



**CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE FUND**

PLAN PL BENEFIT SUMMARY

*The following is a summary of the Health and Welfare benefits offered under the MM200 program - Plan PL.
For further information, including a full Summary Plan Description, please visit the Fund's website at www.centralstates.org*

MAJOR MEDICAL BENEFITS

All amounts payable shown are for covered Medical Services after meeting the Annual Deductible and are subject to Reasonable and Customary limitations.

- Annual Plan Maximum** ■ \$500,000 per person, per year
- Annual Deductible** ■ \$200 per Individual; \$500 per Family
- Annual Out-of-Pocket Expense Limit** ■ \$2,500 per Individual; \$5,000 per Family in non-deductible Covered Charges

- Hospital Expense** ■ After Plan Deductible, 80% of Semi-Private Room Rate, then 100% after Out-of-Pocket Expense Limit is met. No Maximum Day Limit.

- Surgery and Obstetrical** ■ After Plan Deductible, 80%, then 100% after Out-of-Pocket Expense Limit is met.

- Outpatient Diagnostic X-Ray and Laboratory** ■ After Plan Deductible, 80%, then 100% after Out-of-Pocket Expense Limit is met.

- Ambulance Expense Benefit** ■ After Plan Deductible, 80%, then 100% after Out-of-Pocket Expense Limit is met.

- Outpatient Accidental Injury** ■ After Plan Deductible, 80%, then 100% after Out-of-Pocket Expense Limit is met.

- Hearing Aid Benefit** ■ After Plan Deductible, Maximum \$2,000 for two (2) Aids every 36 months.

- Chiropractic Expense** ■ After Plan Deductible, 50%. Maximum \$500 per person per calendar year. Out-of-Pocket Expense Limit does not apply.

- Psychiatric, Drug Abuse and Alcoholism Treatment - Inpatient** ■ After Plan Deductible, 80% of Covered Charges. Out-of-Pocket Expense Limit does not apply. Maximum 13 Days per person per calendar year; Maximum 26 Days per person Lifetime.

- Psychiatric, Drug Abuse and Alcoholism Treatment - Outpatient** ■ After Plan Deductible, 80% of Covered Charges. Out-of-Pocket Expense Limit does not apply. Maximum 30 Visits per person per calendar year.

- TeamCare PPO Physician Office Visit** ■ \$20 member co-payment is due at time of visit

- TeamCare Wellness Benefit - Adult** ■ For covered dependents Age 18 and older, a \$20 TeamCare office visit co-payment covers an Annual Physical Exam in full. Additionally, after Plan Deductible, routine screening tests and procedures are covered at 80%. Maximum \$1,000 per person per calendar year. A TeamCare physician must be used.

- TeamCare Wellness Benefit - Child** ■ For covered dependents through Age 6, a \$20 TeamCare office visit co-payment covers Well Child Exams in full and Immunizations at 100%. A TeamCare physician must be used.

- Out-of-TeamCare-Network Benefits** ■ Non-emergency care outside the TeamCare network will result in a 10% reduction in payable benefits by the Plan.

SHORT-TERM DISABILITY (Member Only)

Also referred to as Loss of Time

- \$300 per week for the first 10 weeks, \$350 per week for the next 16 weeks. Maximum 26 weeks. **Includes** continued coverage while on Short-Term Disability.

PRESCRIPTION DRUGS (TeamCareRx)

If a generic equivalent of a brand name drug is available, the member must take the generic or be responsible for the cost difference. Additionally, by the third fill, long-term maintenance medications must be filled through the Mail Order Program or be subject to a 50% co-pay if filled through the Retail Card program.

- 75%; Under Retail Card program, insured pays 25% co-pay
- 80%; Under Mail Order program, insured pays 20% co-pay
- Member's maximum expense is capped at \$200 per prescription.
- Out-of-Pocket Expense Limit does not apply.

DENTAL BENEFITS		VISION BENEFITS		LIFE INSURANCE		
Annual Max Per Person	\$1,500	Eye Exam	\$25	Members can also use TeamCare Vision where at preferred providers, insured pays a co-payment and receives spectacle exam, lenses and frames (up to \$100 retail value) or contacts (up to \$80 retail value).	Member	\$50,000
Preventive Services	100%	Frames	\$30		Accidental	\$50,000
Diagnostic	85%	Single	\$30		Spouse	\$ 4,000
Restorative	85%	Bi-Focals	\$40		Dependents	\$ 2,000
Crown/Bridge Work	70%	Tri-Focals	\$50		TPD / Waiver	\$16,000
Dentures (Full or Partial)	70%	Lenticular	\$60		(Member Only)	
Orthodontic, to Age 18 Only	50% to \$1,000	Contacts	\$60			
	Lifetime Max					

The Plan Deductible and Out-of-Pocket Expense Limit does not apply to Dental, Vision and Life Insurance Benefits.
Dental, Vision and Life Insurance Benefits are provided on covered dependent children through age 18 only.