reached; then 100%
Semi-Private Room & Board	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR after deductible until Out-of-Pocket is reached; then 100%
Intensive Care Unit	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR after deductible until Out-of-Pocket is reached; then 100%
Surgical	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR after deductible until Out-of-Pocket is reached; then 100%

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BENEFITS	PPO NETWORK	OUT OF NETWORK
HOSPITALIZATION CONTINUED….		
Emergency – Accident or Sickness	$100.00 copay	$100.00 copay
AMBULANCE TRANSPORT/ LIFE FLIGHTS *	$100.00 copay; Fund pays 100% of balance	$100.00 copay Fund pays 100% of balance
DIAGNOSTIC *	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR or 80% of billed if there is no UCR after deductible until Out-of-Pocket is reached; then 100%
PHYSICIAN'S MEDICAL EXPENSES INPATIENT*	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR or 80% of billed if there is no UCR after deductible until Out-of-Pocket is reached; then 100%
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
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

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BENEFITS	PPO NETWORK	OUT OF NETWORK
THERAPY SERVICES * (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 *	90% after deductible up to 240 hours in the benefit year. Over 240 hours payable at 50%	80% of UCR after deductible until Out-of-Pocket is reached; then 100% 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%	80% of UCR after deductible until Out-of-Pocket is reached; then 100%
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.
OPTIONAL BENEFITS: 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
	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.	**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.

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BENEFITS	PPO NETWORK	OUT OF NETWORK
DEATH AND ** DISMEMBERMENT CONTINUED…..	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. Accidental loss of thumb and index finger of the same hand or uniplegia-$8,750.	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. 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 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.	**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.

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SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2016

BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
DENTAL **	Delta Dental Network	
Routine	**A.**100% of contracted rate up to $1,000.00/person/year **B.** 80% of contracted rate up to $800.00/person/year **C.** 60% of contracted rate up to $600.00/person/year	**A.** 100% up to UCR maximum of $1,000.00/person/year **B**. 80% up to UCR maximum of $800.00/person/year **C.** 60% up to UCR maximum of $600.00/person/year
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	$2,000.00/person/lifetime No balance to Dental Benefit No adults
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	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR or 80% of billed if there is no UCR after deductible until Out-of-Pocket is reached; then 100%
Inpatient Physician	90% of UCR after deductible until Out-of-Pocket is reached; then 100%	80% of UCR or 80% of billed if there is no UCR after deductible until Out-of-Pocket is reached; then 100%
	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 provided required documentation submitted. **C.**$100 per week-26 weeks -no extended benefits	**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 provided required documentation submitted. **C.**$100 per week-26 weeks -no extended benefits

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BENEFITS	PPO NETWORK	OUT OF NETWORK
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 **D**. Copay for each 34-day supply: $10 Generics/$30 Brand Preferred/$50 Brand Non-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-	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 **D**. Copay for each 34-day supply: $10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list), **with a $100.00 deductible** Please see Additional Notes at the end

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BENEFITS	PPO NETWORK	OUT OF NETWORK
PRESCRIPTION DRUGS ** CONTINUED…..	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	
**VISION ** **	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 ** **	$1,000.00 per family per year	$1,000.00 per family per year. Hearing benefits based on UCR.

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

[+]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 Plan Provisions. 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.

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.