CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND
PLAN R-7 65
SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2012
NOTE: PLAN R-7 65 DOES NOT INCLUDE BENEFITS FOR MENTAL ILLNESS/SUBSTANCE ABUSE, DENTAL, VISION AND HEARING, LIFE INSURANCE, TRANSPLANTS, AND SHORT-TERM DISABILITY

BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
MAJOR MEDICAL	**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 plus Deductible	$2,500 plus Deductible
Family Out-of-Pocket Maximum*	$5,000 plus Deductible	$5,000 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	$100.00 copay Subject to Major Medical deductible/out-of-pocket maximum, up to UCR.
Outpatient Surgical Procedure	$100.00 copay	$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.
Intensive Care Unit	100%	Subject to Major Medical deductible/out-of-pocket maximum, up to UCR.

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BENEFITS	PPO NETWORK	OUT OF NETWORK
HOSPITALIZATION CONTINUED Surgical	100%	Subject to Major Medical Deductible/out-of-pocket maximum, up to UCR. $100.00 copay for emergency room visits
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
DIAGNOSTIC	100%	Fund pays 90% of lesser of bill or UCR
MEDICAL EXPENSES **PHYSICIAN OFFICE VISITS** Basic 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	$15 maximum per visit up to 17 visits per Benefit Year ($255 per person/per year)	$15 maximum per visit up to 17 visits per Benefit Year ($255 per person/per year).
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
FLU/PNEUMONIA		

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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
VACCINATIONS	100%	Fund pays lesser of UCR or billed charges
IMMUNIZATIONS (recommended by the Centers for Disease Control)		
Dependent Children through age 26	100%	The Fund pays lesser of UCR or billed charges
Participants and Spouses	$15 reimbursement if no Physician Office Visit	$15 reimbursement if no Physician Office Visit
Immunizations or injections not on the Centers for Disease Control list	100%	The Fund pays lesser of UCR or billed charges
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	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: $5 Generic/$15 Brand $30 Negative Formulary (see attached list) Mail-Order Program up to a 90-day supply: $15 Generic/$30 Brand $60 Negative Formulary	Copay plus excess over PPO cost for each 34 day supply: $5 Generic/$15 Brand $30 Negative Formulary (see attached list)
PRE-CERTIFICATION	Outpatient and inpatient 14 days prior to non-emergency	Outpatient and inpatient 14 days prior to non-emergency

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BENEFITS	PPO NETWORK	OUT OF NETWORK
	outpatient procedures or inpatient hospitalization.	outpatient procedures or inpatient hospitalization.

ADDITIONAL NOTES

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 Notes:

When eligible, all participants and dependents must enroll in Medicare Part A and B. Medicare is always primary and this Plan is considered secondary.

Co-pays apply whether the Fund is considered primary or secondary.

Transplants are only covered if the transplant was performed while the participant/dependent was covered under an active Plan.

***** 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.**