

**CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND**

**PLAN 13Y**

**SUMMARY OF BENEFITS**

<b><u>BENEFITS</u></b>	<b><u>PPO NETWORK</u></b>	<b><u>OUT OF NETWORK</u></b>
<b><u>MAJOR MEDICAL</u></b>	** Major Medical applies to special items and services only.	
Deductible & Out-of-pocket	Each Year	Each Year
Individual Deductible	\$150	\$150
Family Maximum Deductible	\$450	\$450
Out-of-Pocket	10%, plus any balances over UCR	10%, plus any balances over UCR
	*	
Individual Out-of-Pocket Max	\$2,000 plus Deductible	\$2,000 plus Deductible
Family Out-of-Pocket Max *	\$4,000 plus Deductible	\$4,000 plus Deductible
Fund Payment	90% plus balances over Out-of-Pocket Maximum	90% plus balances over Out-of-Pocket Maximum
Lifetime Maximum Benefit	\$1,000,000/person	\$1,000,000/person
<b><u>HOSPITALIZATION</u></b>		
Semi-Private Room & Board	100%	
Intensive Care Unit	100%	
Surgical	100%	Subject to Major Medical Deductible/out-of-pocket maximum, up to UCR. \$50 copay for emergency room visits (waived if admitted)
Hospital Miscellaneous	100%	
Emergency-Accident	\$50 copay (waived if admitted)	
Emergency-Sickness (includes ER/Dr.)	\$50 copay (waived if admitted)	

**BENEFITS**

**PPO NETWORK**

**OUT OF NETWORK**

**MENTAL ILLNESS/  
SUBSTANCE ABUSE**

Outpatient

\$15 Copay.  
Fund pays 100% of balance

\$25 Copay  
Fund pays lesser of UCR or  
billed charges

Limitation

30 days/year  
90 days lifetime

30 days/year  
90 days lifetime

Inpatient Hospital

100%

100% of UCR or 85% of  
billed charges if there is no  
UCR

Limitation

30 days/year  
90 days lifetime

30 days/year  
90 days lifetime

Inpatient Physician

100%

100% of UCR or 85% of  
billed charges if there is no  
UCR

**DIAGNOSTIC**

100%

Fund pays 90% of lesser of  
bill or UCR.

**MEDICAL EXPENSES  
INPATIENT**

100%

Subject to Major Medical  
Deductible and paid as Major  
Medical up to UCR.

**MEDICAL EXPENSES  
PHYSICIAN OFFICE  
VISITS**

Basic office visits include:  
General Practitioner, OB-  
GYN, Internist, Pediatrician  
and Doctors of Osteopathy

\$15 Copay  
Fund pays 100% of balance

\$25 Copay  
Fund pays lesser of UCR or  
balance billed charges

Specialists

\$25 Copay  
Fund pays 100% of balance

\$50 Copay  
Fund pays lesser of UCR  
or billed charges

**BENEFITS**

Chiropractors

**PPO NETWORK**

\$25 maximum per visit up to 20 visits per Benefit Year (\$500 per person/per year)

**OUT OF NETWORK**

\$25 maximum per visit up to 20 visits per Benefit Year (\$500 per person/per year)

**FLU/PNEUMONIA VACCINATIONS**

100%

Fund pays lesser of UCR or billed charges

**TRANSPLANT**

100% up to a maximum of \$300,000 per person per lifetime for costs related to transplant, as measured from the date of the transplant surgery through six weeks from the date of surgery.

Subject to Major Medical Deductible and paid as Major Medical up to UCR. \$300,000 maximum per person per lifetime for costs related to transplant, as measured from the date of the transplant surgery through six weeks from the date of surgery.

**IMMUNIZATIONS (recommended by the Centers for Disease Control)**

Dependent Children through age 23 (provided that between 19 and 23, the child is a full-time student)

100%

The Fund pays lesser of UCR or billed charges

Participants and Spouses

\$25 reimbursement if no Physician Office Visit

\$25 reimbursement if no Physician Office Visit

**THERAPY SERVICES**

(Including Physical, Occupational, Speech and Work Hardening)

\$15 Copay per visit  
Fund pays 100% of balance  
Limit - 3 modalities/visit & 24 visits/person/year  
Extensions reviewed

\$25 Copay per visit  
Fund pays lesser of UCR or billed charges.  
Limit - 3 modalities/visit & 24 visits/person/year  
Extensions reviewed

**BENEFITS**

**PPO NETWORK**

**OUT OF NETWORK**

**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%.

**PRESCRIPTION DRUGS**

Retail Pharmacy:  
Copay for each 34-day supply:  
\$10 Generic/\$30 Brand  
\$50 Negative Formulary (see attached list)

Copay plus excess over PPO cost for each 34 day supply:  
\$10 Generic/\$30Brand  
\$50 Negative Formulary (see attached list)

Mail-Order Program up to a 90-day supply:  
\$30 Generic/\$60 Brand  
\$100 Negative Formulary

**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.

**PRE-EXISTING CONDITION**

12-month waiting period for new participants/dependents for any conditions treated within 90-days prior to participant's hire date reduced by applicable periods of prior coverage under HIPAA.

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**DENTAL**

Routine

80% of contracted rate up to \$800.00/person/year

80% up to UCR Maximum of \$800.00/person/year

Accidental

\$1,000/person/lifetime

\$1,000/person/lifetime

**BENEFITS**  
**DENTAL CONTINUED..**

**PPO NETWORK**

**OUT OF NETWORK**

Orthodontic

\$3,000/person/lifetime  
No balance to Dental Benefit  
No adults

\$2,000/person/lifetime  
No balance to Dental Benefit  
No adults

Effective 1/1/05-Delta Dental  
PPO Network available

**VISION**

Davis Vision (see attached  
program description)

\$45 exam  
\$75 lenses/frames or contacts

**HEARING**

\$1,000 per family per year.

\$1,000 per family per year.  
Hearing benefits based on  
UCR.

**DEATH**

\$10,000 death  
\$10,000 accidental death  
\$ 2,000 spouse death  
\$ 2,000 child death

\$10,000 death  
\$10,000 accidental death  
\$ 2,000 spouse death  
\$ 2,000 child death

**Dismemberment**

Loss of life (including exposure and disappearance); loss of both hands, both feet or both eyes; loss of both hearing & speech, quadriplegia or a third degree burn covering 75% or more of the covered person's body- \$10,000. Loss of hearing or speech; loss of a hand, foot or eye; paraplegia, hemiplegia or a third degree burn covering 50-74% of the covered of person's body - \$5,000. Loss of thumb & index finger of same hand; uniplegia-\$2,500

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**SHORT-TERM**  
**DISABILITY**

None

None

## **ADDITIONAL NOTES**

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

**PRE-EXISTING CONDITION:** 12-month waiting period for new participants/dependents for any conditions treated within 90-days prior to participant's hire date reduced by applicable periods of prior coverage under HIPAA.

### **REQUIREMENTS FOR OBTAINING RETIRED COVERAGE:**

Effective August 1, 2000, Retired coverage will only be offered to retirees, who, within the 15 year window prior to retirement, have a total of 10 years of participation with the Fund. Furthermore, in order to satisfy the 10 years of participation requirement, a participant must have two years of continuous coverage immediately prior to retirement, and additional coverage for at least eight of the prior thirteen years (actually 96 of the prior 156 months). A participant cannot retroactively satisfy any unpaid periods, except for the coverage period immediately prior to retirement.

**\*\*\* 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, transplants or visit limits for physical therapy), and any amount billed in excess of the Fund's UCR where applicable.**