CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND
PLAN 14P
SUMMARY OF BENEFITS – EFFECTIVE APRIL 1, 2025

BENEFITS	IN NETWORK	OUT OF NETWORK
Note: ***Base Benefit** ****Optional Benefit** *****See additional notes starting on page 7** **+See additional notes starting on page 7**		
BASE BENEFITS AT LEVEL A*		
Deductible & Out-of-pocket	Each Year	Each Year
Individual Deductible	$0	$3,000
Family Maximum Deductible	$0	$6,000
Co-Insurance[1]	$0	30%, plus any balances over UCR
Individual Out-of-Pocket Maximum+	$2,500	Unlimited
Family Out-of-Pocket Maximum+	$5,000	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited
HOSPITALIZATION*		
Inpatient Hospitalization Admission	$100 copay Fund pays 100% of contracted rate	$100 copay 70% of UCR after deductible
Outpatient Surgical Procedure Facility	$100 copay Fund pays 100% of contracted rate	$100 copay 70% of UCR after deductible
Outpatient Surgical Procedure Office	100% of contracted rate	70% of UCR after deductible

[1] In-Network Coinsurance only applies to Outpatient Nursing, Durable Medical Equipment and Durable Medical Supplies. See page 4.

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HOSPITALIZATION * CONTINUED….		
Hospital Miscellaneous	100% of contracted rate	70% of UCR after deductible
Emergency – Accident	$100 copay Fund pays 100% of contracted rate	$100 copay Fund pays 100% of balance
Emergency – Sickness (includes ER/Dr.)	$100 copay Fund pays 100% of contracted rate	$100 copay Fund pays 100% of balance
MENTAL ILLNESS/ * SUBSTANCE ABUSE		
Outpatient	$20 copay Fund pays 100% of contracted rate	$30 copay Fund pays lesser of UCR or billed charges
Inpatient Hospital	$100 copay Fund pays 100% of contracted rate	$100 copay 70% of UCR after deductible
Inpatient Physician	100% of contracted rate	70% of UCR after deductible
DIAGNOSTIC *	100% of contracted rate	Fund pays 70% of lesser of bill or UCR.
PHYSICIAN'S MEDICAL EXPENSES INPATIENT*	100% of contracted rate	70% of UCR after deductible

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MEDICAL EXPENSES		
PHYSICIAN'S OFFICE VISITS *		
Office visits include: General Practitioner, OB-GYN, Internist, Pediatrician and Doctors of Osteopathy	$20 copay Fund pays 100% of contracted rate	$30 copay Fund pays lesser of UCR or billed charges
Specialists	$30 copay Fund pays 100% of contracted rate	$55 copay Fund pays lesser of UCR or billed charges
Chiropractors	Fund pays 80% of contracted rate up to 25 visits or $2,000 maximum, whichever occurs first	Fund pays 80% of lesser of UCR or billed charges up to 25 visits or $2,000 maximum, whichever occurs first
FLU/PNEUMONIA * VACCINATIONS	100% of contracted rate	Fund pays lesser of UCR or billed charges
TRANSPLANT *	$100 copay 100% of contracted rate. *Cost related to transplant surgery through six weeks from date of surgery.	$100 copay 70% of UCR after deductible *Cost related to transplant surgery through six weeks from date of surgery.
AMBULANCE TRANSPORT/ LIFE FLIGHTS *	$100 copay Fund pays 100% of contracted rate	$100 copay 70% of UCR after deductible
IMMUNIZATIONS * (recommended by the Centers for Disease Control)		
Dependent Children through age 26	100% of contracted rate	Fund pays lesser of UCR or billed charges
Participants and Spouses	100% of contracted rate	Fund pays lesser of UCR or billed charges
Immunizations or injections not on the Centers for Disease Control list	$25 reimbursement	$25 reimbursement

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THERAPY SERVICES * (Including Physical, Occupational, Speech and Work Hardening)	$10 copay per visit Fund pays 100% of contracted rate. Limit-3 therapeutic services/visit and 24 visits/condition. Extensions reviewed.	$30 copay per visit. Fund pays lesser of UCR or billed charges. Limit- 3 therapeutic services/visit and 24 visits/condition. Extensions reviewed.
OUTPATIENT NURSING *[1]	90% of contracted rate up to 240 hours in the benefit year. Over 240 hours payable at 50%.	70% of UCR after deductible up to 240 hours in the benefit year. Over 240 hours payable at 50%.
DURABLE MEDICAL*[1] EQUIPMENT	90% of contracted rate until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
DURABLE MEDICAL SUPPLIES	90% of contracted rate until Out-of-Pocket is reached; then 100%	90% of UCR
PRESCRIPTION DRUGS **	**Retail Pharmacy Copay:** **A.** $0 Generic up to a 90-day supply $15 Brand Preferred/$30 Brand Non-Preferred for a 34-day supply (see attached list) $150 Specialty up to a 30-day supply **B.** $0 Generic up to a 90-day supply $20 Brand Preferred/$40 Brand Non-Preferred for a 34-day supply (see attached list) $150 Specialty up to a 30-day supply **C.** $0 Generic up to a 90-day supply $30 Brand Preferred/$50 Brand Non-Preferred for a 34-day supply (see attached list) $150 Specialty up to a 30-day supply	Copay plus excess over cost: **A.** $0 Generic up to a 90-day supply $15 Brand Preferred/$30 Brand Non-Preferred for a 34-day supply (see attached list) $150 Specialty up to a 30-day supply **B.** $0 Generic up to a 90-day supply $20 Brand Preferred/$40 Brand Non-Preferred for a 34-day supply (see attached list) $150 Specialty up to a 30-day supply **C.** $0 Generic up to a 90-day supply $30 Brand Preferred/$50 Brand Non-Preferred for a 34-day supply (see attached list) $150 Specialty up to a 30-day supply

[1] In-Network Coinsurance only applies to Outpatient Nursing, Durable Medical Equipment and Durable Medical Supplies.

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BENEFITS	**IN NETWORK**	**OUT OF NETWORK**
PRESCRIPTION DRUGS CONTINUED…**	**D.** $0 Generic up to a 90-day supply $30 Brand Preferred/$50 Brand Non-Preferred for a 34-day supply (see attached list), **with a $100 deductible** $150 Specialty up to a 30-day supply No CVS or Walgreens Please see Additional Notes at the end	**D**. $0 Generic up to a 90-day supply $30 Brand Preferred/$50 Brand Non-Preferred for a 34-day supply (see attached list), **with a $100 deductible** $150 Specialty up to a 30-day supply Please see Additional Notes at the end
DENTAL ** Routine	**A.**100% of contracted rate up to $2,000/person/year **B.** 80% of contracted rate up to $1,600/person/year **C.** 60% of contracted rate up to $1,200/person/year	**A.** 100% up to UCR maximum of $2,000/person/year **B**. 80% up to UCR maximum of $1,600/person/year **C.** 60% up to UCR maximum of $1,200/person/year
Accidental (same for all levels A, B, and C)	$2,000/per person/per injury	$2,000/per person/per injury
Orthodontic (same for all levels A, B, and C)	$3,000/person/lifetime No balance to Dental Benefit No adults	$2,000/person/lifetime No balance to Dental Benefit No adults
VISION ** (same for all levels A, B, and C)	Davis Vision (see attached program description)	$45 exam $75 lenses/frames or contacts
HEARING ** (same for all levels A, B, and C)	$1,000 per family per year	$1,000 per family per year. Hearing benefits based on UCR.
DEATH AND DISMEMBERMENT **	**A.**$35,000 death $35,000 accidental death $ 2,000 spouse death $ 2,000 child death **B.**$20,000 death $20,000 accidental death	**A.**$35,000 death $35,000 accidental death $ 2,000 spouse death $ 2,000 child death **B.**$20,000 death $20,000 accidental death

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BENEFITS	IN NETWORK	OUT OF NETWORK
	$ 2,000 spouse death $ 2,000 child death	$ 2,000 spouse death $ 2,000 child death
	C. $10,000 death $10,000 accidental death $ 2,000 spouse death $ 2,000 child death	**C.** $10,000 death $10,000 accidental death $ 2,000 spouse death $ 2,000 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.
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	**Dismemberment – Level C:** Accidental loss of life, two

BENEFITS	IN NETWORK	OUT OF NETWORK
	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.	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 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted. **B.**$175 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted. **C.**$100 per week-26 weeks -no extended benefits	**A.**$275 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted. **B.**$175 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted. **C.**$100 per week-26 weeks -no extended benefits

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.

DURABLE MEDICAL EQUIPMENT INCLUDES, BUT NOT LIMITED TO: Oxygen, blood, orthopedic braces, artificial eyes, artificial larynx, prostheses for arms, hands and legs, durable medical equipment, orthotics, and breast prostheses.

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

+ 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 provisions of the Plan. In addition to these amounts, the participant will be responsible for the payment of all

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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.

Plan 14 Base Benefit level A Summary of Benefits
Effective 4/1/2025