

Teamsters Joint Council No. 83 of VA Health & Welfare Fund

Plan 11-2

Effective July 1, 2010

BENEFIT	PLAN 11-2	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	
Free Coverage	22 weeks	
HOSPITALIZATION - INPATIENT ■ 120 days per person per year (in-patient)		
<u>In-Network (In-patient or Out-patient)</u> In-network hospital charges for room/board and miscellaneous (necessary services & supplies)	85% 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)	65% 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)	85% of BCBS allowable charge	
HOSPITALIZATION & SURGERY - OUTPATIENT		
In-Network	85% of BCBS allowable charge	CI, DED, OOP, LM
In-Network Colonoscopy (Out-patient only)	100% of BCBS allowable charge	LM
Out-of-network	65% 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 - \$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"> • \$15 co-pay for charges incurred at family or general practitioner, pediatrician, internal medical physician or urgent care center (i.e., Patient First) • \$25 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> 65% of BlueCross BlueShield allowable charge		CI, DED, OOP, LM

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 11-2	SUBJECT TO
CHIROPRACTIC/MUSCULOSKELETAL		
Benefit	\$25 co-pay	CP, AVL, LM
Annual Max/Year	10 visits per year	
HEARING AIDS		
Benefit	80% of BCBS allowable charge (maximum allowable charge - \$700)	DED, AM, LM, CI
Maximum Benefit	One hearing aid per ear every five years	
X-RAY		
In-Network (In or Out-Patient)	85% 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)	65% of BCBS allowable charge	CI, DED, LM, OOP, AM
LAB		
In-Network (Out-Patient)	100% of BCBS allowable charge	LM
In-Network (In-Patient)	85% of BCBS allowable charge	CI, DED, LM, OOP, AM
Out-of-Network (Out-Patient)	65% of BCBS allowable charge	CI, DED, LM, OOP, AM
Out-of-Network (In-patient)	65% of BCBS allowable charge	CI, DED, LM, OOP, AM
ANNUAL DEDUCTIBLE (NOT INCLUDED IN OUT-OF-POCKET LIMIT)		
Individual - \$200 Family - \$600	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 -- 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"> \$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. 		
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	85% of BCBS allowable charge (i.e., administration of allergy injections)	DED, LM, CI, OOP, AVL, AM
Other allowable, out-of-network expenses	65% of BCBS allowable charge	

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BENEFIT	PLAN 11-2	SUBJECT TO																											
TRANSPLANT COVERAGE - HOSPITAL & SURGICAL																													
In-network	85% of BCBS allowable charge	CI, OOP, LM, DED																											
Out-of-network	70% of BCBS allowable charge																												
TRANSPLANT COVERAGE FOLLOW-UP CARE																													
	<table border="1"> <thead> <tr> <th>Organ</th> <th>Annual Follow-up</th> <th>Lifetime Follow-up</th> </tr> </thead> <tbody> <tr> <td>Heart</td> <td>\$15,000</td> <td>\$75,000</td> </tr> <tr> <td>Heart/lung</td> <td>\$20,000</td> <td>\$100,000</td> </tr> <tr> <td>Lung</td> <td>\$20,000</td> <td>\$100,000</td> </tr> <tr> <td>Liver</td> <td>\$15,000</td> <td>\$75,000</td> </tr> <tr> <td>Pancreas</td> <td>\$10,000</td> <td>\$50,000</td> </tr> <tr> <td>Kidney</td> <td>\$10,000</td> <td>\$50,000</td> </tr> <tr> <td>Bone marrow</td> <td>\$10,000</td> <td>\$50,000</td> </tr> <tr> <td>Cornea</td> <td>None</td> <td>None</td> </tr> </tbody> </table>	Organ	Annual Follow-up	Lifetime Follow-up	Heart	\$15,000	\$75,000	Heart/lung	\$20,000	\$100,000	Lung	\$20,000	\$100,000	Liver	\$15,000	\$75,000	Pancreas	\$10,000	\$50,000	Kidney	\$10,000	\$50,000	Bone marrow	\$10,000	\$50,000	Cornea	None	None	AM, LM DED, CI
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Cornea	None	None																											
DENTAL (INCLUDING TMJ)																													
100% of dental schedule		AM, CI																											
Dental annual max	\$3,000/family																												
Orthodontic/eligible dependent	\$2,000 Lifetime Maximum (24 month waiting period)	LM, CI																											
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	\$35.00	CI, AM																											
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	LM, AM																											
EyeMed Vision Care Network Plan Option	High																												

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