

**CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND
PLAN 16
SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2016**

<u>BENEFITS</u>	<u>PPO NETWORK</u>	<u>OUT OF NETWORK</u>
<u>Note:</u>		
*Base Benefit		
**Optional Benefit		
***See additional notes on page eight		
+See additional notes on page eight		
<u>MAJOR MEDICAL*</u>		
	***Major Medical applies to special items and services only.	
Deductible & Out-of-pocket	Each Year	Each Year
Individual Deductible	\$200.00	\$200.00
Family Maximum Deductible	\$600.00	\$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
<u>HOSPITALIZATION*</u>		
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.

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<u>HOSPITALIZATION*</u>		
<u>CONTINUED....</u>		
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
<u>MENTAL ILLNESS/ **</u>		
<u>SUBSTANCE ABUSE</u>		
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.
<u>DIAGNOSTIC *</u>	100%	Fund pays 90% of lesser of bill or UCR.
<u>PHYSICIAN’S MEDICAL VISITS INPATIENT *</u>	100%	Subject to Major Medical Deductible and paid as Major Medical up to UCR.

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<u>MEDICAL EXPENSES</u> *		
<u>PHYSICIAN OFFICE VISITS</u>		
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)
<u>FLU/PNEUMONIA</u> * <u>VACCINATIONS</u>	100%	Fund pays lesser of UCR or billed charges
<u>TRANSPLANT</u> *	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
<u>AMBULANCE TRANSPORT/ LIFE FLIGHTS</u> *	\$100.00 copay Funds pays 100% of balance	\$100.00 copay Subject to Major Medical Deductible and paid as Major Medical up to UCR.
<u>IMMUNIZATIONS</u> * <u>(recommended by the Centers for Disease Control)</u>		
Dependent Children through age 26	100%	The Fund pays lesser of UCR or billed charges
Participants and Spouses	100%	100%
Immunizations or injections not on the Centers for Disease Control list	\$25 reimbursement if no Physician Office Visit	\$25 reimbursement if no Physician Office Visit

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<u>THERAPY SERVICES</u> * (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.
<u>OUTPATIENT NURSING</u> *	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%.
<u>DURABLE MEDICAL EQUIPMENT</u> *	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%
<u>PRESCRIPTION DRUGS</u> **	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 Please see Additional Notes at the end	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 Please see Additional Notes at the end

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<u>PRESCRIPTION DRUGS **</u> <u>CONTINUED.....</u>	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 Please see Additional Notes at the end	
<u>DENTAL **</u>	Effective 1/1/05 – Delta Dental PPO Network available	
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/.00person/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
<u>VISION **</u> (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.

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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
\$35,000.00 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.\$10,000.00death
\$10,000.000 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.
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 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.
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

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.

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**DEATH AND **
 DISMEMBERMENT
 CONTINUED....**

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-\$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 \$100.00 extended – 10 weeks provided required documentation submitted.
B.\$175.00 per week-26 weeks \$100.00 extended – 10 weeks provided required documentation submitted.
C.\$100.00 per week-26 weeks -no extended benefits

A.\$275.00 per week-26 weeks \$100.00extended – 10 weeks provided required documentation submitted.
B.\$175.00 per week-26 weeks \$100.00 extended – 10 weeks provided required documentation submitted.
C.\$100.00 per week-26 weeks -no extended benefits

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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.

***** 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.