

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

BENEFIT	PLAN 8B	SUBJECT TO
<b>LIFE INSURANCE</b>		
Employee	\$10,000	
Accidental Death & Dismemberment (Employee Only)	\$10,000	
Permanent and Total Disability (Employee Only)	\$5,000	
Spouse	\$2,000	
Child	\$1,000	
<b>SHORT TERM DISABILITY</b>		
Employee Only	\$140/week	
Maximum Weeks	20	
Free Coverage	11 weeks	
<b>HOSPITALIZATION</b> ▪ 45 days per person per year (in-patient)		
<b><u>In-Network</u></b> In-network hospital charges for room/board and miscellaneous (necessary services & supplies)	90% of BCBS allowable charge	AM, CI, DED, OOP, LM
<b><u>Out-of-Network - Non-emergency room based admission</u></b> Out-of-network hospital charges for room/board and miscellaneous (necessary services & supplies)	70% of BCBS allowable charge	
<b><u>Out-of-Network - Admission after visit to emergency room</u></b> Out-of-network hospital charges for room/board and miscellaneous (necessary services & supplies)	90% of BCBS allowable charge	
<b>SURGERY</b>		
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
<b>PRESCRIPTION DRUGS</b> ▪ 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"> <li>• 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</li> <li>• 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</li> </ul>		
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	
<b>DOCTOR VISIT</b> ▪ One co-pay applies per person per date of service. (Higher co-pay will apply when specialist is seen.)		
<b><u>In-network</u></b>		CP, LM
<ul style="list-style-type: none"> <li>• \$25co-pay for charges incurred at family or general practitioner, pediatrician, internal medical physician or urgent care center (i.e., Patient First)</li> <li>• \$40co-pay for charges incurred at specialist</li> <li>• 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.)</li> <li>• Increased co-pays apply if you have a condition treatable by the Horse Power Healthy Rewards Program and do not agree to participate</li> </ul>		
<b><u>Out-of-network</u></b>		CI, DED, OOP, LM
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
<b>X-RAY</b>		
In-Network (In or Out-Patient)	90% of BCBS allowable charge	CI, DED, LM, OOP, AM
<b>Exceptions (only apply to in-network/out-patient services):</b> 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
<b>LAB</b>		
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
<b>ANNUAL DEDUCTIBLE (NOT INCLUDED IN OUT-OF-POCKET LIMIT)</b>		
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.	
<b>LIFETIME MAXIMUM - PER PERSON -- \$600,000</b>		
<b>ANNUAL OUT-OF-POCKET LIMIT</b>		
	<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
<b>EMERGENCY ROOM AND ALL RELATED CHARGES</b>		
<ul style="list-style-type: none"> <li>\$150 co-pay applies whether in-network or out-of-network</li> <li>Increased co-payments apply if you have a condition treatable by the Horse Power Healthy Rewards Program and do not agree to participate.</li> </ul>		
<b>TRANSPLANT COVERAGE -- HOSPITAL AND SURGICAL</b>		
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	
<b>OTHER ALLOWABLE MAJOR MEDICAL EXPENSES</b> 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	
<b>DENTAL (INCLUDING TMJ)</b>		
100% of dental schedule		CI, AM
Dental annual max	\$1,500/family	
<b>VISION (OUT-OF-NETWORK)</b> 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
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