Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund
Plan ZR Schedule of Benefits
As of April 1, 2025

All inpatient stays, DME over $1000, and outpatient drug infusions over $15,000 require pre-certification by HealthLink. To request pre-certification, call 877-284-0102. For a complete listing of admissions/procedures requiring pre-certification, visit the Fund's website at www.tjc83funds.org/precertification.asp.

BENEFIT	PLAN ZR	SUBJECT TO
Hospitalization 90 cumulative days per person per calendar year (inpatient) You or your provider must call HealthLink prior to any elective admission and within 2 calendar days of any emergency inpatient hospital admission.		
In-Network- inpatient Hospital charges for room/board and necessary services and supplies	90% of allowable amount	CI, DED, OOP, LM
In-Network - outpatient For services performed in the hospital, not covered by any other benefit	80% of allowable amount	
Out-of-Network – inpatient Hospital charges for room/board and necessary services and supplies	90% of allowable amount	
Out-of-Network – outpatient For services performed in the hospital, not covered by any other benefit	70% of allowable amount	
Surgery		
In-Network (inpatient or outpatient)	90% of allowable amount	CI, DED, OOP, LM
In Network Colonoscopy (outpatient only)	100% of allowable amount	LM
Out-of-Network (inpatient)	90% of allowable amount	CI, DED, OOP, LM
Out-of-Network (outpatient)	70% of allowable amount	CI, DED, OOP, LM
Prescription Drugs		
Prior Authorization is required for certain drugs. For a complete listing, visit our website at www.tjc83funds.org/prescription-drugs.asp.		CP, LM, CI
Retail – 30-day supply brand Retail – 30-day supply generic	20% coinsurance - $5 minimum $0 copay	
Mail Order Maintenance Drugs – 90-day supply Mail Order Specialty (injectable) drugs – 30-day supply	$0 copay generic/$45 copay brand $45 copay brand	
Doctor Visit • One copay per person per date of service. (Higher copay applies when specialist is seen.)		
In-Network: • Copay covers all charges billed by the doctor's office, including x-ray, lab, drugs, (i.e., chemotherapy, allergy serum), administration of injections (excluding allergy injections).	$25 copay for charges incurred at family or general practitioner, pediatrician, internal medicine or urgent care center (e.g., Patient First) $50 copay for charges incurred at specialist	CP, LM
Out-of-Network	70% of allowable amount	CI, DED, OOP, LM
Imaging		
In-Network (inpatient or outpatient)	90% of allowable amount	CI, DED, OOP, LM
Exceptions (only apply to in-network/outpatient services): EKG Bone Density (medical guidelines only) Mammography (routine)	100% of allowable amount	LM
Out-of-Network (inpatient or outpatient)	90% of allowable amount	CI, DED, OOP, LM

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

BENEFIT	PLAN ZR	SUBJECT TO
Lab		
In-Network (inpatient)	90% of allowable amount	CI, DED, OOP, LM
In-Network (outpatient)	100% of allowable amount	LM
Out-of-Network (inpatient)	90% of allowable amount	CI, DED, OOP, LM
Out-of-Network (outpatient)	90% of allowable amount	CI, DED, OOP, LM
Annual Deductible (Not included in Out-of-Pocket Limit)		
Deductible applies to all charges incurred except dental claims, vision claims, amounts above allowable charge, lab and x-ray procedures paid at 100%, copays for doctor and emergency room visits and prescription drug claims.	Individual - $250 Family - $750	
Lifetime Maximum		
Per Person	$500,000	
Annual Out-of-Pocket Limit		
	In-Network $2,000 per person $6,000 per family Out-of-Network $6,000 per person $18,000 per family	
Emergency Room and All Related Charges		
• Copay applies whether in-network or out-of-network.	$100 copay	CP, LM
Other Allowable Major Medical Expenses		
Anesthesia (in-network)	90% of allowable amount	DED, CI, OOP, AVL, LM
Anesthesia (out-of-network)	90% of allowable amount	
Ambulance Services (in-network)	90% of allowable amount	
Ambulance Services (out-of-network)	90% of allowable amount	
Other allowable, in-network expenses (i.e., administration of allergy injections)	80% of allowable amount	
Other allowable, out-of-network expenses	70% of allowable amount	
Transplant Coverage and Follow-Up Care		
In-Network	90% of allowable amount	CI, OOP, LM, DED
Out-of-Network	70% of allowable amount	
Dental (Including TMJ)		
All Dental Services	100% of dental schedule	AM
Dental annual max	$1,900/year	
Full Time Employment After Teamsters Retirement If you are employed after retirement and the cost of purchasing insurance from your new employer is equal to or less than the monthly retiree premium charged by the Fund, you must enroll in your new employer's program, if you want insurance. Retiree coverage through the Fund would then be secondary coverage.		
Spouse of Retiree Terminated from Retiree Health Coverage When a retiree terminates their coverage, a spouse or dependent can continue coverage for up to three years unless coverage ended due to the retiree reaching age 65 or becoming eligible for Medicare.		

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