

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

<u>BENEFITS</u>	<u>IN NETWORK</u>	<u>OUT OF NETWORK</u>
<u>BASE BENEFITS</u>		
Deductible & Out-of-pocket	Each Year	Each Year
Individual Deductible		
Level A	\$0	\$3,000
Level B	\$500	\$3,000
Level C	\$1,000	\$3,000
Family Maximum Deductible		
Level A	\$0	\$6,000
Level B	\$1,000	\$6,000
Level C	\$2,000	\$6,000
Co-Insurance¹		
Level A	\$0	30%, plus any balances over UCR
Level B	10%	30%, plus any balances over UCR
Level C	20%, plus any balances over contracted rate	30%, plus any balances over UCR
Individual Out-of-Pocket Maximum+		
Level A	\$2,500	Unlimited
Level B	\$1,000 plus Deductible	Unlimited
Level C	\$2,000 plus Deductible	Unlimited
Family Out-of-Pocket Maximum+		
Level A	\$5,000	Unlimited
Level B	\$2,000 plus Deductible	Unlimited
Level C	\$4,000 plus Deductible	Unlimited
Lifetime Maximum Benefit (same for all Levels A, B, and C)	Unlimited	Unlimited
<u>HOSPITALIZATION</u>		
Inpatient Hospitalization Admission		
Level A	\$100 copay Fund pays 100% of contracted rate	\$100 copay 70% of UCR after deductible
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	\$100 copay 70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	\$100 copay 70% of UCR after deductible

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

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Outpatient Surgical Procedure Facility		
Level A	\$100 copay Fund pays 100% of contracted rate	\$100 copay 70% of UCR after deductible
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	\$100 copay 70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	\$100 copay 70% of UCR after deductible
Outpatient Surgical Procedure Office		
Level A	100% of contracted rate	70% of UCR after deductible
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Hospital Miscellaneous		
Level A	100% of contracted rate	70% of UCR after deductible
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Emergency – Accident (same for all levels A, B, and C)	\$100 copay Fund pays 100% of contracted rate	\$100 copay Fund pays 100% of balance
Emergency – Sickness (includes ER/Dr.) (same for all levels A, B, and C)	\$100 copay Fund pays 100% of contracted rate	\$100 copay Fund pays 100% of balance

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<u>MENTAL ILLNESS/ SUBSTANCE ABUSE</u>		
Outpatient (same for all levels A, B, and C)	\$20 copay Fund pays 100% of contracted rate	\$30 copay Fund pays lesser of UCR or billed charges
Inpatient Hospital		
Level A	\$100 copay Fund pays 100% of contracted rate	\$100 copay 70% of UCR after deductible
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	\$100 copay 70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	\$100 copay 70% of UCR after deductible
Inpatient Physician		
Level A	100% of contracted rate	70% of UCR after deductible
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
<u>DIAGNOSTIC</u>		
Level A	100% of contracted rate	Fund pays 70% of lesser of bill or UCR.
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible

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<u>BENEFITS</u>	<u>IN NETWORK</u>	<u>OUT OF NETWORK</u>
<u>PHYSICIAN'S MEDICAL EXPENSES INPATIENT</u>		
Level A	100% of contracted rate	70% of UCR after deductible
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
<u>MEDICAL EXPENSES PHYSICIAN'S OFFICE VISITS</u> (same for all levels A, B, and C)		
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
<u>FLU/PNEUMONIA VACCINATIONS</u> (same for all levels A, B, and C)		
	100% of contracted rate	Fund pays lesser of UCR or billed charges
<u>TRANSPLANT</u> (same for all levels A, B, and C) -Date of transplant through six-week period immediately following transplant		
Level A	\$100 copay 100% of contracted rate	\$100 copay 70% of UCR after deductible
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible

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<u>BENEFITS</u>	<u>IN NETWORK</u>	<u>OUT OF NETWORK</u>
<u>AMBULANCE TRANSPORT/ LIFE FLIGHTS</u> (same for all levels A, B, and C)	\$100 copay Fund pays 100% of contracted rate	\$100 copay 70% of UCR after deductible
<u>IMMUNIZATIONS</u> <u>(recommended by the Centers for Disease Control)</u> (same for all levels A, B, and C)		
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
<u>THERAPY SERVICES</u> (same for all levels A, B, and C)		
(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
<u>OUTPATIENT NURSING¹</u>		
Level A	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%.
Level B	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%.
Level C	80% 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%.

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<u>DURABLE MEDICAL¹</u> <u>EQUIPMENT</u>	90% of contracted rate until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Level A		
Level B	90% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
Level C	80% of contracted rate after deductible until Out-of-Pocket is reached; then 100%	70% of UCR after deductible
<u>DURABLE MEDICAL¹</u> <u>SUPPLIES</u>	90% of contracted rate until Out-of-Pocket is reached; then 100%	90% of UCR
Level A		
Level B	90% of contracted rate until Out-of-Pocket is reached; then 100%	90% of UCR
Level C	80% of contracted rate until Out-of-Pocket is reached; then 100%	80% of UCR
<u>PRESCRIPTION DRUGS</u>	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 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	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 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

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<u>DENTAL</u>		
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	\$2,000person/lifetime No balance to Dental Benefit No adults
<u>VISION</u>		
(same for all levels A, B, and C)	Davis Vision (see attached program description)	\$45 exam \$75 lenses/frames or contacts
<u>HEARING</u>		
(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.
<u>DEATH AND DISMEMBERMENT</u>		
Level A	\$35,000 Member \$ 2,000 Spouse \$ 2,000 Child	\$35,000 Member \$ 2,000 Spouse \$ 2,000 Child
	Accidental Death and Dismemberment (AD&D) -Member Only \$35,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia	Accidental Death and Dismemberment (AD&D) -Member Only \$35,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia
	\$17,500 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia	\$17,500 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia
	Common Carrier AD&D* \$70,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia	Common Carrier AD&D \$70,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia
	\$35,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia	\$35,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia

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Level B	\$20,000 Member \$ 2,000 Spouse \$ 2,000 Child Accidental Death and Dismemberment (AD&D) -Member Only \$20,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia \$10,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia Common Carrier AD&D* \$40,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia \$20,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia	\$20,000 Member \$ 2,000 Spouse \$ 2,000 Child Accidental Death and Dismemberment (AD&D) -Member Only \$20,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia \$10,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia Common Carrier AD&D \$40,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia \$20,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia
Level C	\$10,000 Member \$ 2,000 Spouse \$ 2,000 Child Accidental Death and Dismemberment (AD&D) -Member Only \$10,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia \$5,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia Common Carrier AD&D* \$20,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia \$10,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia	\$10,000 Member \$ 2,000 Spouse \$ 2,000 Child Accidental Death and Dismemberment (AD&D) -Member Only \$10,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia \$5,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia Common Carrier AD&D \$20,000 for Accidental loss of life, 2 limbs (hand, foot, or eye), Quadriplegia \$10,000 for loss limb (hand, foot, or eye), Paraplegia, Hemiplegia

***“Common Carrier Accident”**

is a covered accidental bodily injury, which is sustained while riding as a fare paying passenger by Common Carrier including land, air, or water operated under a license to transport passengers for hire. **This does not include a pilot, operator or crew member.** (limitations apply)

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<u>BENEFITS</u>	<u>IN NETWORK</u>	<u>OUT OF NETWORK</u>
<u>SHORT-TERM DISABILITY</u>	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.

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.

Plan 14 Summary of Benefits
Effective 4/1/2025