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

Plan E

BENEFITS AND COVERAGE	TEAMSTERS DIRECT PAY PLAN PLAN E[1] BLUE CROSS	TEAMSTERS DIRECT PAY PLAN PLAN E[1] NON-BLUE CROSS	KAISER FOUNDATION HEALTH PLAN	ANTHEM BLUE CROSS HMO
HEALTH				
Maximum Annual Benefit	Unlimited	Same	Unlimited	Unlimited
Annual Deductible:				
Per Individual	$250	$250	None	None
Family maximum	$500	$500		
HOSPITAL				
Daily Room and Board	Semi-private	Semi-private	No charge	No charge
Other Hospital Charges	80%	50%[2]	No charge	No charge
Ambulance per Trip	80%	50%[2]	No charge within area when authorized by Plan physician	No charge if approved by PMG or IPA
Emergency Room	80%	50%[2]	$35 copay; waived if admitted	$50 copay; waived if admitted
100% (PPO only) after $10,000 in covered expenses incurred each calendar year (PPO only)				
PHYSICIAN'S SERVICES				
Outpatient and Inpatient Services	80%	60%[2]	$15 (outpatient)	$15 (outpatient)
Surgical	80%	60%[2]	No charge	No charge
Lab/X-Ray	80%	60%[2]	No charge	No charge
Home Health and Hospice	80%	60%[2]	$15	No charge
100% after $10,000 in covered expenses incurred each calendar year (PPO only).				
SPECIAL				
Physical Exams	100%	Not covered	No charge	No charge
Well Baby Care	100%	Not covered	No charge	No charge
Conversion Coverage	Not available	Not available	Available if requested	Available if requested
PRESCRIPTION DRUG BENEFIT				
Copay per Rx	$10 generic, $20 brand name	$10 generic, $20 brand name	$10 generic, $20 brand	$10 generic, $20 brand

[1] Plans determined by Collective Bargaining Agreement, Enrollment choices are for carrier, which are Teamsters Direct Pay, Kaiser and United Healthcare.
[2] The plan's UCR (Usual, Customary and Reasonable) allowance.