Northern California General Teamsters Security Fund
SELECT PLUS PLAN

PPO MEDICAL PLAN	Anthem Blue Cross Prudent Buyer Network
Deductible	No Deductible
Annual Medical Out of Pocket Max	$1,000 per person / $2,000 per family for PPO Providers (includes copays and coinsurance)
Hospital Benefits	
Hospital Facility Charges	100% PPO Inpatient & Outpatient / 50% Non-PPO Facilities
Emergency Room	$100 Co-Pay, then 100%. Copay is waived if admitted
Outpatient Surgery Center	100% PPO / Not covered at Non-PPO Facilities
Mental Health/Substance Abuse (TARP)	100% PPO / 50% Non-PPO
Skilled Nursing Facility	100% to a maximum of 120 days per disability period
Preventive Care Benefits	100% Benefit at PPO Providers only / No benefit at Non-PPO Providers
Medical Benefits*	
Primary Care Office Visits Includes Family Practice, General Practice, Internal Medicine, OB/GYN, and Pediatric office visits	$20 Co-Pay per primary care visit
All Other PPO Providers	80% Benefit to Out of Pocket Max, then 100% benefit
Specialists and Urgent Care	Payable as Medical*
X-Ray and Lab	Payable as Medical*
Ambulance	Payable as Medical*
Surgeons/Anesthesiologists	Payable as Medical*
Outpatient Mental Health	Payable as Medical*
Alcohol & Substance Abuse	Payable as Medical*
Blood Screening	100% Benefit thru WellnessFx
Telemedicine	100% Benefit thru PlushCare
Chiropractic	Payable as Medical* - $1,500 calendar year maximum
Physical, Speech, Occupational Therapies	Payable as Medical* - 24 visits per year maximum

**Non-PPO Medical benefits are payable at 50% of reasonable allowance, unless emergency or otherwise indicated.*

PPO PRESCRIPTION DRUGS *(WellDyne)*	Retail Co-Pay per 30 day Supply	Mail Order Co-Pay per 100 day Supply
	$10 Generics	$20 Generics
	$20 Formulary	$40 Formulary
	$40 Non-Formulary	$80 Non-Formulary
	$50 Specialty Medications	$100 Specialty Medications

PPO VISION PLAN *(VSP)*	Provided through Vision Service Plan
Deductible	$10 Co-Pay
Benefit Schedule	Exams 12 months Frames 24 months Lenses 24 months Contacts 24 months (in lieu of frames/lenses)
Optional HMO	Kaiser Permanente (where available)
Medical / Prescription Drug / Vision	See enclosed Kaiser Benefit Summary

DENTAL PLAN OPTIONS	**PPO DENTAL PLAN**	**CYPRESS DHMO***	**NEWPORT DHMO***
Deductible	No Deductible	No Deductible	No Deductible
Percentage Payable	100% Preventive 80% Restorative 50% Prosthodontic	100% of eligible services	100% of eligible services
Maximum Dental Benefit	$2,000 per person/cal year	None	$1,500/Specialty care
Orthodontia	70%; $1,000 lifetime maximum	$1,970 child / $2,170 adult (co pays); 24 mos of treatment; once per lifetime	70% up to $2,000 off of discounted fees

NOTE: PPO Dental benefits are paid based on the Cypress Dental allowance for PPO providers. If you choose to go to a non-PPO dental provider, dental benefits will be paid based on Usual, Customary & Reasonable (UCR). If you elect the Cypress or Newport DHMO, you must go to a DHMO provider. There is no benefit if you go to a provider outside of the Network.

EMPLOYEE LIFE	$10,000 Life Insurance and $10,000 AD&D