Teamsters Local 830 Health & Welfare Fund
Coverage Snapshot: PepsiCo (ENHA, R3, D1, V1)

Medical Plan: ENHANCED	Your Costs: In-Network	Your Costs: Out-of-Network
Benefits per Contract Year (9/1)		
Deductible (Embedded)[1]	$500 Individual/$1,500 Fam	$5,000 Ind/$10,000 Fam
Out-of-Pocket Maximum (Embedded)[2]	$5,000 Ind/$10,000 Fam	$50,000 Ind/$100,000 Fam
Coinsurance	0%	50%
Preventive Care	No charge no deductible	50% no deductible
PCP Office Visit/Telemedicine/Clinic	$15 no deductible	50% after deductible
Specialist Office/Telemedicine	$45 no deductible	50% after deductible
Urgent Care	$125 no deductible	50% after deductible
Physical Therapy/Occupational Therapy (maximum 30 visits per year combined.)[3]	$35 no deductible	50% after deductible
Speech Therapy (maximum 20 visits per year)	$35 no deductible	50% after deductible
Emergency Room (copay waived if admitted)	$250 no deductible	Covered at In-Network level
Emergency Ambulance	$50 no deductible	Covered at In-Network level
Non-Emergency Ambulance	$50 no deductible	50% after deductible
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[4]	No charge after deductible (applicable to facility charges only)	50% after deductible
Observation Services	$250	50% after deductible
Outpatient Surgery	No charge after deductible (applicable to facility charges only)	50% after deductible
Diagnostic Medical (X-Ray/EKG)	$25 no deductible	50% after deductible
Advanced Imaging (MRI/MRA/CT/CTA Scans/PET Scan)	$50 no deductible	50% after deductible
Lab and Pathology	No charge no deductible	50% after deductible
Spinal Manipulations (maximum 20 visits/year)	$35 no deductible	50% after deductible
Standard/Allergy Injections	No charge no deductible	50% after deductible
Biotech/Specialty Injections	$75 no deductible	50% after deductible
Chemotherapy/Dialysis	No charge no deductible	50% after deductible
Skilled Nursing Facility (In-Network 120 days/year. Out-of-Network: 60 days/year)	$150/Day; max of 5 copays per admission no deductible	50% after deductible
Home Health	$20 no deductible	50% after deductible
Hospice	No charge no deductible	50% after deductible
Durable Medical Equipment (DME)	15% no deductible	50% after deductible
Mental Health – Outpatient	$45 no deductible	50% after deductible
Mental Health – Inpatient	No charge	50% after deductible

1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

3 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.

4 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

SEE OTHER COVERAGE ON REVERSE SIDE

Teamsters Local 830 Health & Welfare Fund
Coverage Snapshot: PepsiCo (ENHA, R3, D1, V1)

Prescription Drug Plan: Rx3
Offered by Benecard PBM
Plan Year: September 1st through August 31st (Out-of-Pocket Maximum)

	Your Costs: In-Network
Deductible	None
Out-of-Pocket Maximum	$1,250 Individual/$2,500 Family
Generic Medications	20% min $10 (up to 30-day supply)/20% min $25/max $50 (up to 90-day supply)
Preferred Brand Medications	20% min $20/max $100 (up to 30-day supply)/20% min $55/max $100 (up to 90-day supply)
Non-Preferred Brand Medications	50% (30-day or 90-day supply)[1]
Approved Specialty Medications	Standard copays for preferred. $150 for non-preferred[2]

1 If Medical Necessity is demonstrated, Preferred Brand copay will apply.

2 Approved specialty generic medications are available through the plan at standard copays. Clinically appropriate high-cost specialty medications are available through the plan at 100% patient copay. The plan has implemented a specialty pharmacy copay assistance program to better manage the cost of these expensive medications. Patients must apply for financial assistance through BeneCard PBF's copay assistance program at 1-888-907-2820 to receive specialty brand and qualified generic medications at a reduced cost. If you qualify for financial assistance, you will pay $0 for a 30 or 90-day supply and the medication will be dispensed via the funding source. Copays for certain specialty medications may be set to the max of the current plan design or any available manufacturer-funded copay assistance.

Dental Plan: Trust Dental
Offered by Louis P Mattucci & Associates PPO
Plan Year: June 1st through May 31st
Maximum Annual Benefit: $2,000/Lifetime Orthodontia Benefit: $4,700
Out-of-Network Claims Reimbursed Using a Fee Schedule and Subject to Balance Billing

	Your Costs: In-Network
Fixed prosthodontics (crowns and bridges)	$30 per tooth
Removable prosthodontics (full or partial dentures)	$50 per unit
Periodontal surgery	$25 per quadrant
Endodontic surgery (root canal, etc.)	$25 per tooth
Oral surgery	$25 per tooth
Orthodontic care (age 10-18 only)	$100 per case

Vision Plan: NVA Vision
Offered by National Vision Administrators (NVA)

	Participating Provider	**Non-Participating Provider**
	Plan Pays	**Plan Pays**
Examination (every 12 months)	100%	Up to $35
Lenses (every 24 months)	100% (standard glass or plastic)	Up to $50 (single), $65 (bifocal), $80 (trifocal)
Lense Options (Anti-glare, tints, polycarbonate, progressives, etc.)	Scheduled pricing with up to $45 paid by Plan	N/A
Frame (every 24 months)	Up to $60 wholesale allowance	Up to $50
Contact Lenses (every 24 months) Fit/Follow-Up	Up to $150 retail (in lieu of lenses/frames) 100%	Up to $65 (in lieu of lenses/frames) N/A