Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund
Plan 8B
Effective January 1, 2012

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 weeks	
Free Coverage	11 weeks	
Hospitalization • 45 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.		
In-Network - In-patient Hospital charges for room/board and necessary services and supplies	90% of BCBS allowable charge	AM, CI, DED, OOP
In-Network – Out-patient For services performed in the hospital, not covered by any other benefit	80% of BCBS allowable charge	
Out-of-Network In-patient Hospital charges for room/board and necessary services and supplies	90% of BCBS allowable charge	
Out-of Network – Out-patient For services performed in the hospital, not covered by any other benefit	70% of BCBS allowable charge	
Surgery		
In-Network (In-patient or Out-Patient)	90% 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)	90% of BCBS allowable charge	CI, DED, OOP, AM
Out-of-Network (Out-patient)	70% of BCBS allowable charge	CI, DED, OOP, AM
Prescription Drugs • If you have a condition treatable by the Horse Power Healthy Rewards Program, all generic medicines are free while participating in the Rewards Program.		
Prior Authorization is required for certain drugs. Below is a sample listing. Contact the Fund Office to inquire about other drugs not listed. • 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 Victoza, Byetta, Cyanocobalamin, Delatestryl, Delestrogen, DepoTestosterone, Dexamethasone, Furosemide, Haloperidol, Herapin, Insulin, Lidocaine, Lorazepam, Methotrexate, Nubain, Progesterone, Promethazine, Sodium Bicarbonate, Symlin		CP, AM, CI
Retail – 30 day supply Viagra, Cialis, or equivalent drug limited to 8 units per month	20% co-insurance - $10 minimum	
Mail Order Maintenance Drugs – 90 day supply Mail Order Specialty (injectable) drugs – 30 day supply	$40 Generic $80 Brand	
Doctor Visit • One co-pay per person per date of service. (Higher co-pay applies when specialist is seen.)		
In-Network: • 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.	$25 co-pay for charges incurred at family or general practitioner, pediatrician, internal medicine, or urgent care center (i.e., Patient First) $40 co-pay for charges incurred at specialist	CP, AM
Out-of-Network	70% of BCBS allowable charge	CI, DED, OOP, AM

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

BENEFIT	**PLAN 8B**	**SUBJECT TO**
X-Ray		
In-Network (In-patient or Out-patient)	90% 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)	90% of BCBS allowable charge	CI, DED, OOP, AM
Out-of-Network (Out-patient)	70% of BCBS allowable charge	CI, DED, OOP, AM
Lab		
In-Network (In-Patient)	90% of BCBS allowable charge	CI, DED, OOP, AM
In-Network (Out-Patient)	100% of BCBS allowable charge	AM
Out-of-Network (In-Patient)	90% of BCBS allowable charge	CI, DED, OOP, AM
Out-of-Network (Out-Patient)	70% 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 - $475 Family - $1,425	
Annual Maximum (per person)		
	$1.25 million	
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		
• 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.	$150 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)	90% of BCBS allowable charge	DED, CI, OOP, AVL, AM
Ambulance Services (in or out-of-network)	90% of BCBS allowable charge	
Other allowable, in-network expenses	80% of BCBS allowable charge (i.e. administration of allergy injections)	
Other allowable, out-of-network expenses	70% of BCBS allowable charge	
Transplant Coverage		
In-Network	90% of BCBS allowable charge	CI, OOP, AM, DED
Out-of-Network	70% of BCBS allowable charge	
Transplant Coverage Follow-Up Care	NONE	
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	$350/family	
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	$20.00	AM, CI
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	AM

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LVM – Lifetime Visit Maximum