

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

BENEFIT	PLAN ZR	SUBJECT TO
HOSPITALIZATION ■ 90 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: <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 		CP, LM, CI
Retail - 30 day supply Viagra, Cialis, or equivalent drug limited to 8 units per month	20% co-pay - \$5 minimum	
Mail Order Maintenance Drugs -100 day supply Mail Order Specialty (Injectable) drugs - 30 day supply	\$20 Generic \$45 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> <ul style="list-style-type: none"> • \$25 co-pay for charges incurred at family or general practitioner, pediatrician, internal medical physician or urgent care center (i.e., Patient First) • \$50 co-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 		CP, LM
<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 ZR	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 - \$250 Family - \$750	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 -- \$500,000		
ANNUAL OUT-OF-POCKET LIMIT		
<u>In-network</u> \$2,000 per person \$6,000 per family	<u>Out-of-network</u> \$6,000 per person \$18,000 per family	
EMERGENCY ROOM AND ALL RELATED CHARGES		
<ul style="list-style-type: none"> \$100 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 & 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, AM
Other allowable, out-of-network expenses	70% of BCBS allowable charge	
DENTAL (INCLUDING TMJ)		
100% of dental schedule		AM, CI
Dental annual max	\$1,000/family	
FULL-TIME EMPLOYMENT AFTER TEAMSTERS' RETIREMENT		
If you are employed after retirement and the cost of purchasing insurance from your new employer is equal to or less than the monthly retiree premium charged by the Fund, you must enroll in your new employer's program, if you desire insurance. Retiree coverage through the Fund can then be purchased as a secondary coverage.		
SPOUSE OF RETIREE TERMINATED FROM RETIREE HEALTH COVERAGE		
At termination of the member's coverage, spouse and dependent coverage is available for up to three years unless coverage first terminates due to reaching 65 or becoming eligible for Medicare.		

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