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		
In-Network - outpatient For services performed in the hospital, not covered by any other benefit	80% of allowable amount	OLDED COD IM	
Out-of-Network – inpatient Hospital charges for room/board and necessary services and supplies	90% of allowable amount	CI, DED, OOP, LM	
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 lis www.tjc83funds.org/prescription-drugs.asp .			
Retail – 30-day supply brand	20% coinsurance - \$5 minimum	CP, LM, CI	
Retail – 30-day supply generic	\$0 copay	OI , LIVI, OI	
<u>Mail Order Maintenance Drugs</u> – 90-day supply <u>Mail Order Specialty (injectable) drugs</u> – 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 special	ist 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)	100% of allowable amount	LM	
Mammography (routine) Out-of-Network (inpatient or outpatient)	90% of allowable amount	CL DED OOD IM	
Out-or-metwork (inpatient or outpatient)	90% of allowable amount	CI, DED, OOP, LM	

AM – Annual Maximum
CI – Co-Insurance
DED – Deductible
LVM – Lifetime Visit Maximum
OOP – Out of Pocket Limit
OOD – Out of Pocket Limit

Lab In-Network (inpatient) 90% of allowable amount LM Out-of-Network (outpatient) 90% of allowable amount LM Out-of-Network (inpatient) 90% of allowable amount CI, DED, OOP, 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. Lifetime Maximum Per Person \$\$500,000\$ Annual Out-of-Pocket Limit In-Network \$2,000 per person \$6,000 per family Qut-of-Network \$6,000 per person \$18,000 per family Qut-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. Other Allowable Major Medical Expenses Anesthesia (in-network) 90% of allowable amount Anesthesia (out-of-network) 90% of allowable amount Anbulance Services (in-network) 90% of allowable amount Ambulance Services (out-of-network) 90% of allowable amount Transplant Coverage and Follow-Up Care Transplant Coverage and Follow-Up Care In-Network 90% of allowable amount CI, OOP, AVL, LM All Dental Services 100% of deltal schedule Dental (Including TMJ) All Dental Services 100% of deltal schedule Dental annual max \$1,900/year	BENEFIT	PLAN ZR	S UBJECT T O
In-Network (outpatient)	Lab		
Out-of-Network (inpatient) Out-of-Network (outpatient) Out-of-Network (out-of-network) Out-of-Network Out-of-Network (out-of-network) Out-of-Network Out-of-Network (out-of-network) Out-of-Network (out-of-networ	In-Network (inpatient)	90% of allowable amount	CI, DED, OOP, LM
Out-of-Network (outpatient) Annual Deductible (Not included in Out-of-Pocket Limit) Deductible applies to all charges incurred except dental claims, sion claims, amounts above allowable charge, lab and x-ray procedures paid at 100%, copays for doctor and emergency room visits and prescription drug claims. Lifetime Maximum Per Person Annual Out-of-Pocket Limit In-Network	In-Network (outpatient)	100% of allowable amount	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. Lifetime Maximum Per Person \$500,000 Annual Out-of-Pocket Limit In-Network \$2,000 per person \$6,000 per family	Out-of-Network (inpatient)	90% of allowable amount	CI, DED, OOP, LM
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. Lifetime Maximum Per Person \$\$500,000 Annual Out-of-Pocket Limit In-Network	Out-of-Network (outpatient)	90% of allowable amount	CI, DED, OOP, LM
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. Lifetime Maximum Per Person \$500,000 Annual Out-of-Pocket Limit In-Network \$2,000 per person \$6,000 per family	Annual Deductible (Not included in Out-of-Pocket Limit)		
room visits and prescription drug claims. Lifetime Maximum Per Person \$500,000 Annual Out-of-Pocket Limit In-Network \$2,000 per person \$6,000 per family	vision claims, amounts above allowable charge, lab and x-ray	Individual - \$250	
Per Person \$500,000 Annual Out-of-Pocket Limit In-Network		Family - \$750	
Annual Out-of-Pocket Limit In-Network	Lifetime Maximum		
In-Network	Per Person	\$500,000	
## St. 000 per person \$6,000 per family Out-of-Network \$6,000 per person \$18,000 per person \$18,000 per person \$18,000 per family Emergency Room and All Related Charges	Annual Out-of-Pocket Limit		
## Second per person \$18,000 per family Emergency Room and All Related Charges		\$2,000 per person	
◆ Copay applies whether in-network or out-of-network. \$100 copay CP, LM Other Allowable Major Medical Expenses Power of allowable amount Power of allowable amount Anesthesia (in-network) 90% of allowable amount Power of allowable amount Ambulance Services (in-network) 90% of allowable amount Power of allowable amount Other allowable, in-network expenses (i.e., administration of allergy injections) 80% of allowable amount LM Other allowable, out-of-network expenses 70% of allowable amount CI, OOP, AVL, LM In-Network 90% of allowable amount CI, OOP, LM Out-of-Network 70% of allowable amount LM, DED Dental (Including TMJ) AM		\$6,000 per person	
Other Allowable Major Medical Expenses Anesthesia (in-network) 90% of allowable amount 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, OOP, Out-of-Network Out-of-Network 70% of allowable amount LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule	Emergency Room and All Related Charges		
Anesthesia (in-network) Anesthesia (out-of-network) Anesthesia (out-of-network) Ambulance Services (in-network) Ambulance Services (out-of-network) Other allowable, in-network expenses (i.e., administration of allergy injections) Other allowable, out-of-network expenses Transplant Coverage and Follow-Up Care In-Network Out-of-Network DED, CI, OOP, AVL, LM 80% of allowable amount 70% of allowable amount CI, OOP, LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule	Copay applies whether in-network or out-of-network.	\$100 copay	CP, LM
Anesthesia (out-of-network) Ambulance Services (in-network) Ambulance Services (out-of-network) Other allowable, in-network expenses (i.e., administration of allergy injections) Other allowable, out-of-network expenses Other allowable, out-of-network expenses Transplant Coverage and Follow-Up Care In-Network Out-of-Network Out-of-Network Out-of-Network Dental (Including TMJ) All Dental Services 90% of allowable amount CI, OOP, LM, CI, OOP, LM, DED AM	Other Allowable Major Medical Expenses		
Ambulance Services (in-network) Ambulance Services (out-of-network) Other allowable, in-network expenses (i.e., administration of allergy injections) Other allowable, out-of-network expenses Transplant Coverage and Follow-Up Care In-Network Out-of-Network DED, CI, OOP, AVL, LM 80% of allowable amount 70% of allowable amount CI, OOP, OP, Out-of-Network 70% of allowable amount CI, OOP, LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule	Anesthesia (in-network)	90% of allowable amount	
Ambulance Services (out-of-network) Other allowable, in-network expenses (i.e., administration of allergy injections) Other allowable, out-of-network expenses 70% of allowable amount Transplant Coverage and Follow-Up Care In-Network 90% of allowable amount CI, OOP, Out-of-Network 70% of allowable amount CI, OOP, LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule	Anesthesia (out-of-network)	90% of allowable amount	
Ambulance Services (out-of-network) Other allowable, in-network expenses (i.e., administration of allergy injections) Other allowable, out-of-network expenses Transplant Coverage and Follow-Up Care In-Network Out-of-Network Out-of-Network Dental (Including TMJ) All Dental Services Ambulance Services (out-of-network) 80% of allowable amount 70% of allowable amount CI, OOP, 100% of allowable amount LM, DED	Ambulance Services (in-network)	90% of allowable amount	
Other allowable, in-network expenses (i.e., administration of allergy injections) Other allowable, out-of-network expenses 70% of allowable amount Transplant Coverage and Follow-Up Care In-Network 90% of allowable amount CI, OOP, Out-of-Network 70% of allowable amount LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule	Ambulance Services (out-of-network)	90% of allowable amount	
Transplant Coverage and Follow-Up Care In-Network 90% of allowable amount CI, OOP, Out-of-Network 70% of allowable amount LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule		80% of allowable amount	
In-Network 90% of allowable amount CI, OOP, Out-of-Network 70% of allowable amount LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule	Other allowable, out-of-network expenses	70% of allowable amount	
Out-of-Network 70% of allowable amount LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule	Transplant Coverage and Follow-Up Care		
Out-of-Network 70% of allowable amount LM, DED Dental (Including TMJ) All Dental Services 100% of dental schedule	In-Network	90% of allowable amount	CI, OOP,
All Dental Services 100% of dental schedule	Out-of-Network	70% of allowable amount	
AM	Dental (Including TMJ)		
Dental annual max \$1,900/year	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.