

Teamsters Joint Council No. 83 of VA Health & Welfare Fund
Plan 8B
Effective July 1, 2009

BENEFIT	PLAN 8B	SUBJECT TO
LIFE INSURANCE		
Employee	\$10,000	
Accidental Death & Dismemberment (Employee Only)	\$10,000	
Permanent and Total Disability (Employee Only)	\$5,000	
Spouse	\$2,000	
Child	\$1,000	
SHORT TERM DISABILITY		
Employee Only	\$140/week	
Maximum Weeks	20	
Free Coverage	11 weeks	
HOSPITALIZATION ▪ 45 days per person per year (in-patient)		
<u>In-Network</u> In-network hospital charges for room/board and miscellaneous (necessary services & supplies)	90% of BCBS allowable charge	AM, CI, DED, OOP, LM
<u>Out-of-Network - Non-emergency room based admission</u> Out-of-network hospital charges for room/board and miscellaneous (necessary services & supplies)	70% of BCBS allowable charge	
<u>Out-of-Network - Admission after visit to emergency room</u> Out-of-network hospital charges for room/board and miscellaneous (necessary services & supplies)	90% of BCBS allowable charge	
SURGERY		
In-Network	90% of BCBS allowable charge	CI, DED, OOP, LM
In-Network Colonoscopy (Out-patient only)	100% of BCBS allowable charge	LM
Out-of-network	70% of BCBS allowable charge	CI, DED, OOP, LM
PRESCRIPTION DRUGS ▪ If you have a condition treatable by the Horse Power Healthy Rewards Program, all generic medicines are free while participating in the Reward Program.		
Prior Authorization Required for:		CP, LM, CI
<ul style="list-style-type: none"> • Anti-obesity drugs (Xenical, Meridia), Second generation antihistamines, (e.g. Clarinex, Allegra, Zyrtec, Clarinex D, Allegra D), Proton pump inhibitors (e.g., Prevacid, Protonox, Nexium, Aciphex), Actiq, Gleevec, Iressa, Revlimid, Tarceva, Thalomid, Tracleer • All injectable medications with the exception of Byetta, Cyanocobalamin, Delatestryl, Delestrogen, DepoTestosterone, Dexamethasone, Furosemide, Haloperidol, Heparin, Insulin, Lidocaine, Lorazepam, Methotrexate, Nubain, Progesterone, Promethazine, Sodium Bicarbonate, Symlin 		
Retail - 30 day supply Viagra, Cialis, or equivalent drug limited to 8 units per month	20% co-pay - \$10 minimum	
Mail Order Maintenance Drugs -100 day supply Mail Order Specialty (Injectable) drugs - 30 day supply	\$40 Generic \$80 Brand	
DOCTOR VISIT ▪ One co-pay applies per person per date of service. (Higher co-pay will apply when specialist is seen.)		
<u>In-network</u>		CP, LM
<ul style="list-style-type: none"> • \$25co-pay for charges incurred at family or general practitioner, pediatrician, internal medical physician or urgent care center (i.e., Patient First) • \$40co-pay for charges incurred at specialist • Co-pay covers all charges incurred at doctor's office. This could include x-ray, lab, drugs (i.e., chemotherapy, allergy serum, administration of injections, etc.) • Increased co-pays apply if you have a condition treatable by the Horse Power Healthy Rewards Program and do not agree to participate 		
<u>Out-of-network</u>		
70% of BlueCross BlueShield allowable charge		

AM -- Annual Maximum	AVL -- Annual Visit Limit
CI -- Co-Insurance	CP -- Co-Payment
DED -- Deductible	LM -- Lifetime Maximum
LVL -- Lifetime Visit Limit	OOP -- Out of Pocket Limit

BENEFIT	PLAN 8B	SUBJECT TO
X-RAY		
In-Network (In or Out-Patient)	90% of BCBS allowable charge	CI, DED, LM, OOP, AM
Exceptions (only apply to in-network/out-patient services): EKG Bone Density (Medical guidelines only) Mammography (Routine)	100% of BCBS allowable charge	LM
Out-of-Network (In or Out-Patient)	70% of BCBS allowable charge	CI, DED, LM, OOP, AM
LAB		
In-Network (Out-Patient)	100% of BCBS allowable charge	LM
In-Network (In-Patient)	90% of BCBS allowable charge	CI, DED, LM, OOP, AM
Out-of-Network (Out-Patient)	70% of BCBS allowable charge	CI, DED, LM, OOP, AM
Out-of-Network (In-patient)	70% of BCBS allowable charge	CI, DED, LM, OOP, AM
ANNUAL DEDUCTIBLE (NOT INCLUDED IN OUT-OF-POCKET LIMIT)		
Individual - \$475 Family - \$1,425	Deductible applies to all charges incurred except dental claims, amounts above BCBS allowable charges, lab and x-ray procedures paid at 100%, co-pays for doctors and emergency room visits and prescription drug claims.	
LIFETIME MAXIMUM - PER PERSON -- \$600,000		
ANNUAL OUT-OF-POCKET LIMIT		
	<u>In-network</u> \$8,000 per person \$24,000 per family	<u>Out-of-network</u> \$16,000 per person \$48,000 per family
EMERGENCY ROOM AND ALL RELATED CHARGES		
<ul style="list-style-type: none"> \$150 co-pay applies whether in-network or out-of-network Increased co-payments apply if you have a condition treatable by the Horse Power Healthy Rewards Program and do not agree to participate. 		
TRANSPLANT COVERAGE -- HOSPITAL AND SURGICAL		
In-Network	90% of BCBS allowable charge	CI, OOP, LM, DED
Out-of-Network	70% of BCBS allowable charge	
Transplant Coverage Follow-Up Care	NONE	
OTHER ALLOWABLE MAJOR MEDICAL EXPENSES Physical Therapy, Speech Therapy, and Occupational Therapy - Maximum 20 visits each per person, per year		
Other allowable, in-network expenses	80% of BCBS allowable charge (i.e., administration of allergy injections)	DED, LM, CI, OOP, AVL
Other allowable, out-of-network expenses	70% of BCBS allowable charge	
DENTAL (INCLUDING TMJ)		
100% of dental schedule		CI, AM
Dental annual max	\$350/family	
VISION (OUT-OF-NETWORK) Only one exam is payable during a calendar year. Two lenses and one set of frames or two contact lenses (includes a one-time purchase of disposable contact lenses, payable as shown below) are payable during a calendar year. No combination of frames and contact lenses will be covered.		
Exam	\$20.00	CI, AM
Frames	\$20.00	
Single Lenses, Pair	\$20.00	
Bifocal Lenses, Pair	\$30.00	
Trifocal Lenses, Pair	\$40.00	
Lenticular Lenses, Pair	\$45.00	
Contacts	\$40.00	
EyeMed Vision Care Network Plan Option	Low	LM, AM

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DED -- Deductible	LM -- Lifetime Maximum
LVL -- Lifetime Visit Limit	OOP -- Out of Pocket Limit