TEAMSTERS LOCAL UNION NO. 856 HEALTH & WELFARE FUND
SCHEDULE OF BENEFITS

Anthem Blue Cross PPO - Select Plan

BENEFITS AND COVERAGE	TEAMSTERS DIRECT PAY PLAN Select Plan ANTHEM BLUE CROSS PROVIDERS	TEAMSTERS DIRECT PAY PLAN Select Plan NON-ANTHEM BLUE CROSS PROVIDERS
HEALTH		
Maximum Annual Benefit	Unlimited	Same
Annual Deductible:		
Per Individual	$250	$250
Family maximum	$500	$500
HOSPITAL		
Daily Room and Board	Semi-private	Semi-private
Other Hospital Charges	80%	50%[1]
Emergency Room	80%	80%[1]
In-Network (PPO only): Co-insurance maximum of $2,000 per family (does not include copayments or deductible)[2]		
PHYSICIAN'S SERVICES		
Physician & Specialist Office Visit	$20 (Deductible Waived)	60%[1]
Outpatient and Inpatient Services	80%	60%[1]
Surgical	80%	60%[1]
Lab/X-Ray	80%	60%[1]
Home Health and Hospice	80%	60%[1]
In-Network (PPO only): Co-insurance maximum of $2,000 per family (does not include copayments or deductible) [2]		
SPECIAL		
Physical Exams	100%	Not covered
Well Baby Care	100%	Not covered
Conversion Coverage	Not available	Not available
PRESCRIPTION DRUG BENEFIT		
Copay per Rx	$10 generic, $20 brand name	$10 generic, $20 brand name

[1] The plan's UCR (Usual, Customary and Reasonable) allowance. Emergency services shall be paid in accordance with applicable regulations.

[2] Total out of pocket expense shall never exceed the amount mandated by applicable regulations.