

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

Select Plan

BENEFITS AND COVERAGE	TEAMSTERS DIRECT PAY PLAN	
	Select Plan	
	BLUE CROSS	NON-BLUE CROSS
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
Ambulance per Trip	80%	50% ¹
Emergency Room	80%	50% ¹
100% (PPO only) after \$10,000 in covered expenses incurred each calendar year (PPO only)		
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
100% after \$10,000 in covered expenses incurred each calendar year (PPO only).		
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.