**CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND**
**PLAN 14 – BASE BENEFIT LEVEL "B"**
**SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2020**

| **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 B:*** | | |
|---|---|---|
| Deductible & Out-of-pocket | Each Year | Each Year |
| Individual Deductible | $500.00 | $3,000.00 |
| Family Maximum Deductible | $1,000.00 | $6,000.00 |
| Co-Insurance | 10% | 30%, plus any balances over UCR |
| Individual Out-of-Pocket Maximum+ | $1,000.00 plus Deductible | Unlimited |
| Family Out-of-Pocket Maximum+ | $2,000.00 plus Deductible | Unlimited |
| Lifetime Maximum Benefit | Unlimited | Unlimited |
| **HOSPITALIZATION*** | | |
| Inpatient Hospitalization Admission | 90% of contracted rate after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |
| Outpatient Surgical Procedure Facility | 90% of contracted rate after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |
| Outpatient Surgical Procedure Office | 90% of contracted rate after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |

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| **BENEFITS** | **IN NETWORK** | **OUT OF NETWORK** |
|---|---|---|
| **HOSPITALIZATION CONTINUED…..*** | | |
| Hospital Miscellaneous | 90% of contracted rate after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |
| Emergency – Accident | $100.00 copay<br>Fund pays 100% of contracted rate | $100.00 copay<br>Fund pays 100% of balance |
| Emergency – Sickness (includes ER/Dr.) | $100.00 copay<br>Fund pays 100% of contracted rate | $100.00 copay<br>Fund pays 100% of balance |
| **MENTAL ILLNESS/ * SUBSTANCE ABUSE** | | |
| Outpatient | $20.00 copay<br>Fund pays 100% of contracted rate | $30.00 copay<br>Fund pays lesser of UCR or billed charges |
| Inpatient Hospital | 90% of contracted rate after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |
| Inpatient Physician | 90% of contracted rate after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |
| **DIAGNOSTIC *** | 90% of contracted rate after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |
| **PHYSICIAN'S MEDICAL EXPENSES INPATIENT*** | 90% of contracted rate after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |
| **MEDICAL EXPENSES PHYSICIAN'S OFFICE VISITS *** | | |
| Office visits include:<br>General Practitioner, OB-GYN, Internist, Pediatrician and Doctors of Osteopathy | $20.00 copay<br>Fund pays 100% of contracted rate | $30.00 copay<br>Fund pays lesser of UCR or billed charges |

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| BENEFITS | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| **MEDICAL EXPENSES PHYSICIAN'S OFFICE VISITS CONTINUED…*** | | |
| Specialists | $30.00 copay<br>Fund pays 100% of contracted rate | $55.00 copay<br>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 *** | 90% of contracted rate after deductible until Out-of-Pocket is reached, then 100%<br>*Cost related to transplant surgery through six weeks from date of surgery. | 70% of UCR after deductible<br>*Cost related to transplant surgery through six weeks from date of surgery. |
| **AMBULANCE TRANSPORT/ LIFE FLIGHTS *** | $100.00 copay<br>Fund pays 100% of contracted rate | $100.00 copay<br>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 | $25.00 reimbursement | $25.00 reimbursement |

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**PLAN 14 – BASE BENEFIT LEVEL "B"**
**SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2020**

| BENEFITS | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| **THERAPY SERVICES** * (Including Physical, Occupational, Speech and Work Hardening) | $20.00 copay per visit<br>Fund pays 100% of contracted rate.<br>Limit-3 therapeutic services/visit and 24 visits/condition.<br>Extensions reviewed. | $30.00 copay per visit.<br>Fund pays lesser of UCR or billed charges.<br>Limit- 3 therapeutic services/visit and 24 visits/condition.<br>Extensions reviewed. |
| **OUTPATIENT NURSING** * | 90% of contracted rate after deductible 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 after deductible until Out-of-Pocket is reached; then 100% | 70% of UCR after deductible |
| **DURABLE MEDICAL*[1] EQUIPMENT** | 90% of contracted rate until Out-of-Pocket is reached; then 100% | 90% of UCR |
| **PRESCRIPTION DRUGS** ** | **Retail Pharmacy:**<br>**A.** Copay for each 34-day supply:<br>$5 Generic/$15 Brand Preferred/<br>$30 Brand Non-Preferred (see attached list)<br>Specialty - $150 for each 30-day supply<br>**B.** Copay for each 34-day supply:<br>$10/Generics/$20 Brand Preferred/$40 Brand Non-Preferred (see attached list)<br>Specialty - $150 for each 30-day supply<br>**C.** Copay for each 34-day supply:<br>$10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list)<br>Specialty - $150 for each 30-day supply | Copay plus excess over PPO cost for each 34 day supply:<br>**A.** $5 Generic/$15 Brand Preferred/<br>$30 Brand Non-Preferred (see attached list)<br>Specialty - $150 for each 30-day supply<br>**B.** Copay plus excess over PPO cost for each 34-day supply:<br>$10/Generics/$20 Brand Preferred/$40 Brand Non-Preferred (see attached list)<br>Specialty - $150 for each 30-day supply<br>**C.** Copay plus excess over PPO cost for each 34-day supply:<br>$10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list)<br>Specialty - $150 for each 30-day supply |

**CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND**
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**SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2020**

| **BENEFITS** | **IN NETWORK** | **OUT OF NETWORK** |
|---|---|---|
| **PRESCRIPTION DRUGS** CONTINUED…** | **D**. Copay for each 34-day supply:<br>$10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list), **with a $100.00 deductible**<br>$150.00 Specialty Copay for each 30-day supply<br><br>No CVS or Walgreens<br><br>Please see Additional Notes at the end<br><br>**Mail-Order Program** up to a 90-day supply:<br>**A.** $15 Generic/$30 Brand Preferred/<br>$60 Brand Non-Preferred<br>Specialty - $300 for each 90-day supply<br>**B.** $30 Generic/$40 Brand Preferred/$80 Brand Non-Preferred(see attached list)<br>Specialty - $300 for each 90-day supply<br>**C.** $30 Generic/$60 Brand Preferred/$100 Brand Non-Preferred (see attached list)<br>Specialty - $300 for each 90-day supply<br>**D**. $30 Generics/$60 Brand Preferred/$100 Brand Non-Preferred (see attached list), **with a $100.00 deductible**<br>$300.00 Specialty Copay for each 90-day supply<br><br>Please see Additional Notes at the end | **D**. Copay for each 34-day supply:<br>$10 Generics/$30 Brand Preferred/$50 Brand Non-Preferred (see attached list), **with a $100.00 deductible**<br>$150.00 Specialty Copay<br><br>Please see Additional Notes at the end |

**CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND**
**PLAN 14 – BASE BENEFIT LEVEL "B"**
**SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2020**

| BENEFITS | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| **DENTAL** ** | | |
| Routine | **A.**100% of contracted rate up to $1,000.00/person/year<br>**B.** 80% of contracted rate up to $800.00/person/year<br>**C.** 60% of contracted rate up to $600.00/person/year | **A.** 100% up to UCR maximum of $1,000.00/person/year<br>**B**. 80% up to UCR maximum of $800.00/person/year<br>**C.** 60% up to UCR maximum of $600.00/person/year |
| Accidental<br>(same for all levels A, B, and C) | $1,000.00/per person/per injury | $1,000.00/per person/per injury |
| Orthodontic<br>(same for all levels A, B, and C) | $3,000.00/person/lifetime<br>No balance to Dental Benefit<br>No adults | $2,000.00/person/lifetime<br>No balance to Dental Benefit<br>No adults |
| **VISION** ** | Davis Vision (see attached program description) | $45.00 exam<br>$75.00 lenses/frames or contacts |
| **HEARING** ** | $1,000.00 per family per year | $1,000.00 per family per year.<br>Hearing benefits based on UCR. |
| **DEATH AND DISMEMBERMENT** ** | **A.**$35,000.00 death<br>$35,000.00 accidental death<br>$ 2,000.00 spouse death<br>$ 2,000.00 child death<br>**B.**$20,000.00 death<br>$20,000.00 accidental death<br>$ 2,000.00 spouse death<br>$ 2,000.00 child death<br>**C.**$10,000.00 death<br>$10,000.00 accidental death<br>$ 2,000.00 spouse death<br>$ 2,000.00 child death<br>**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<br>$35,000.00accidental death<br>$ 2,000.00 spouse death<br>$ 2,000.00 child death<br>**B.**$20,000.00 death<br>$20,000.00 accidental death<br>$ 2,000.00 spouse death<br>$ 2,000.00 child death<br>**C.**$10,000.00 death<br>$10,000.00 accidental death<br>$ 2,000.00 spouse death<br>$ 2,000.00 child death<br>**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. |

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| BENEFITS | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| **DEATH AND ** DISMEMBERMENT CONTINUED…..** | Paraplegia or triplegia (paralysis of three limbs)-$26,250.<br>Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$17,500.<br>Accidental loss of thumb and index finger of the same hand or uniplegia-$8,750<br>**Dismemberment – Level B:**<br>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.<br>Paraplegia or triplegia (paralysis of three limbs)-$15,000.<br>Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$10,000.<br>Accidental loss of thumb and index finger of the same hand or uniplegia-$5,000.<br>**Dismemberment – Level C:**<br>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.<br>Paraplegia or triplegia (paralysis of three limbs)-$7,500.<br>Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$5,000<br>Accidental loss of thumb and index finger of the same hand or uniplegia-$2,500. | Paraplegia or triplegia (paralysis of three limbs)-$26,250.<br>Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$17,500.<br>Accidental loss of thumb and index finger of the same hand or uniplegia-$8,750<br>**Dismemberment – Level B:**<br>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.<br>Paraplegia or triplegia (paralysis of three limbs)-$15,000.<br>Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$10,000.<br>Accidental loss of thumb and index finger of the same hand or uniplegia-$5,000.<br>**Dismemberment – Level C:**<br>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.<br>Paraplegia or triplegia (paralysis of three limbs)-$7,500.<br>Accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia-$5,000<br>Accidental loss of thumb and index finger of the same hand or uniplegia-$2,500. |

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**PLAN 14 – BASE BENEFIT LEVEL "B"**
**SUMMARY OF BENEFITS – EFFECTIVE JANUARY 1, 2020**

| BENEFITS | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| **SHORT-TERM DISABILITY** ** | **A.**$275.00 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted.<br>**B.**$175.00 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted.<br>**C.**$100 per week-26 weeks -no extended benefits | **A.**$275.00 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted.<br>**B.**$175.00 per week-26 weeks $100 extended – 10 weeks provided required documentation submitted.<br>**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 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.**