

Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund
Plan 11 Series II
Effective January 1, 2012

BENEFIT	PLAN 11 SERIES II	SUBJECT TO
Life Insurance		
Employee	\$100,000	
Accidental Death & Dismemberment (Employee only)	\$27,000	
Permanent and Total Disability (Employee only)	\$13,500	
Spouse	\$3,000	
Child	\$1,500	
Short Term Disability		
Employee Only	\$600/week	
Maximum Weeks	26 weeks	
Free Coverage	22 weeks	
Hospitalization <ul style="list-style-type: none"> • 120 days per person per year (in-patient) • Call must be made to SHPS within 48 hours of non-emergency admissions and 72 hours of emergency admissions to avoid penalty. 		
<u>In-Network (In-patient)</u> Hospital charges for room/board and necessary services and supplies	85% of BCBS allowable charge	AM, CI, DED, OOP
<u>In-Network (Out-patient)</u> For services performed in the hospital, not covered by any other benefit	85% of BCBS allowable charge	
<u>Out-of-Network (In-patient)</u> Hospital charges for room/board and necessary services and supplies	85% of BCBS allowable charge	
<u>Out-of-Network (Out-patient)</u> For services performed in the hospital, not covered by any other benefit	65% of BCBS allowable charge	
Surgery		
In-Network (In-patient or Out-Patient)	85% of BCBS allowable charge	CI, DED, OOP, AM
In Network Colonoscopy (Out-Patient only)	100% of BCBS allowable charge	AM
Out-of-Network (In-patient)	85% of BCBS allowable charge	CI, DED, OOP, AM
Out-of-Network (Out-patient)	65% of BCBS allowable charge	CI, DED, OOP, AM
Prescription Drugs <ul style="list-style-type: none"> • If you have a condition treatable by the Horse Power Healthy Rewards Program, all generic medicines are free while participating in the Rewards Program. 		
<p><u>Prior Authorization is required for certain drugs. Below is a sample listing. Contact the Fund Office to inquire about other drugs not listed.</u></p> <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, Protonix, Nexium, Aciphex), Actiq, Gleevec, Ireesa, Revlimid, Tarceva, Thalomid, Tracleer • All injectable medications with the exception of Byetta, Cyanocobalamin, Delatestryl, Delestrogen, DepoTestosterone, Dexamethasone, Furosemide, Haloperidol, Herapin, Insulin, Lidocaine, Lorazepam, Methotrexate, Nubain, Progesterone, Promethazine, Sodium Bicarbonate, Symlin 		CP, AM, CI
<u>Retail – 30 day supply</u> Viagra, Cialis, or equivalent drug limited to 8 units per month	20% co-insurance - \$5 minimum	
<u>Mail Order Maintenance Drugs – 90 day supply</u>	\$20 Generic	
<u>Mail Order Specialty (injectable) drugs – 30 day supply</u>	\$45 Brand	
Doctor Visit <ul style="list-style-type: none"> • One co-pay per person per date of service. (Higher co-pay applies when specialist is seen.) 		
In-Network: <ul style="list-style-type: none"> • 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 (excluding allergy injections). • Increased co-pays apply if you have a condition treatable by the Horse Power Healthy Rewards Program and do not agree to participate. 	\$15 co-pay for charges incurred at family or general practitioner, pediatrician, internal medicine or urgent care center (i.e., Patient First) \$25 co-pay for charges incurred at specialist	CP, AM
Out-of-Network	65% of BCBS allowable charge	CI, DED, OOP, AM
Chiropractic/Musculoskeletal		
Benefit	\$25 co-pay	CP, AVL, AM
Annual Max/Year	10 visits per year	
Hearing Aids		
Benefit	80% of BCBS allowable charge (maximum allowable charge - \$700)	DED, AM, CI
Maximum Benefit	1 hearing aid per ear every 5 years	

BENEFIT	PLAN 11 SERIES II	SUBJECT TO
X-Ray		
In-Network (In-patient or Out-patient)	85% of BCBS allowable charge	CI, DED, OOP, AM
Exceptions (only apply to in-network/out-patient services): EKG Bone Density (medical guidelines only) Mammography (routine)	100% of BCBS allowable charge	AM
Out-of-Network (In-patient)	85% of BCBS allowable charge	CI, DED, OOP, AM
Out-of-Network (Out-patient)	65% of BCBS allowable charge	CI, DED, OOP, AM
Lab		
In-Network (In-Patient)	85% of BCBS allowable charge	CI, DED, OOP, AM
In-Network (Out-Patient)	100% of BCBS allowable charge	AM
Out-of-Network (In-Patient)	85% of BCBS allowable charge	CI, DED, OOP, AM
Out-of-Network (Out-Patient)	65% of BCBS allowable charge	CI, DED, OOP, AM
Annual Deductible (Not included in Out-of-Pocket Limit)		
Deductible applies to all charges incurred except dental claims, vision claims, amounts above BCBS allowable charge, lab and x-ray procedures paid at 100%, co-pays for doctor and emergency room visits and prescription drug claims.	Individual - \$200	
	Family - \$600	
Annual Maximum (per person)		
	Unlimited	
Annual Out-of-Pocket Limit		
	<u>In-Network</u> \$2,225 per person \$6,675 per family <u>Out-of-Network</u> \$6,675 per person \$20,025 per family	
Emergency Room and All Related Charges		
<ul style="list-style-type: none"> 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. 	\$100 co-pay	CP, AM
Other Allowable Major Medical Expenses • Physical Therapy, Speech Therapy and Occupational Therapy – Maximum 20 visits per person per year.		
Anesthesia (In or Out-of-Network)	85% of BCBS allowable charge	DED, CI, OOP, AVL, AM
Ambulance Services (In or Out-of-Network)	85% of BCBS allowable charge	
Other allowable, in-network expenses	85% of BCBS allowable charge (i.e. administration of allergy injections)	
Other allowable, out-of-network expenses	65% of BCBS allowable charge	
Transplant Coverage		
In-Network	85% of BCBS allowable charge	CI, OOP, AM, DED
Out-of-Network	70% of BCBS allowable charge	
Dental (Including TMJ) • Benefits paid for Qualifying Children under the age of 18 are not subject to or applied to the annual family maximum.		
All Dental Services	100% of dental schedule	AM, CI
Dental annual max	\$3,000/family	
Orthodontic/eligible dependent (under 18 years of age) in cases where severe deformity does not exist	\$2,000 Lifetime Maximum (24 month waiting period)	LM, CI
Orthodontic/eligible dependent (under 18 years of age) in cases where severe deformity does exist as determined by the Fund's Medical Consultant	Not applicable to Lifetime Maximum (24 month waiting period)	AM, CI
Vision • 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	\$35.00	AM, CI
Frames	\$40.00	
Single Lenses, Pair	\$40.00	
Bifocal Lenses, Pair	\$55.00	
Trifocal Lenses, Pair	\$70.00	
Lenticular Lenses, Pair	\$80.00	
Contacts	\$80.00	
EyeMed Vision Care Network Plan Option	High	AM

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