- CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND
PLAN 14P
SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2019

BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
Note: ***Base Benefit** ****Optional Benefit** *****See additional notes starting on page 7** **+See additional notes starting on page 7**		
Deductible & Out-of-pocket	Each Year	Each Year
Individual Deductible	$0	$200.00
Family Maximum Deductible	$0	$600.00
Co-Insurance	10%	10%, plus any balances over UCR
Individual Out-of-Pocket Maximum+	$2,500.00	$2,500.00 plus Deductible
Family Out-of-Pocket Maximum+	$5,000.00	$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
HOSPITALIZATION*		
Inpatient Hospitalization Admission	$100.00 copay Fund pays 100% of contracted rate	$100.00 copay 90% of UCR after deductible until Out-of-Pocket is reached, then 100%
Outpatient Surgical Procedure Facility	$100.00 copay Fund pays 100% of contracted rate	$100.00 copay 90% of UCR after deductible until Out-of-Pocket is reached, then 100%
Outpatient Surgical Procedure Office	100% of contracted rate	90% of UCR after deductible until Out-of-Pocket is reached, then 100%

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HOSPITALIZATION * CONTINUED….		
Hospital Miscellaneous	100% of contracted rate	90% of UCR after deductible until Out-of-Pocket is reached, then 100%
Emergency – Accident	$100.00 copay Fund pays 100% of contracted rate	$100.00 copay Fund pays 100% of balance
Emergency – Sickness (includes ER/Dr.)	$100.00 copay Fund pays 100% of contracted rate	$100.00 copay Fund pays 100% of balance
MENTAL ILLNESS/ ** SUBSTANCE ABUSE		
Outpatient	$20.00 copay Fund pays 100% of contracted rate	$30.00 copay Fund pays lesser of UCR or billed charges
Inpatient Hospital	$100.00 copay Fund pays 100% of contracted rate	$100.00 copay 90% of UCR after deductible until Out-of-Pocket is reached, then 100%
Inpatient Physician	100% of contracted rate	90% of UCR after deductible until Out-of-Pocket is reached, then 100%
DIAGNOSTIC *	100% of contracted rate	Fund pays 90% of lesser of bill or UCR.
PHYSICIAN'S MEDICAL EXPENSES INPATIENT*	100% of contracted rate	90% of UCR after deductible until Out-of-Pocket is reached, then 100%

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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 contracted rate	$30.00 copay Fund pays lesser of UCR or billed charges
Specialists	$30.00 copay Fund pays 100% of contracted rate	$55.00 copay Fund pays lesser of UCR or billed charges
Chiropractors	$25.00 maximum per visit up to $500.00 per person/per year	$25.00 maximum per visit up to $500.00 per person/per year
FLU/PNEUMONIA * VACCINATIONS	100% of contracted rate	Fund pays lesser of UCR or billed charges
TRANSPLANT *	$100.00 copay 100% of contracted rate. *Cost related to transplant surgery through six weeks from date of surgery.	$100.00 copay 90% of UCR after deductible until Out-of-Pocket is reached, then 100%*Cost related to transplant surgery through six weeks from date of surgery.
AMBULANCE TRANSPORT/ LIFE FLIGHTS *	$100.00 copay Fund pays 100% of contracted rate	$100.00 copay 90% of UCR after deductible until Out-of-Pocket is reached, then 100%
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	$25.00 reimbursement if no Physician Office Visit	$25.00 reimbursement if no Physician's Office Visit

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THERAPY SERVICES * (Including Physical, Occupational, Speech and Work Hardening)	$20.00 copay per visit Fund pays 100% of contracted rate. Limit-3 therapeutic services/visit and 24 visits/condition. Extensions reviewed.	$30.00 copay per visit. Fund pays lesser of UCR or billed charges. Limit- 3 therapeutic services/visit and 24 visits/condition. Extensions reviewed.
OUTPATIENT NURSING *	90% of contracted rate up to 240 hours in the benefit year. Over 240 hours payable at 50%.	90% of UCR after deductible up to 240 hours in the benefit year. Over 240 hours payable at 50%.
DURABLE MEDICAL* EQUIPMENT	90% of contracted rate until Out-of-Pocket is reached; then 100%	90% of UCR after deductible until Out-of-Pocket is reached; then 100%
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	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

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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
PRESCRIPTION DRUGS CONTINUED…**	**D**. Copay for each 34-day supply: $10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list), **with a $100.00 deductible** $150.00 Specialty Copay 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-day supply **D**. $30 Generics/$60 Brand Preferred/$100 Brand Non-Preferred (see attached list), **with a $100.00 deductible** $300.00 Specialty Copay Please see Additional Notes at the end	**D**. Copay for each 34-day supply: $10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list), **with a $100.00 deductible** $150.00 Specialty Copay Please see Additional Notes at the end

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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
DENTAL **		
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 person/per injury	$1,000.00/per person/per injury
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
VISION ** (same for all levels A, B, and C)	Davis Vision (see attached program description)	$45.00 exam $75.00 lenses/frames or contacts
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 **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.	**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.

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 **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.	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 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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BENEFITS	**PPO NETWORK**	**OUT OF NETWORK**
SHORT-TERM ** **DISABILITY**	**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

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.

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.

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.

+ 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.