

TEAMSTERS LOCAL 14 BENEFIT COMPARISON

TEAMSTERS LOCAL 14 IS PLEASED TO OFFER TWO DIFFERENT MEDICAL PLAN OPTIONS TO CHOOSE FROM -
AN INDEMNITY PLAN AND AN HMO PLUS PLAN

	TEACHERS HEALTH TRUST DIAMOND PLAN		TEACHERS HEALTH TRUST PLATINUM PLAN		TEAMSTERS INDEMNITY PPO PLAN		TEAMSTERS HMO PLUS PLAN		
Benefits	PPO (In Network) Providers	Non-PPO (Out of Network) Providers	PPO (In Network) Providers	Non-PPO (Out of Network) Providers	Teamsters Local 14 Indemnity PPO Plan	Teamsters Local 14 Indemnity Non-PPO Plan	Teamsters 14 Health Plan of Nevada Tier I (HMO)	Teamsters 14 Health Plan of Nevada Tier II (PPO)	Teamsters 14 Health Plan of Nevada Tier III (Non-Plan Provider)
Deductibles									
Calendar Year Deductible (CYD)	\$0 per individual	\$1,500 per individual	\$0 per individual	\$2,500 per individual	\$250 per individual, maximum of \$750 per family	\$500 per individual, maximum of \$1,500 per family	No calendar year deductible	\$500 per Member \$1500 per Family	combined Tier 2 and 3
Inpatient Admission	\$150 per day up to \$450 per admission	\$150 per day up to \$900 per admission	\$300 per day up to \$900 per admission	\$150 per day up to \$450 per admission	\$100 per admission	\$1,000 per admission	No hospital deductible	After CYD, Member pays 20% of EME	After CYD, Member pays 40% of EME plus all charges in excess of EME
Out of Pocket Maximum									
Individual	\$5,000	No out of pocket maximum for non-PPO providers	\$10,000	No out of pocket maximum for non-PPO providers	\$500 plus deductibles & applicable copays	No out of pocket maximum for non-PPO providers	Not applicable	\$2,000 EME per Member after CYD	\$4,000 EME per Member after CYD
Family	No Family Cap	No Family Cap	No Family Cap	No Family Cap	\$1,500 plus deductibles & applicable copays	No out of pocket maximum for non-PPO providers	Not applicable	\$6,000 EME per Family after CYD	\$12,000 EME per Family after CYD
Physician Office Visits									
Primary Care	\$20 per visit	Member pays 30% of allowable cost	\$30 per visit	Member pays 30% of allowable cost	\$10 office visit copay	50% of UCR after deductible	\$15 office visit copay	\$30 office visit copay	After CYD, Member pays 40% of EME plus all charges in excess of EME
Specialists	\$20 per visit	Member pays 30% of allowable cost	\$30 per visit	Member pays 30% of allowable cost	\$15 office visit copay	50% of UCR after deductible	\$30 office visit copay	\$45 office visit copay	After CYD, Member pays 40% of EME plus all charges in excess of EME
Chiropractic Care	\$20 per visit	Member pays 30% of allowable cost	\$30 per visit	Member pays 30% of allowable cost	\$15 office visit copay up to \$500 per calendar year	50% of UCR after deductible	\$30 office visit copay	\$45 office visit copay	After CYD, Member pays 40% of EME plus all charges in excess of EME

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Well Baby Care Primary Care	0-6 years \$20 office visit copay then 100%	0-6 years Member pays 30% of allowable cost	0-6 years \$30 office visit copay then 100%	0-6 years member pays 30% of allowable cost	0-12 months \$10 office visit copay	0-12 months 50% of UCR after deductible	\$15 office visit copay	\$30 office visit copay	After CYD, Member pays 40% of EME plus all charges in excess of EME
Specialists	\$20 office visit copay then 100%	Member pays 30% of allowable cost	\$30 office visit copay then 100%	member pays 30% of allowable cost	\$15 office visit copay	50% of UCR after deductible	\$30 office visit copay	\$45 office visit copay	After CYD, Member pays 40% of EME plus all charges in excess of EME
Routine Mammogram	\$20 office visit copay then 100%	Member pays 30% of allowable cost	\$30 office visit copay then 100%	Member pays 30% of allowable cost	\$15 per procedure, limited to once per calendar year	50% of UCR after deductible	\$15 office visit copay	Member pays 20% of EME. Not subject to CYD. Maximum benefit applies.	Member pays 40% of EME. Not subject to CYD. Maximum benefit applies.
Routine Pap Smear	\$20 office visit copay then 100% up to \$300	Member pays 30% of allowable cost	\$30 office visit copay then 100% up to \$300	Member pays 30% of allowable cost	\$10 office visit copay	50% of UCR after deductible	\$15 office visit copay	\$30 office visit copay	After CYD, Member pays 40% of EME plus all charges in excess of EME
Outpatient Diagnostic Lab, X-Ray & Allergy Testing									
Allergy Testing/Allergy Injections	\$20 office visit copay, then \$1 per test/\$5 per injection	Member pays 30% of allowable cost	\$30 office visit copay, \$2 per test/\$10 per injection	Member pays 30% of allowable cost	\$15 per visit copay	50% of UCR after deductible	\$15 office visit copay	\$45 office visit copay	After CYD, Member pays 40% of EME plus all charges in excess of EME
Routine X-Ray	\$10 per test	Member pays 30% of allowable cost	\$20 per test	Member pays 30% of allowable cost	\$15 per test copay	50% of UCR after deductible	\$15 office visit copay	\$15 office visit copay	After CYD, Member pays 30% of EME
Lab	\$0 per test if performed by Quest/\$10 if performed by other provider	Member pays 30% of allowable cost	\$0 per test if performed by lab/\$15 if performed by other provider	Member pays 30% of allowable cost	\$15 per facility copay	50% of UCR after deductible	\$15 office visit copay	\$15 office visit copay	After CYD, Member pays 40% of EME
Ambulance	Member pays 20% of allowable cost	Member pays 20% of allowable cost	Member pays 30% of allowable cost	Member pays 30% of allowable cost	\$50 per trip	\$50 per trip	\$50 per trip	\$50 per trip	\$50 per trip

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Emergency Services/Urgent Care	\$100 copay for emergency room visit; \$20 copay per visit for urgent care	Deductible waived, member pays 30% of allowable cost	\$200 copay for emergency room visit; \$30 copay per visit for urgent care	Deductible waived, member pays 30% of allowable cost	Emergency: \$25 emergency room visit copay; \$25 emergency room physician copay. Emergency must be life threatening or due to an accident. Otherwise, a \$75 maximum benefit applies. Urgent Care: \$15 per visit copay	Emergency: Treatment covered at 90% of UCR after deductible. Follow up care paid at 50% of UCR Urgent Care: 50% of UCR after deductible	Emergency: <i>Within Service Area:</i> Physician \$25 per visit, Emergency Room \$50 per visit <i>Outside Service Area:</i> Physician's Services \$50 per visit Emergency Room \$75 per visit Urgent Care: <i>Within Service Area:</i> \$20 per visit <i>Outside Service Area:</i> \$40 per visit	Emergency and Urgent Care services are covered under the HMO-Tier I benefit	Emergency and Urgent Care services are covered under the HMO-Tier I benefit
Hospital Inpatient Services									
Hospital Admission & Room and Board	\$150 per day up to \$450 per admission	\$150 per day up to \$900 per admission	\$300 per day up to \$450 per admission	\$300 per day up to \$900 per admission	\$100 deductible per admission, 90% of next \$5,000 then 100%	50% of UCR after deductible	\$400 per admission	After CYD, Member pays 20% of EME	After CYD, Member pays 40% of EME plus all charges in excess of EME
Surgical Services									
Surgeon	\$125 per surgical session	Member pays 30% of allowable cost	\$250 per surgical session	Member pays 30% of allowable cost	\$50 copay per procedure	50% of UCR after deductible	\$100 per surgery	After CYD, Member pays 20% of EME	After CYD, Member pays 40% of EME plus all charges in excess of EME
Assistant Surgeon*	\$125 per surgical session	Member pays 30% of allowable cost	\$250 per surgical session	Member pays 30% of allowable cost	No copay	50% of UCR after deductible	No copay	After CYD, Member pays 20% of EME	After CYD, Member pays 40% of EME plus all charges in excess of EME
Anesthesia	\$100 per surgical session	Member pays 30% of allowable cost	\$150 per surgical session	Member pays 30% of allowable cost	\$100 copay	50% of UCR after deductible	\$150 per surgery	After CYD, Member pays 20% of EME	After CYD, Member pays 40% of EME plus all charges in excess of EME

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Obstetrical Care	\$150 copay per day up to \$450 per admission	Member pays 30% of allowable cost	\$300 coalmen per day up to \$900 per admission	Member pays 30% of allowable cost	\$100 copay	50% of UCR after deductible	Office visit: \$15 per visit Physician Inpatient copay: \$100 Hospital copay: \$400 per admission	Office visit: \$30 per visit, Physician Inpatient and Hospital Charges: 20% of EME	After CYD, Member pays 40% of EME plus all charges in excess of EME	
Health Improvement Benefit	Up to \$50 for health club memberships, tobacco prevention counseling, weight management and personal training.	Up to \$50 for health club memberships, tobacco prevention counseling, weight management and personal training.	Up to \$50 for health club memberships, tobacco prevention counseling, weight management and personal training.	Up to \$50 for health club memberships, tobacco prevention counseling, weight management and personal training.	No	No	Yes	Yes	Yes	
Lifetime Maximum Benefit Per Individual	\$2,000,000 (medical and pharmacy combined)	\$2,000,000 (medical and pharmacy combined)	\$2,000,000 (medical and pharmacy combined)	\$2,000,000 (medical and pharmacy combined)	\$2,000,000	\$2,000,000	Unlimited	\$2,000,000 of EME		
							EME (Eligible Medical Expenses) means the maximum amount the Plan will pay for a Covered Service in accordance with the Plan Reimbursement Schedule.			

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Prescription Drugs										
<i>Retail</i>							<i>Prescription drug copays apply across all tiers</i>			
Generic	\$0	\$1,500 deductible; then member pays 30% of allowable amount up to \$2,500 calendar year maximum benefit.	\$0	\$2,500 deductible; then member pays 30% of allowable amount up to \$2,500 calendar year maximum benefit.	\$5 copay	Not Covered	\$7 copay			
Brand - Formulary	\$25	\$1,500 deductible; then member pays 30% of allowable amount up to \$2,500 calendar year maximum benefit.	\$30	\$2,500 deductible; then member pays 30% of allowable amount up to \$2,500 calendar year maximum benefit.	20% co-insurance (min. \$20 copay)	Not Covered	Preferred Brand (without a generic equivalent): \$15 copay	Preferred Brand (with a generic equivalent): \$7 copay		
Brand - Non Formulary	\$40	\$1,500 deductible; then member pays 30% of allowable amount	\$45	\$2,500 deductible; then member pays 30% of allowable amount	45% co-insurance (min. \$45 copay)	Not Covered	\$40 copay			
<i>Mail Order</i>										
Generic	\$0	N/A	\$0	N/A	\$0 copay	Not Covered	\$14 copay for 90 day supply			
Brand - Formulary	\$50	N/A	\$60	N/A	\$30 copay	Not Covered	\$30 copay for 90 day supply			
Brand - Non Formulary	\$80	N/A	\$90	N/A	\$60 copay	Not Covered	Not available			
Dental	Diversified Dental									
Annual Maximum Calendar Year Deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible	\$2,000 per individual No deductible
Coinsurance Rate	Plan pays 100% of contracted rate for preventive services; 80% of contracted rate for basic services; and 60% for major services.	Plan pays 100% of UCR for preventive services; 80% of UCR for basic services; and 60% of UCR for major services.	Plan pays 100% of contracted rate for preventive services; 80% of contracted rate for basic services; and 60% for major services.	Plan pays 100% of UCR for preventive services; 80% of UCR for basic services; and 60% of UCR for major services.	Plan pays 100% of UCR for preventive services; 80% of UCR for basic services; and 60% of UCR for major services.	Plan pays 80% of contracted fee schedule for covered dental services	Plan pays 80% of contracted fee schedule for covered dental services	Plan pays 80% of contracted fee schedule for covered dental services	Plan pays 80% of contracted fee schedule for covered dental services	Plan pays 80% of contracted fee schedule for covered dental services
	Dental - Nevada Pacific				Dental - Nevada Pacific		Dental - Nevada Pacific			
Annual Maximum Calendar Year Deductible	Not available	Not available	Not available	Not available	None	None	None	None	None	None
Coinsurance Rate	Not available	Not available	Not available	Not available	No deductible	No deductible	No deductible	No deductible	No deductible	No deductible
	Not available	Not available	Not available	Not available	Varies by procedure	Varies by procedure	Varies by procedure	Varies by procedure	Varies by procedure	Varies by procedure

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Vision									
Vision Exam	\$20 copay, then one every calendar year	Subject to schedule	\$20 copay, then one every calendar year	Subject to schedule	\$15 copay, then one every 12 months	\$15 copay, then one every 12 months	\$15 copay, then one every 12 months	\$15 copay, then one every 12 months	\$15 copay, then one every 12 months
Lenses	Either one pair of lenses for glasses or one pair of contact lenses per calendar year	Subject to schedule	Either one pair of lenses for glasses or one pair of contact lenses per calendar year	Subject to schedule	One pair every 12 months	One pair every 12 months	One pair every 12 months	One pair every 12 months	One pair every 12 months
Frames	One frame every other calendar year	Subject to schedule	One frame every other calendar year	Subject to schedule	One set every 24 months (up to \$115)	One set every 24 months (up to \$115)	One set every 24 months (up to \$115)	One set every 24 months (up to \$115)	One set every 24 months (up to \$115)

SUMMARY ONLY - NOT A GUARANTEE OF BENEFITS

† not see assistant surgeon listed separately. Assuming same as surgeon benefit.