

Northern California General Teamsters Security Fund	
PLAN E HSA PLAN	
PPO MEDICAL PLAN <i>Annual Deductible</i> <i>Annual Out-of-Pocket Maximum</i> <i>Annual Benefit Maximum</i>	Blue Shield PPO Network \$1,250 per person / \$2,500 per family \$2,500 per person / \$5,000 per family for PPO Providers (No out-of-pocket maximum for non-PPO providers) Unlimited
<i>Annual Deductible applies to Medical and Prescription Drugs. The Annual Out-of-Pocket Maximum includes the deductible and applies to both Medical and Prescription coverage.</i>	
Hospital Benefits <i>Blue Shield PPO</i> <i>Non-PPO Hospital</i> <i>Inpatient Mental Health/Substance Abuse</i> <i>Emergency Room</i> <i>Skilled Nursing Facility</i>	100% Inpatient & Outpatient after deductible met 50% Inpatient & Outpatient after deductible met 100% PPO/ 50% Non-PPO 100% after deductible met, for emergency so serious it demands immediate action or person's life would be in danger/serious harm would be caused 100% to a maximum of 120 days per disability period
Medical Benefits* <i>Blue Shield PPO</i> <i>Doctor Visits</i> <i>X-Ray and Lab</i> <i>Ambulance</i> <i>Surgeon & Related Services</i> <i>Outpatient Mental Health</i> <i>Drug & Substance Abuse</i> <i>Chiropractic</i> <i>Physical Therapy</i> <i>Hearing Aid / Testing</i> Preventive Care Benefits <i>(as recommended per AMA Guidelines: Well Woman Care, Well Child Care, Immunizations, Routine Physical Exams)</i>	80% after deductible met, then 100% after out-of-pocket maximum is met. Payable as Medical* Payable as Medical* Payable as Medical* Payable as Medical* Payable as Medical* Payable as Medical* Payable as Medical* - \$1,500 calendar year maximum Payable as Medical* - 24 visits calendar year maximum Payable as Medical* - \$800 in 3 year period maximum 100% Benefit at PPO Providers; not subject to deductible No benefit at non-PPO providers
PPO PRESCRIPTION DRUGS <i>Retail – 34 day supply</i> <i>Mail – 100 day supply</i>	Generics: 80% after deductible; 100% after out-of-pocket is met Brand: 70% after deductible; 100% after out-of-pocket is met
PPO DENTAL PLAN <i>(Dental Plan determined by CBA)</i> <i>Deductible</i> <i>Percentage Payable*</i> <i>Maximum</i> <i>Orthodontia</i>	Blue Cross PPO Dental Network* Standard Plan No Deductible 80% Preventive 70% Restorative 50% Prosthodontic \$1,500 per person per calendar yr 70% up to \$1,000 max lifetime Enhanced Plan No Deductible 80% Preventive 80% Restorative 80% Prosthodontic \$1,500 per person per calendar yr 70% up to \$1,000 max lifetime
*Dental benefits are paid based on the Blue Cross allowance for PPO providers. If you choose to go to a non-PPO dental provider, dental benefits will be paid based on Usual, Customary & Reasonable (UCR).	
PPO VISION PLAN <i>Deductible</i> <i>Benefit Schedule</i>	Provided through Vision Service Plan \$10 Co-Pay per office visit Exams - 12 months Frames - 24 months Lenses - 24 months Contacts - 24 months in lieu of lenses/frames, \$130 in-network allowance
EMPLOYEE LIFE	\$10,000 Basic plus \$10,000 AD&D

*Non-PPO Medical benefits are payable at 50% of usual, customary and reasonable allowance, unless emergency or otherwise indicated.
This is a brief summary of benefits for illustrative purposes only.