

# Teamsters Health and Welfare Fund

*of Philadelphia and Vicinity*

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6981 NORTH PARK DRIVE, SUITE 400 • PENNSAUKEN, NJ 08109 • (856) 382-2400  
TOLL-FREE 1-800-523-2846 • FAX (856) 382-2401 • [www.teamsterfunds.com](http://www.teamsterfunds.com)

As a newly-enrolled member of our Health & Welfare Fund, we have enclosed important information about the valuable benefits provided under your Fund's benefit program. Please take the time to familiarize yourself with these materials. Included in this packet are – *(click on the blue highlighted items to navigate directly to that page)*

- The Fund's [Summary Plan Description](#) which describes, in straightforward terms, the details of what is and what is not covered by the Fund;
- A [Summary of Benefits Schedule](#) which describes the eligibility schedule, benefit amounts and benefit limits of the particular Plan in which you participate (determined by your employer's contribution rate);
- A special bulletin concerning the [Continuation of Coverage](#) provisions of the Fund's Plan, commonly known as "COBRA";
- A copy of the [Fund's Privacy Policy](#);
- A notice required under the [Women's Health and Cancer Rights Act of 1998](#);
- A [Declaration](#) that must be completed, signed and returned to the Fund office if you have a spouse covered as a dependent under the Plan;
- Information about the Fund's **Preferred Provider Organization ("PPO")** programs for [Dental](#) , [Vision](#) [Outpatient Lab](#) , [Outpatient Radiology](#) and [Diabetic Testing Supply](#) benefits. Using these providers can greatly reduce (if not eliminate) your out-of-pocket expenses for these services;
- An initial supply of [Claim Forms](#) for dental and vision benefits. Additional forms can be obtained from the Fund or your Local Union. Also enclosed are Direct Reimbursement Claim Forms to be used if you have to purchase any prescriptions before you receive your **Prescription Drug Card**. That card will be mailed to you separately in about two to three weeks. Information is enclosed regarding the [Rx Drug Formulary](#) and [Maintenance Drugs](#) available through mail order.

Additionally, you will separately receive an identification card to be used whenever you obtain any in-patient or out-patient hospital services. You have the option, as a newly eligible member, to choose to enroll in either the Horizon Blue Cross PPO medical program or the Aetna HMO program. A comparative chart of the two programs is enclosed. You are automatically enrolled in the PPO program. If you do not elect to switch to the Aetna program within the next sixty (60) days, you must wait until the next open enrollment period (generally November 1<sup>st</sup> – December 5<sup>th</sup>) to switch coverage effective the following January 1<sup>st</sup>.

As we all know, health coverage can be very complicated and confusing. For that reason, we have staffed a Member Services Department to answer any questions you may have concerning your eligibility and benefit coverage. Our representatives are standing by to help you Monday, Tuesday, Thursday and Friday, 8:00 a.m. to 5:00 p.m., with extended hours on Wednesday from 8:00 a.m. to 8:00 p.m. If you have any questions, please feel free to call us at 1-800-523-2846 or 856-382-2400.

## HOW TO USE YOUR MEDICAL BENEFITS

***Need to find a participating network provider?*** There are several ways to find the medical provider or hospital you need:

- ***Consult the PPO Directory*** - If the provider is listed in the directory, you will enjoy “in-network” benefits. When traveling outside of this area, you can still enjoy “in-network” benefits by using a PPO provider of the local Blue Cross plan. (That’s the purpose of the “suitcase” symbol with PPO inside of it.) If the provider claims that they “don’t accept that card,” tell them it’s part of the Blue Cross PPO Suitcase program and that the claims should be submitted through the local Blue Cross plan for processing. Point out the PPO logo that appears on your card, the toll free “800” number for providers (800-676-BLUE) on the back of the card, **and the instructions to providers to “submit claims to your local Blue Cross/Blue Shield Plan.”**
- ***Call 1-800-810-BLUE*** – This toll free number will put you in contact with a Blue Cross representative who can assist you in finding a convenient, qualified provider. Just tell the representative that you are a Blue Cross BlueCard subscriber and the area within which you wish to find a provider.
- ***Access the web*** – [www.bluecares.com](http://www.bluecares.com). Click on the “BlueCard Doctor and Hospital Finder,” fill in your location, choose the PPO provider option, identify the type of provider you are looking for and a list will be generated for you!

### ***Going into the hospital?***

Make the call to 1-800-664-2583 to pre-certify your hospital stay. If you are admitted through the Emergency Room or on an emergency basis – make sure to call the “800” number within 48 hours after you are admitted. The telephone numbers you will need are on the back of the card.

### ***Still have questions?***

Feel free to call the Fund’s Member Services Department at 1-800-523-2846.

### **FOR BEHAVIORAL HEALTH/SUBSTANCE ABUSE BENEFITS**

Your **Behavioral Health** benefits are coordinated through Total Care Network, **not** Horizon Blue Cross or Aetna HMO. **To obtain behavioral health benefits you must call Total Care Network at 1-800-298-2299.**

### **FOR PRESCRIPTIONS**

Present your **Express Scripts Card** to the pharmacy. **DO NOT USE YOUR BLUE CROSS PPO or AETNA HMO PROGRAM CARD FOR PRESCRIPTIONS.** If you have any problems, call the “800” number found on the back of the *prescription card*.

### **FOR DENTAL**

There is a panel of dentists that have agreed to accept the Fund’s allowances as full payment. You may use them or any dentist of your choosing. However, if you go to a non-PPO dentist, you may be responsible for some of the charges. A listing of participating dentists is available from the Fund office or may be found on the Fund’s website ([www.teamsterfunds.com](http://www.teamsterfunds.com)).

Tell the dentist that you are covered by the **TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA AND VICINITY** and claims should be sent to the Fund office at 6981 North Park Drive, Suite 400, Pennsauken, NJ 08109. The dentist can confirm your eligibility by calling 1-800-523-2846. Either the Fund's Dental Form or a universal dental claim form can be used to submit dental claims. **DO NOT USE YOUR BLUE CROSS PPO or AETNA HMO PROGRAM CARD FOR DENTAL CLAIMS.**

**REMEMBER:** There is a difference between a dentist saying that they **accept** Teamsters Insurance and **accepting our payments as payment in full**, as is the case with dentists on our Fund's PPO panel.

#### **FOR VISION SERVICES**

Tell the vision provider that you are covered by the **TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA AND VICINITY** and claims should be sent to the Fund office at 6981 North Park Drive, Suite 400, Pennsauken, NJ 08109. The provider can confirm your eligibility by calling 1-800-523-2846. The Fund's Vision Claim Form is available from the Fund office or may be found on the Fund's website ([www.teamsterfunds.com](http://www.teamsterfunds.com)). **DO NOT USE YOUR BLUE CROSS PPO or AETNA HMO PROGRAM CARD – IT DOES NOT COVER ROUTINE VISION SERVICES.**

#### **WEEKLY DISABILITY BENEFITS**

Contact the Fund office at 1-800-523-2846 to have a form sent to you. The form is also available on the Fund's website ([www.teamsterfunds.com](http://www.teamsterfunds.com)). The form must be filled out by you, the doctor and the Company and returned to the Fund office at 6981 North Park Drive, Suite 400, Pennsauken, NJ 08109.

**Still have questions?  
Feel free to call the Fund's  
Member Services Department at 1-800-523-2846.**

# Enhanced and Secure Web Access Now Available for All Members!

Ever wonder if your Employer contributed the proper amount of covered days for you? How about how much you have earned thus far towards your monthly pension at retirement? Is your Census information up-to-date? Did that claim ever get paid? Am I eligible? Under what medical plan am I covered and what is the extent of coverage?

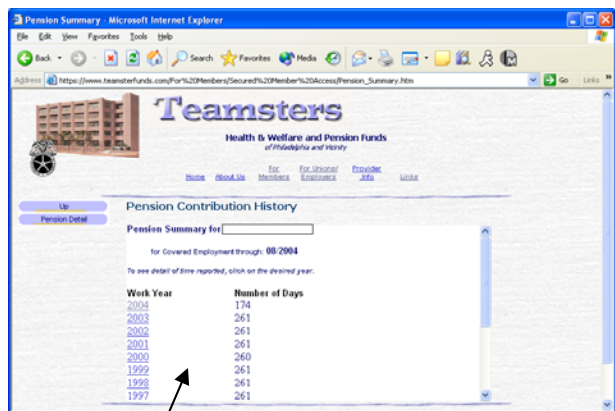
In the past, these questions could only be answered with a call or a letter to the Fund office. Not any more! Now you can register yourself on the Funds' secured web site and "click on" at anytime to obtain up-to-date information, "24/7"! Visit [www.teamsterfunds.com](http://www.teamsterfunds.com), click on "For Members" at the top of the page, then select "Secured Member Access" at the left of the screen. You will be prompted to Register, provide some identifying information and a "logon ID" of your choosing; if the proper information is provided, you will be given a system-assigned Password (that you can change at any time). After that, log on and "go surfing!"

*Having problems logging on? Just call the Funds' Member Services Department at 800-523-2846, Monday—Friday, 8 am—5 pm for assistance.*

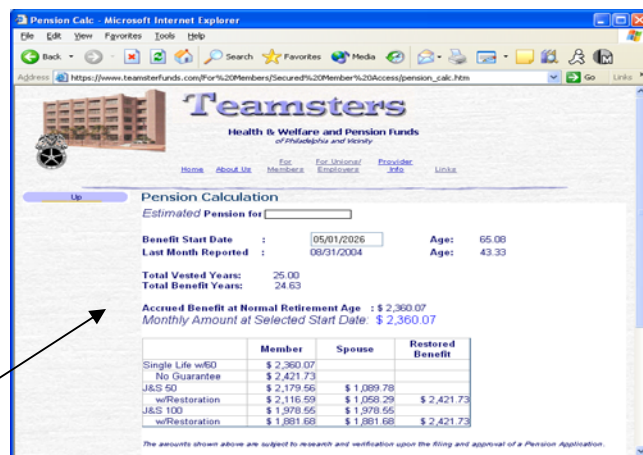


Look for the "Secured Member Access" tab in the "For Members" section of the web site

Once you're logged in, a wealth of information is available to you!



Check whether the proper number of contribution days have been remitted



Check your Pension accrual and find out what you have earned thus far and what your options would be at a given retirement date

**And much, much more!**



# **SUMMARY PLAN DESCRIPTION**

of the

**Plan of Benefits**

of the

**TEAMSTERS HEALTH  
AND WELFARE FUND**

*OF PHILADELPHIA AND VICINITY*

**Top Plan – Composite Rate  
(PPO)**

**January 2008**

This Booklet and the accompanying Summary of Benefits Schedule constitute the Fund's Plan document. This Booklet contains the Fund's complete Health and Welfare Benefit program as of the date of publication. The only benefits to which you are entitled are those stated in the Summary of Benefits Schedule which accompanies this booklet, and are determined by the rate of contribution as defined in the Collective Bargaining Agreement between your Employer and Union.

**Please note:** For those participants enrolled in the PPO Plan, your hospital and medical/ surgical benefits are those set forth in the Horizon Blue Cross/Blue Shield of New Jersey Member Handbook appended to this document. The content of that booklet is incorporated in this document by reference. For those enrolled in that program, please consult that booklet for an explanation of your benefit coverage. However, no matter which medical program you choose for you and your eligible dependents (Blue Cross PPO or Aetna HMO) certain benefits are common to all programs – dental, vision, weekly disability, death, and prescription drug benefits. These benefits are described in this booklet.

From time to time, the Fund's Trustees may amend your Plan of Benefits the details of which are set forth in this Booklet. Should that occur, the Fund routinely advises you of such changes in the Fund's newsletter or by way of special bulletins.

***The only person authorized to advise you of your rights under this Plan is the Fund Administrator, William J. Einhorn, or his specific designee.***

***Reliance upon information from any other source is at your own risk.***

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***Reach us on the Web at [www.teamsterfunds.com](http://www.teamsterfunds.com)***

Among other employees, the Health & Welfare Fund covers  
employees represented by these Teamsters Locals

Local 107    Local 312    Local 331    Local 463    Local 500    Local 628    Local 929  
Local 115    Local 326    Local 384    Local 470    Local 623    Local 676

**BOARD OF TRUSTEES**

**LABOR TRUSTEES**

Paul Cardullo, President  
I.B.T. Local 929  
4345 Frankford Avenue  
Philadelphia, PA 19124

William T. Hamilton, President  
I.B.T. Local 107  
2845 Southampton Road  
Philadelphia, PA 19154

Anthony F. Volpe, Secretary/Treasurer  
I.B.T. Local 470  
3565 Sepviva Street  
Philadelphia, PA 19134

**MANAGEMENT TRUSTEES**

Kenneth F. Leedy  
c/o Transport Employers Association  
56 Main Street, Second Floor  
Camillus, NY 13031

Bob Schaeffer, Jr., Executive Director  
Transport Employers Association  
56 Main Street, Second Floor  
Camillus, NY 13031

Tom J. Ventura, Vice-President  
YRC Worldwide, Inc  
10990 Roe Avenue  
Overland Park, KS 66211

**FUND ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS**

(Legal process may also be served upon a Trustee)

William J. Einhorn, Administrator  
Teamsters Health & Welfare Fund  
6981 N. Park Drive, Suite 400  
Pennsauken, NJ 08109

\*\*\*\*\*

Stevens & Lee, P.C.  
1818 Market Street, 29<sup>th</sup> Floor  
Philadelphia, PA 19103

**LEGAL COUNSEL**

Freedman & Lorry, P.C.  
1601 Market Street, 2<sup>nd</sup> Floor  
Philadelphia, PA 19103

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**AUDITOR**

Bond Beebe  
4600 East-West Highway, Suite 900  
Bethesda, MD 20814-3423

**PRESCRIPTION DRUG PROGRAM**

Express Scripts, Inc.  
P.O. Box 66583  
St. Louis, MO 63166

**INVESTMENT MANAGER**

SEI Investments  
One Freedom Valley Drive  
Oaks, PA 19456

**DENTAL PROGRAM CONSULTANT**

Louis P. Mattucci & Associates  
1037 Mill Creek Drive, Suite A-1  
Feasterville, PA 19053

**INVESTMENT CONSULTANT**

Courtney Investment Consulting Group  
Six Tower Bridge, Suite 500  
Conshohocken, PA 19428

**DISEASE MANAGEMENT PROGRAM CONSULTANT**

HealthCare Strategies, Inc.  
9841 Broken Land Parkway, Ste. #315  
Columbia, MD 21046

**BEHAVIORAL HEALTH PROGRAM ADMINISTRATOR**

Total Care Network  
1341 N. Delaware Avenue, Suite 403  
Philadelphia, PA 19125-4300

**HOSPITAL CLAIMS ADMINISTRATION SERVICE**

The Fund has entered into an Administrative Services arrangement with the following and its subsidiaries:  
Horizon BC/BS of NJ                      Aetna, Inc.  
Three Penn Plaza                            16 Farmington Avenue  
Newark, NJ 07105                            Hartford, CT 06156

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## TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY

6981 N. Park Drive, Suite 400  
Pennsauken, NJ 08109  
(856) 382-2400 (800) 523-2846  
[www.teamsterfunds.com](http://www.teamsterfunds.com)  
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Dear Member:

January 2008

Several years have passed since our last Benefit Booklet was published. In the intervening years, many amendments to the Plan and new types of benefit programs have been adopted by your Board of Trustees. Every effort has been made to keep you abreast of these changes either through special bulletins or notices in the Fund's newsletter, *Philadelphia Update*, which is published several times each year.

New and innovative programs have been implemented by the Fund in recent years. The "Dual Option" medical program, the Dental PPO, Vision PPO, Behavioral Health and Disease Management Programs have served as models upon which other benefit plans have relied and copied. The Fund's service agreements with Horizon Blue Cross and Horizon Blue Cross have given members what they have wanted for the longest time - a permanent identification card, good anywhere in the country - and at the same time, has streamlined hospital claim processing with significant savings to the Fund.

You can help conserve your valuable benefits by:

- Discussing fees with your physician. He or she estimates what he or she thinks you can pay. If you do not act concerned, he or she may overestimate.
- Requesting outpatient hospital care whenever possible.
- Questioning what appears to be unnecessary hospital treatment or charges as you would if you were paying the bill. Remember, your medical coverage has a lifetime limit!
- Requesting that your physician not keep you in the hospital for any longer than necessary.
- Following your physician's advice regarding steps to take care of your medical condition.
- Taking advantage of the services offered through the Fund's Disease Management program.

Take the time to read the material in this booklet. These are valuable benefits that are of critical importance to you and your family. Every effort has been made to describe your benefit coverage in easy-to-understand language. Nevertheless, health coverage is a complicated item that oftentimes does not lend itself to easily described terms and concepts. For that reason, the Fund maintains a Member Services Department staffed with highly trained personnel, well versed in the Fund's plans, and ready to answer your questions and benefit inquiries.

We hope you will agree that these are valuable benefits to be used wisely. Get the most value for each of your Fund dollars by being an *aware, informed and concerned* health benefits consumer.

Sincerely,

### THE BOARD OF TRUSTEES

Paul Cardullo, Local 929 (Union Co-Chairman)  
William Hamilton, Jr., Local 107  
Anthony F. Volpe, Local 470

Kenneth F. Leedy (Employer Co-Chairman)  
Bob Schaeffer, Jr., Transport Employers Assoc.  
Tom J. Ventura, YRC Worldwide, Inc.

## ELIGIBILITY PROVISIONS

### ELIGIBILITY

A member of the Teamsters Health and Welfare Fund of Philadelphia and Vicinity will become and remain eligible for the Benefits Program in accordance with the "Qualifying Schedule" shown in the eligibility provisions of the Summary of Benefits Schedule. It is important to consult that schedule because, depending upon the terms of the collective bargaining agreement between your Local Union and your Employer, there are different methods of determining when you become eligible for benefits and when you lose eligibility for those benefits.

A Family Member means, in addition to yourself, any one of your eligible dependents who is covered under this Plan as defined below under "Dependents." Benefits for each of your covered dependents will be determined on the same basis as for you except where noted.

### DEPENDENTS

- a. Your spouse (as defined herein), provided you are not separated (living separate and apart as defined by Pennsylvania law).
- b. Your unmarried children (including any stepchildren, adopted children or children living with you for whom you are appointed legal guardian by a court and for whom you are financially responsible) until their 19th birthday.

Dependent children will be covered for benefits up to their 23rd birthday or date of graduation (whichever occurs first) if they are enrolled as full-time students at an accredited educational institution. Proof of attendance as a full-time student must be submitted to the Fund each semester.

Any individual who is a full-time member of the Armed Forces or who is eligible for coverage as an Employee under this or any other employer-sponsored plan is not eligible to be a Dependent under this Plan.

- c. Your wholly dependent, unmarried children who are physically or mentally incapable of self-support upon attaining age nineteen (19) will continue to be covered PROVIDED you furnish the Fund office with proof of this incapacity before their coverage terminates at age nineteen (19). You should request the appropriate form from the Fund office. Thereafter, yearly certifications are required to verify the continuing nature of the dependent's handicapped status.
- d. Your wholly dependent parents, providing you are unmarried and have no other dependents and such parents are living in your household. The Fund's coverage will be secondary for parents who are eligible to apply for benefits under any medical assistance program for the aged provided by a State or the Federal Government.

**NOTE:** When both a husband and wife are covered by the Fund as eligible members, Plan deductibles and co-payments will not be taken. Beyond that, payment will be determined based upon Fund allowances (UCR, etc.) and under Coordination of Benefits (see General Provisions and Definitions section).

#### ***Change in Family Status:***

It is important that you give prompt, written, notice to the Fund office on the Census Card found in this Booklet of any change in your Family Members, such as marriage, birth of a child, death of your spouse, divorce, or separation. (Furthermore, a description of the procedures governing qualified medical child support order determinations can be obtained, without charge, from the Fund office.) Failure to report any change in your Family Members may result in a delay of payment of a claim at a future date or may adversely affect your COBRA right to continued coverage. Census Cards are always available at the Fund office or on the Fund's web site, [www.teamsterfunds.com](http://www.teamsterfunds.com). In certain situations you may be required to submit a certified copy of your most recent federal income tax return and other necessary documents in order to establish proof of dependency for a particular Family Member. Similarly, it is most important that you immediately notify the Fund of any change in your address.

## TERMINATION OF COVERAGE PROVISIONS

### **LOSS OF MEMBER ELIGIBILITY**

A member's eligibility shall automatically terminate if any of the following take place:

- a. When a member has less than the required number of days' contributions to his credit in accordance with the Qualifying Schedule of Eligibility set forth in the Summary of Benefits Schedule and does not qualify for the Extension of Benefits Provisions on the following page; or
- b. When a member ceases to be a member of a class of employees covered by his employer's Collective Bargaining Agreement with a participating Local Union, or otherwise no longer qualifies as a Member as defined herein, (except if a member leaves Covered Employment prior to retirement, he or she may continue to exhaust earned eligibility credits for a period not to exceed two (2) months); or
- c. When a member becomes self-employed outside the scope of a Collective Bargaining Agreement; or
- d. When a member enters full-time military, naval or air service; or
- e. When the benefit program is terminated; or
- f. Immediately upon the date on which any Participating Local Union and Contributing Employer(s) agree that the then Contributing Employer(s) shall no longer make contributions to the Fund.

**NOTE:** No matter what else might be written in this Booklet, a member shall not be eligible for benefits incurred during any Benefit period in which:

1. His employer is not a Contributing Employer, or
2. His employer is making contributions or payments of any kind to any party (other than this Fund) for the purpose of providing Health and Welfare benefits which duplicate in any way the benefits provided under this Fund.

### **LOSS OF DEPENDENT ELIGIBILITY**

A dependent's eligibility shall automatically terminate if any of the following take place:

- a. When the member's eligibility terminates; or
- b. When a dependent becomes an employee of any Employer and earns enough income to lose dependency status under the Internal Revenue Code; or
- c. When a dependent enters full-time military, naval or air service; or
- d. When a dependent ceases to be a "dependent" as defined herein; or
- e. In the case of children:
  1. When you can no longer claim your child as a dependent on your Federal Income Tax Return; or
  2. When a member's child(ren) attain the age of 19 years (or 23 if attending an accredited school or college on a full-time basis), except children who are physically or mentally incapable of self-support (see page 3, item c); or
  3. When a dependent child is married; or
  4. When a dependent child becomes eligible as an employee under a group health plan sponsored by any employer.

## **EXTENSION OF BENEFITS**

Should the member lose eligibility because he has less than the required number of contribution days to his credit as set forth in the Qualifying Schedule of Eligibility, then Covered Expenses incurred after a Family Member is no longer eligible for the Benefit Program will be considered Covered Expenses payable under this Plan provided the following conditions are satisfied:

A medical or dental claim will be considered related to a previous eligible claim and have all benefits continued (not treated as a new claim) provided:

1. The current actual charges are related to a diagnosis which was initially treated while the patient was eligible for benefits, and
2. The current actual charges were incurred within ninety (90) days of the initial treatment (that is, first date of service by a medical service provider) of the related injury or disease.

## COBRA CONTINUATION COVERAGE

In some cases, should you and/or your dependents become ineligible for coverage under the Fund's Plan of Benefits, you have certain rights, under certain conditions, to continue your coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Under this law, there are circumstances under which you can receive a temporary extension of your health care coverage at group rates. This extension applies to you and your dependents if you and they were covered by the Fund on the day before your or their coverage ended. COBRA refers to these people as "Qualified Beneficiaries."

A Qualified Beneficiary need not show evidence of good health in order to continue coverage. However, the Qualified Beneficiary is obligated to pay a set amount as a premium for this continuation of coverage. The premium that must be paid may be different than the contribution rate being paid by your employer. The COBRA premium rates are formulated by the Fund's Actuary in accordance with formulas defined in the federal COBRA law. Pro rated credits are given in those cases where the Employer has made some contributions on your behalf, but not enough for you to qualify for normal eligibility.

A member has the right to extend his coverage if the coverage ends because:

- a. You leave employment with an employer for reasons other than gross misconduct on your part; or
- b. You no longer meet the eligibility requirements.

Your spouse has the right to extend coverage if:

- a. You die;
- b. You leave employment as described above, or no longer meet the eligibility requirements;
- c. You are divorced or separated; or
- d. You become eligible for Medicare.

Your dependent children have the right to this extended coverage if:

- a. You die;
- b. You leave employment as described above, or no longer meet the eligibility requirements;
- c. You are divorced or separated;
- d. You become eligible for Medicare; or
- e. They are no longer considered dependents under the provisions of the Fund's Plan of Benefits.

***It is the responsibility of the person who will lose coverage to inform the Administrator of a divorce, separation or a loss of dependent child status. The Administrator must be notified, in writing, within sixty (60) days after one of these events occur. If the Administrator is not notified, then that person will not be able to elect to continue his or her other coverage.***

Once the Administrator is notified of an event that affects the coverage of a Qualified Beneficiary, the Qualified Beneficiary will be notified that he or she has the right to choose continuation coverage. He or she then has at least sixty (60) days from the date he or she would lose coverage to let the Administrator know that he or she wants to continue coverage. If the Qualified Beneficiary did not choose it, the right to continue the group health coverage would then end. If he or she does choose it, he or she will be offered the right to continue the same coverage he or she was receiving the day before he or she lost coverage, except for the Death Benefit, Accidental Death and Dismemberment Benefit and Weekly Disability Income Benefits. Each Qualified Beneficiary can make a separate choice on whether to continue coverage. However, one person can make an effective choice to continue coverage for everybody. You can choose to continue only your core benefits - hospital, medical, surgical and prescription drug benefits - or these benefits plus your non-core benefits - vision and dental benefits.

### ***Certificate of Former Coverage***

If you or your dependents lose coverage under the Plan, you will receive a certificate of former coverage. You may need the certificate if your new plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required,

and after COBRA coverage stops. You may request another copy of the certificate within 24 months of losing coverage.

If coverage ended because you left employment, or no longer meet the eligibility requirements, coverage may continue for up to 18 months. If coverage ended for any other reason, then coverage may be continued for up to thirty-six (36) months. These time periods may be shortened if:

- a. The Fund no longer provides group health coverage for any employee;
- b. You do not pay the required premium in a timely fashion;
- c. You are later employed and are covered by another group health plan that does not contain any exclusion or limitation with respect to a pre-existing medical condition that is applied by the plan;
- d. You become eligible for Medicare; or
- e. You are divorced, subsequently remarry and are covered under your new spouse's group health plan.

***Special Rule for Multiple Qualifying Events***

If you elect continuation coverage following a termination of employment or reduction in hours and, during the 18 month period of continuation coverage, a second event (other than a bankruptcy proceeding) occurs that would have caused you to lose coverage under the Plan (if you had not lost coverage already), you may be given the opportunity to extend the period of continuation coverage to a total of 36 months. If you elected continuation coverage as the spouse or dependent of a covered employee who experienced a termination of employment or reduction in hours and, during the continuation period the employee or former employee becomes entitled to Medicare, you may be given the opportunity to extend coverage for 36 months from your initial qualifying event.

***Special Rule for Totally Disabled Qualified Beneficiaries***

The 18-month period of continuation coverage may be extended for an additional 11 months (up to a total of 29 months), for any individual who is determined to have been disabled (for Social Security purposes) at the time your work hours were reduced, or your employment ended, or any time during the first sixty (60) days of the 18 month period during which you are enrolled in the COBRA program. To qualify for this additional coverage, the individual must provide the Plan with notice, within sixty (60) days of the date of the determination and before the end of the 18-month coverage period, of Social Security's disability determination, and must remain disabled throughout the additional coverage period. The premium cost for COBRA continuation during the additional coverage period will be approximately 50 percent higher.

If you have any questions about this continuation coverage, please contact the Fund office.

## HOW TO FILE A CLAIM

You can help us process your claims in a speedy and accurate fashion by providing the necessary information in those limited circumstances in which a paper claim form is required. Much of the delay in processing claims can be directly related to incomplete or incorrectly completed claim forms being submitted to the Fund or to Horizon Blue Cross. If you follow the instructions outlined below, you will be helping the Fund provide you with the fastest claim service possible.

The benefits described in this Booklet have a heading for each type of benefit and state who may be covered for that benefit (for example, "Member only," "Member and Spouse only," etc.). For any limitations in your particular plan, please refer to the Summary of Benefits Schedule.

### When a Claim Form is Not Needed:

1. Present your PPO or HMO identification card for both hospital and non-hospital charges - no claim form is necessary unless you are seeking services from an "Out-of-Network" provider.
2. If you are receiving treatment for behavioral health/substance abuse issues, your Provider should submit the claim directly to Total Care Network at the address noted on the back of your medical identification card.

### IN ALL OTHER CASES, USE A CLAIM FORM AND FOLLOW THE INSTRUCTIONS AND GUIDELINES SET FORTH BELOW.

#### a) **GENERAL INSTRUCTIONS:**

- a. Claim forms may be obtained from the Fund office or the Fund's web site ([www.teamsterfunds.com](http://www.teamsterfunds.com)), from your Local Union or from your Employer.
- b. Use a separate claim form for each Family Member.
- c. Use a separate claim form for each Provider of Service.
- d. Check each charge and report any errors to the Fund immediately.
- e. **MOST IMPORTANT:** Care in filling out your claim form is important. Make sure each appropriate section is completed in full. A great deal of the delay in processing a claim is the result of our having to return claims to busy physicians or members for missing information. Be particularly accurate when writing names, dates of birth, social security numbers, accident information, etc.
- f. **PAYMENT TO DOCTOR OR HOSPITAL** - If you wish payment to be made directly to the Provider of Service, sign the appropriate "Assignment of Benefits Statement" contained on the claim form.
- g. **PAYMENT DIRECTLY TO YOU** - If payment is to be made to you, please attach an original, itemized bill (not a copy) on the physician's or hospital's stationary to the claim form, along with a paid receipt to verify charges and payment.
- h. **BE SPECIFIC** - Have your physician provide a detailed bill listing the following: diagnosis, dates of treatment, treatment performed, and charges for each treatment.

**2. FOR MEDICAL EXPENSES:**

Use your medical plan identification card. If the card cannot be used, the Fund has developed a single claim form which may be used for most of your medical expenses. These forms may be obtained either from the Fund office, the Fund's web site or from your Local Union. All you need to do is check the appropriate block at the top of the claim form and follow the instructions given above to obtain your benefits.

**3. FOR WEEKLY DISABILITY BENEFITS:**

You may use the same claim form you would use for obtaining your medical expense benefits, only please be sure a separate claim form is used for any charges being made by the attending physician.

Be very certain your doctor has completed his section in full, excluding his charges for services (the doctor's charges must be submitted on a separate claim form).

Have your employer complete the Company Statement section on the back of the claim form.

**4. FOR DEATH BENEFITS:**

Death of Member - Use the Death Benefit claim form. Complete the patient information section of the form and attach a certified copy of the death certificate.

Death of Spouse - Same information as described above, plus a copy of your marriage certificate.

Death of a Child- Same information as for death of a member, plus a copy of the child's birth certificate.

**5. FOR MEMBER TOTAL DISABILITY EXTENDED DEATH BENEFITS:**

This is a special form obtained only from the Fund office. This form must be completed yearly in order to qualify for coverage.

**6. FOR VISION BENEFITS:**

The Vision Form may be obtained from the Fund office, the Fund's web site or your Local Union.

**7. FOR PHARMACY BENEFITS:**

Use your Prescription Drug Card when obtaining your prescription. If the pharmacy does not accept your card, you may still have your prescription filled (or refilled) and file a completed "Direct Pay Card" with the Fund. The "Direct Pay Cards" are obtained from the Fund office for reimbursement by the Pharmacy Card Company. Keep in mind that when using the "Direct Pay Cards" your out-of-pocket expense may be larger because your druggist is charging you whatever the market will bear, but the Pharmacy Card Company will only pay you the Usual, Customary and Reasonable allowance for the prescription.



**8. FOR DENTAL BENEFITS:**

Because most of the Fund's eligible participants have been receiving dental treatment on a regular basis, all you need generally do to obtain a Dental Claim Form is call the Fund office or print one from the Fund's web site. If, however, any of the following conditions exist, you may be required to be examined by a dentist selected by the Fund prior to beginning treatment:

- a. Orthodontia (Braces) are anticipated (only for children between the ages of 10 and 18, inclusive).
- b. You are randomly selected as a part of the Fund's Dental Audit Procedure.
- c. Periodontal Care is anticipated.
- d. Temporomandibular Joint Disorders.

**9. HOW SOON SHOULD YOU FILE YOUR CLAIM?** As soon as you can!

Written proof of loss must be furnished to the Fund within ninety (90) days after the date of such loss. Failure to furnish said proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, providing the Fund's liability position has not been prejudiced by the late filing.

All benefits provided by the Fund will be paid promptly upon receipt of proof of loss. Any benefit payable for loss of the Member's life will be payable to the Member's beneficiary; other benefits will be payable to the member, or the member may assign these other benefits to the provider of service.

In the event of an overpayment, either to you or to a "provider of service" on your behalf or on a Family Member's behalf, the Fund reserves the right to reduce subsequent Family Member benefit payments by the amount of such overpayment.

No claim will be honored or payable unless the claim is received in and filed with the Fund office prior to December 31<sup>st</sup> of the third year immediately following the year in which the loss was incurred or services were rendered. No action at law or in equity shall be brought to recover the allowable benefits prior to the expiration of sixty (60) days after proof of loss has been furnished nor shall such action be brought at all unless brought prior to December 31<sup>st</sup> of the third year immediately following the year in which the loss was incurred.

**DEATH BENEFIT  
(FOR MEMBERS AND DEPENDENTS)**

**BENEFIT  
(Occupational and Non-Occupational)**

In the event of your death from any cause, payment of your death benefit will be made to your beneficiary of record. In the event of the death of any other covered Family Member, payment will be made directly to the member. The amount of payment is that shown in the Summary of Benefits Schedule.

A payment of all or a portion of the death benefit may be made directly to a funeral home, provided the Fund receives from the beneficiary of record an appropriate, written and signed assignment of benefits.

Unlike other benefits offered through the Fund's program that are self-insured, the death benefit for active employees and their dependents is a fully-insured benefit purchased by the Fund on a group basis through the Union Labor Life Insurance Company.

**CONTINUANCE OF MEMBER DEATH BENEFIT IN THE EVENT OF TOTAL DISABILITY**

If, while you are eligible, you become totally disabled, your Death Benefit coverage as determined from the Summary of Benefits Schedule will continue after your eligibility stops provided:

You must provide the Fund with written proof, satisfactory to the Trustees or the appropriate Fund representatives, that you are Totally Disabled. THIS WRITTEN PROOF MUST BE PROVIDED TO THE FUND WITHIN SIX MONTHS OF THE DATE ON WHICH YOU FIRST RECEIVED ORAL OR WRITTEN NOTICE FROM THE SOCIAL SECURITY ADMINISTRATION, A PHYSICIAN, A HEALTH PROVIDER, OR ANY OTHER SOURCE THAT YOU ARE TOTALLY DISABLED. Contact the Fund office for this special form.

During the last three months of each subsequent year that you remain Totally Disabled, you must provide the Fund with written proof of your continuing disability. This written proof shall be in a form satisfactory to the Trustees or the appropriate Fund representative.

If you die before the expiration of the six month period set forth in paragraph (1) above, then within one year of your death your beneficiary of record must provide the Fund with written proof that you remained Totally Disabled from the onset of the total disability to the date of your death.

If you apply for disability benefits from the Social Security Administration at any time after you cease working, then you must send a copy of your application and all supporting documentation to the Fund within ninety (90) days after you file the application with the Social Security Administration.

## BENEFICIARIES

You have the sole right to designate the beneficiary to whom your Death Benefit shall be payable. This designation is one of the records which the Fund office maintains along with your census information. Also, you can change your designation at any time, but you must do this in writing and it will take effect on the day your signed request is received in the Fund office.

If you have more than one beneficiary when you die, and you have not specified their respective interests, they all share equally.

If any beneficiary dies before you do, his or her rights and interest shall automatically terminate.

If your designated beneficiary does not file a claim for your Death Benefit within one year from your date of death and the whereabouts of this designated beneficiary are unknown, the Fund shall insert an advertisement in a newspaper of general circulation in the last known place of residence of this designated beneficiary as shown by the Fund's records, to the effect that if the designated beneficiary does not file a claim within ten (10) days of the advertisement, the Trustees will pay your Death Benefit, without interest, to your estate or next of kin as set forth below.

If you have not designated a beneficiary or the beneficiary you named is no longer living or fails to file a Death Benefit claim after the advertisement described above, then the Fund may, at its option, pay an amount not to exceed \$1,000.00 to any person or persons who may have incurred expenses in connection with your last illness or burial. The balance of your Death Benefit, if any, shall be paid to:

Your surviving spouse, or, if none

Equally to your surviving children, or, if none,

Your parent(s), or, if none

Your surviving sibling(s), or, if none,

The personal representative of your estate without restriction to the foregoing order.

The term "sibling" shall include only those persons who share at least one parent with the decedent, either by birth or legal adoption.

Furthermore, should any person to whom the death benefit is payable has not reached the age of eighteen (18) as of the time of payment and for whom a guardian of the estate of the minor has not been appointed, then in such event the Fund shall establish a trust account of the benefit of the minor at a federally regulated bank or similar institution.

**MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT  
(FOR MEMBERS ONLY)**

**BENEFIT  
(Occupational and Non-Occupational)**

If, as a result of external, violent and Accidental Bodily Injury, you suffer the loss of life, limb or sight, and if such loss occurs within twenty-six (26) weeks following the date of the accident, payment will be made of the benefit specified in the Summary of Benefits Schedule upon receipt of due proof of such loss.

Payment will be made for each loss without regard to previous losses, provide that the total amount payable due to two or more losses sustained by you in all accidents does not exceed the principal sum as determined in the Summary of Benefits Schedule.

Unlike other benefits offered through the Fund's program that are self-insured, the accidental death and dismemberment benefit for active employees is a fully-insured benefit purchased by the Fund on a group basis through the Union Labor Life Insurance Company.

<b>LOSSES COVERED</b>	<b>:</b>	<b>AMOUNT OF BENEFIT</b>
Loss of Life	:	
Both Hands or Both Feet	:	
Sight of Both Eyes	:	Principal Sum
One Hand and One Foot	:	
One Hand and Sight of One Eye	:	
One Foot and Sight of One Eye	:	
One Hand or One Foot	:	
Sight of One Eye	:	One-Half of Principal Sum

Loss of Sight means: Total and irrecoverable loss of sight. Loss of Hand or Foot means: Loss by severance at or above wrist or ankle.

**LIMITATIONS**

Claim Date is the date of death or, in the event of loss of sight or dismemberment, the date of the accident.

Accidental Death and Dismemberment does not cover any loss resulting from or caused directly, in whole or in part, by:

- Disease or bodily or mental infirmity or medical or surgical treatment thereof,
- Ptomaine or bacterial infections, except pyogenic infections occurring with and through an accidental wound,
- Suicide or intentionally self-inflicted injury, while sane or insane,
- Participation in or in consequence of having participated in an illegal act which is in violation of any federal or state criminal statute, including driving a motor vehicle while intoxicated
- Flying, unless you were a passenger on a commercial airline,
- War or any act of war, whether declared or undeclared, or insurrection,
- Drug overdose, whether intentional or unintentional.

**WEEKLY DISABILITY BENEFIT  
(FOR MEMBERS ONLY)**

**BENEFIT  
(Non-Occupational)**

If you, prior to retirement, become disabled from a non-occupational accidental injury or disease, and will be prevented by such disability from performing any and every duty pertaining to your occupation, upon receipt of a Weekly Disability claim form, containing proof of disability satisfactory to the Trustees, payment will be made to you as determined from the Summary of Benefits Schedule and continue for the duration of the disability, for a maximum of 26 weeks during any one continuous period of disability whether from one or more causes.

Successive periods of disability will be considered as having occurred during one period of disability unless the subsequent period is due to causes completely and entirely unrelated to the prior accident or disease or unless the prior and subsequent periods are separated by a resumption of active employment for a period of thirty (30) or more full calendar days.

Benefits are payable only while you are under the care of, and treated personally by, a legally qualified physician or surgeon.

**LIMITATIONS**

Disability must commence while you are covered for this benefit.

This benefit is paid in lieu of wages.

Claim date is determined from the date you are first seen and treated by a physician.

Your Weekly Disability Benefit will be coordinated with any short-term disability or wage loss benefit payable to you under any applicable automobile no-fault policy, program, law or regulation.

Weekly Disability benefits will not be payable to a member whose disability resulted in participation in or in consequence of having participated in an illegal act which is in violation of any federal or state criminal statute relating to the possession of controlled substances.

**HOSPITAL, MEDICAL, SURGICAL, ANESTHESIA, MATERNITY, LABORATORY, DIAGNOSTIC  
X-RAY, OUTPATIENT EMERGENCY ACCIDENT & OUTPATIENT THERAPY EXPENSE  
(FOR MEMBER AND DEPENDENTS)**

**BENEFITS  
(Non-Occupational)**

Coverage for these benefits is set forth in the PPO booklet appended to this Summary Plan Description. Please refer to that Section for a description of these coverages, their limitations and applicable patient deductible, co-insurance and co-payment obligations.

**ALTERNATIVE OUTPATIENT LABORATORY  
SERVICES BENEFIT PROGRAM**

Effective March 1, 2008, if you use Laboratory Corporation of America (LabCorp) facilities for outpatient laboratory services, no deductible, co-insurance or copayments will apply. Use of facilities other than LabCorp for such services will be covered under the benefit program, but will be subject to the deductible and co-insurance provisions set forth in the Summary of Benefits Schedule.

**ALTERNATIVE OUTPATIENT RADIOLOGY  
SERVICES BENEFIT PROGRAM**

Effective March 1, 2008, you may obtain outpatient radiology services through the network of providers under contract with Health Care Solutions Corporation. Access to that network of providers may be obtained by calling Health Care Solutions at 1-800-655-8125. If a HCSC provider is utilized a flat \$20 copayment per session is applied. Use of other facilities for such services will be covered under the benefit program, but will be subject to the deductible and co-insurance provisions set forth in the Summary of Benefits Schedule.

**DISEASE MANAGEMENT PROGRAM**

The Fund contracted with HealthCare Strategies to initiate a Disease Management program, known as HealthReach. The purpose of the program is to educate members and their families concerning their individual health issues and, at the same time, monitor the quality of care our participants are receiving to be sure that they are getting the best service for the dollars the Fund and participants are spending for health care.

Based upon claims filed with the Fund, a HealthReach Care Counselor (a Registered Nurse) from HealthCare Strategies contacts the patient to ensure that the patient understands his/her medical condition and helps to coordinate their health care needs. Educational materials are provided to the patient. In some cases, the Care Counselor will contact the patient's treating doctors.

Participation in the Disease Management program is mandatory. Effective September 1, 2005, the patient will be REQUIRED to participate in the HealthReach program to assure that the Fund is paying for appropriate services. If the patient refuses to participate in the program and cooperate with the HealthReach Care Counselor, a \$500 penalty deductible (in addition to any other applicable deductible, co-insurance or co-payment) will be applied during each Plan Year to medical claims received after the patient receives final notice to contact the HealthReach Care Counselor.

## **BEHAVIORAL HEALTH (For Members and Dependents)**

**Behavioral Health benefits (for the treatment of mental health and alcohol/substance abuse issues) must be coordinated through Total Care Network (“TCN”), the Fund’s Behavioral Health Administrator. Total Care Network may be reached at 1-800-298-2299 or 1-215-425-8140 (24 hours a day / seven days a week for emergency services).**

This benefit is administered through both closed and open panels of providers.

**Closed Panel:** The Fund, through Total Care Network, has contracted with a panel of licensed behavioral health providers. Providers on this panel have agreed to accept the Fund's allowance for particular behavioral health services as payment in full with no balance billing to the patient and without any up-front deductible or copayment. You will, however, be responsible for services excluded from coverage or which exceed the overall maximum benefit allowance for the patient for the plan year. Names of participating behavioral health providers may be obtained, without charge, from Total Care Network.

**Open Panel:** Means any licensed behavioral health provider of your choice. However, the benefit payable will be limited to 80% (50% for out-patient services) of the Fund's allowance for participating providers, and subject to the out-of-network deductible of \$300/patient, \$600/family per year.

### **Mental Health/Psychiatric Care**

Benefits for the treatment of mental illness and serious mental illness are based on the services provided and reported by the provider. Those services provided by and reported by the provider as mental health/psychiatric services are subject to the mental health/psychiatric limitations in this program. When a provider renders medical care, other than mental health/psychiatric care, for a covered person with mental illness or serious mental illness, payment for such medical care will be based on the medical benefits available, and will not be subject to the mental health/psychiatric limitations in this program.

Preauthorization information must be submitted by the provider to TCN for review and evaluation so that a plan of treatment may be precertified for the covered person. Precertification must be obtained for all treatments, other than emergency care, in order to verify eligibility and to assure the medical appropriateness/necessity of the proposed treatment based on the nature and severity of the covered person's condition. In appropriate cases, a personal assessment by a preferred professional provider may be provided by the Fund at no cost to the covered person to accommodate the precertification process. Emergency care is exempt from the requirements for precertification and will be considered preferred care. However, emergency admissions or services must be reviewed and authorized within one business day of the admission or services, or as soon as possible thereafter as determined by the Fund and/or its Behavioral Health Administrator.

### **Inpatient Treatment**

Benefits are provided, subject to the benefit period limitations stated in the Schedule of Benefits, for an inpatient admission for treatment of mental illness and serious mental illness. Inpatient visits for the treatment of mental illness and serious mental illness are covered when performed by a licensed professional provider/preferred facility provider.

For treatment of serious mental illness, the covered person may trade one (1) for two (2) basis, inpatient days for additional outpatient partial hospitalization days and outpatient facility/professional visits.

Covered services include treatments such as: psychiatric visits, psychiatric consultations, individual, family and Fund assessments, psychotherapy, electroconvulsive therapy and psychopharmacologic management.

## **Outpatient Treatment**

Benefits are provided, subject to the benefit period limitations shown in the Schedule of Benefits for outpatient treatment of mental illness and serious mental illness. Outpatient mental health/psychiatric services shall be covered for the full number of outpatient session visits or an equivalent number of partial hospitalization visits per benefit period. Partial hospitalization is considered as inpatient treatment. For treatment of mental illness, the covered person may trade off: (a) on a one (1) for two (2) basis, inpatient days for additional separate partial hospitalization services; or (b) on a one (1) for two (2) basis, inpatient days for additional outpatient visits. See the Schedule of Benefits for limits on the number of inpatient days that may be exchanged in any benefit period. For treatment of serious mental illness, the covered person may trade on a one (1) for two (2) basis, inpatient days for additional outpatient partial hospitalization days/outpatient session visits. For maximum benefits, treatment must be performed by a preferred professional provider/preferred facility provider. All preferred outpatient services must be precertified by TCN.

Covered services include treatments such as: psychiatric visits, psychiatric consultations, individual, family and Fund assessments, psychotherapy electroconvulsive therapy, psychopharmacologic management, and psychoanalysis.

Benefits are not payable for the following services:

- a) vocational or religious counseling;
- b) activities that are primarily of an educational nature;
- c) treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as primal therapy, rolfing or structural integration, bioenergetic therapy, and obesity control therapy;
- d) psychological testing.

## **Benefit Period Maximums for Mental Health/Psychiatric Care**

All inpatient and outpatient mental health/psychiatric services for both mental illness and serious mental illness are covered up to the maximum day and visit limitations per benefit period specified in the Schedule of Benefits. Non-preferred benefit period maximums are part of, not separate from, preferred benefit period maximums.

## **TREATMENT FOR ALCOHOL OR DRUG ABUSE AND DEPENDENCY**

Alcohol or drug abuse and dependency means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning and which results in a psychological dependency evidenced by physical tolerance or withdrawal.

Benefits are payable for the care and treatment of alcohol or drug abuse and dependency provided by a hospital or facility provider, subject to the maximums shown in the Schedule of Benefits, according to the provisions outlined below. For maximum benefits, treatment must be received from a preferred provider.

Preauthorization information must be submitted by the provider to the Behavioral Health Administrator for review and evaluation so a plan of treatment may be precertified for the covered person. Precertification must be obtained for all treatments other than emergency care in order to verify eligibility and to assure the medical appropriateness/necessity of the proposed treatment based on the nature and severity of the covered person's condition. In appropriate cases, a personal assessment by a preferred professional provider may be provided by the Fund at no cost to the covered person to accommodate the precertification process.

If a patient is facing a crisis and is currently in treatment, contact should be made with the patient's therapist because he/she is most familiar with the patient's condition. Emergency care is exempt from the requirements for precertification and will be considered preferred care. However, emergency admissions or services must be reviewed and authorized within one business day of the admission or service, or as soon as possible as determined by the Behavioral Health Administrator.



## **Inpatient Detoxification**

Inpatient covered services for detoxification shall be covered for 7 days per admission for detoxification with a lifetime maximum of 4 admissions for detoxification per covered person.

Covered services are limited to:

- a) Lodging and dietary services;
- b) Physician, psychological, nurse, certified addictions counselor and trained staff services;
- c) Diagnostic x-rays;
- d) Psychiatric and medical laboratory testing;
- e) Drug, medicines, use of equipment and supplies.

## **Hospital and Non-Hospital Residential Treatment**

Hospital or non-hospital residential treatment of alcohol or drug abuse and dependency shall be covered on the same basis as any other illness covered under the program, but services are limited to 30 days per calendar year.

Additional days may be available as specified below in "Outpatient Alcohol or Drug Services." There is a lifetime maximum of 90 days per covered person.

Cover services include:

- a) Lodging and dietary services;
- b) Physician, psychological, nurse, certified addictions counselor and trained staff services;
- c) Rehabilitation therapy and counseling;
- d) Family counseling and intervention;
- e) Psychiatric and medical laboratory testing;
- f) Drug, medicines, use of equipment and supplies.

## **Outpatient Alcohol or Drug Services**

Outpatient alcohol or drug services shall be covered for 30 full outpatient sessions or an equivalent number of partial hospitalization visits per calendar year.

Benefits are available for an additional 30 separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a 2 to 1 basis to receive up to 15 more days of non-hospital residential alcohol or drug treatment (i.e., the covered person may trade off on a 2 for 1 basis, up to 30 separate sessions of outpatient services per year, in order to receive up to 15 additional days of hospital and non-hospital residential alcohol or drug abuse treatment days). Any benefits exchanged or traded off under terms of this provision are subject to, and do not increase, the overall lifetime maximum.

There is a lifetime maximum of 120 full session visits or an equivalent number of partial hospitalization visits per covered person. Partial hospitalization is considered as inpatient treatment.

Covered services include:

- a) Physician, psychological, nurse, certified addictions counselor and trained staff services;
- b) Rehabilitation therapy and counseling;
- c) Family counseling and intervention;
- d) Psychiatric and medical laboratory testing;
- e) Drug, medicines, use of equipment and supplies.

## **PRESCRIPTION DRUG EXPENSE (FOR MEMBERS AND DEPENDENTS)**

This Plan provides benefits for prescription legend drugs or refills thereof when dispensed by a pharmacy pursuant to a physician's prescription. These benefits are subject to a patient co-pay for each prescription or refill. Consult your Summary of Benefits Schedule for further details.

In addition, benefits are provided for insulin, disposable syringes to be used in administering the insulin (whether or not you have a prescription for the insulin or these disposable syringes) and other diabetic supplies.

### **LIMITATIONS**

The Fund will not pay any of the cost for:

Vitamins (whether legend or non-legend); cosmetics or other health and beauty aids; dietary aids; prescription drugs prescribed for smoking cessation; drugs available over-the-counter (except proton pump inhibitors and non-sedating antihistamines that are prescribed in lieu of non-over-the-counter equivalents); drugs or compound drugs that have not been approved by the Federal Food and Drug Administration; therapeutic devices and appliances; hypodermic needles and syringes (other than described above); bandages and similar supplies; support garments; and other non-prescription substances.

Contraceptives, unless pre-approved for the treatment of a medical condition.

Administration or injection of any drug.

Refill of covered prescription drugs in excess of the number specified by the physician, or any refill dispensed after one year from the date of the physician's latest order.

Drugs otherwise provided for under the Fund's Hospital, Medical and Surgical Plan.

Drugs otherwise provided for under any government program or law or workmen's compensation or occupational disease laws.

Drugs dispensed prior to the effective date of coverage under this Plan or after the date such coverage terminates.

More than a 34 day supply of any covered prescription drug, except for certain maintenance drugs that are eligible to be filled for a 90 day supply under the Fund's mail order program.

**YOUR PHARMACY CARD IS ONLY VALID AS LONG AS YOU MAINTAIN YOUR ELIGIBILITY. SHOULD YOU USE YOUR CARD WHEN YOU ARE INELIGIBLE, YOU WILL BE LIABLE FOR THE CHARGES.**

Pre-approval is required for any prescription for (1) injectible drugs; (2) drugs for which the cost of a one month supply exceeds \$1,500.00; (3) drugs to treat erectile dysfunction (which will only be approved in those cases in which the condition is secondary to another medical condition); or (4) newly released drugs that have not been approved by the Federal Drug Administration in excess of six (6) months.

**Step Therapy** - Your pharmacy benefits plan includes Express Scripts' step-therapy program. Step-therapy is a type of precertification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. However, if it is medically necessary for you to use a step-therapy medication as initial therapy without trying a prerequisite therapy drug, your doctor can request coverage of the step-therapy medication as a medical exception by contacting Express Scripts at the telephone number listed on your Express Scripts ID card.

**VISION CARE EXPENSE  
(For Members and Dependents)**

**BENEFIT  
(Non-Occupational)**

This benefit is administered through both closed and open panels (see note below) of eye doctors. Your Vision Care Claim form can be obtained from either the Fund office, the Fund's web site or your Local Union.

**TYPE OF BENEFIT**

Eye Examination	The maximum allowances for these items are indicated in Summary of Benefits Schedule
Frames	
Lenses (Two)	
Single Vision	
Bifocal	
Trifocal	
Lenticular	

**LIMITATIONS**

Benefits under this program are payable only for services rendered every twenty-four (24) months. Lenticular Lenses are covered only when they are prescribed in connection with cataract surgery.

**NOTE: Closed Panel:** The Fund office will send to you, without charge, a list of doctors who have agreed to accept the Fund's allowance as payment in full when particular material is selected. This listing is also available on the Fund's web site.

**Open Panel:** Means any doctor of your choice. However, the Fund's maximum allowance is that which is shown in the Summary of Benefits Schedule.

## **DENTAL EXPENSE (FOR MEMBERS AND DEPENDENTS) (EXCLUDING PARENTS)**

This benefit is equal to the actual charges made by a dentist for care and treatment, but will not exceed the amount listed for each procedure in the Summary of Benefits Schedule.

This benefit is administered through both closed and open panels of dentists.

**Closed Panel:** The Fund has contracted with a panel of dentists practicing general dentistry as well as in the specialized fields of dentistry. Dentists on this panel have agreed to accept the Fund's allowance for particular dental services as payment in full with no balance billing to the patient. You will, however, be responsible for services excluded from coverage or which exceed the overall maximum benefit allowance for the patient for the plan year. A listing of the panel members can be obtained, without charge, from the Fund office or on the Fund's web site.

**Open Panel:** Means any dentist of your choice. However, the Fund's maximum allowance is that which is shown in the Summary of Benefits Schedule.

## **BENEFITS**

The Fund has a complete "Dental Table of Allowances" - Please write the Fund if you want to know the Schedule of Allowances for any procedure not listed in the Summary of Benefits Schedule. You should contact the Fund office before you start any non-emergency work to obtain the appropriate claim forms and to insure that you are covered for benefits.

**Orthodontic Care:** Available only to your unmarried dependent children between the ages of 10 and 18 inclusive. Full cases, requiring 24 or more months of care, will be paid at the maximum benefit. Partial cases will be paid at a lesser allowance. All cases must be rated by the Fund's orthodontic consultants. The Fund's maximum is shown in the Summary of Benefits Schedule. Orthodontic benefits are a lifetime benefit and not included in calculating the patient's yearly dental maximum.

## **LIMITATIONS**

**EMERGENCY CARE:** If you have a dental emergency, you may go directly to your dentist for emergency treatment. However, the Fund will pay only for ELIGIBLE COVERED EMERGENCY TREATMENT.

Be advised that the Fund is your secondary carrier when an automobile accident claim arises. In other words, the Fund will only consider for payment those charges not paid under your automobile insurance policy and in certain cases only up to a certain limit. (See "Automobile Insurance" under General Provisions and Definitions.)

Keep in mind that the Fund has the right of subrogation when you are involved in any accident and where you recover any expenses which have been paid to you under this Plan from a third party.

No dental expense benefits are provided for the following:

Routine dental examinations performed more frequently than once in any six (6) consecutive month period.

Prophylaxis (cleaning of teeth) expenses in excess of the amount shown in the Summary of Benefits Schedule more often than once during any six (6) month period.

Dental treatments and services in connection with dentures, bridgework, and crowns will not be covered. -

If the work in making the denture, bridge or crown started prior to the effective date of coverage of the individual, or

If expenses are for more than one denture, either full or partial, or for any bridge or crown within any five year period.

Treatment by other than a licensed dentist, except charges for dental prophylaxis (cleaning of teeth) under the direction of a licensed dentist.

Orthodontic care falling outside of the age and lifetime maximum limitations (See the Summary of Benefits Schedule for details).

## GENERAL BENEFIT EXCLUSIONS AND LIMITATIONS

### Important Note Regarding Relationship Between the Fund and Health Care Providers:

No health care provider is an agent or representative of the Fund. The Fund does not control or direct the provision of health care services and/or supplies to Fund members or their covered dependents by anyone. The Fund makes no representation or guarantee of any kind concerning the quality of health care services or supplies furnished by any provider. The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan of Benefits. The statement also applies to all entities (their agents, representatives and employees) which contract with the Fund to offer preferred provider networks or other health-related supplies to Fund members and their covered dependents. Nothing in this Plan affects the ability of a health care provider to disclose alternative treatment options to a Fund member or covered dependent. Although subject to benefit allowances and limitations in the Plan with regard to payment, the choice of a provider and/or treatment remains with the patient.

In addition to the exclusions provided elsewhere in this Booklet or the exclusions set forth in the Horizon Blue Cross PPO booklet, benefits are not payable for the following:

- Charges arising from, or occurring in the course of, any gainful occupation or employment. This exclusion applies regardless of whether a claim is actually made or filed under any applicable workers' compensation statute or program.
- Charges for services or supplies which are not Medically Necessary or Medically Appropriate as determined by the Fund, its Claims Administrator and/or its Medical Consultant.
- Charges for treatments or procedures that are experimental or investigative.
- Charges for treatments which are not approved by the attending physician.
- Charges which are not Usual, Customary and Reasonable.
- Charges in excess of the payment the provider of service accepted as payment in full from any other source.
- Charges for custodial care or for maintenance of chronic conditions.
- Charges for services rendered by a member of the patient's immediate family (including in-laws).
- Charges that are made only because this coverage exists, or charges that no covered individual is legally obligated to pay.
- Charges for treatments, services and/or supplies provided, ordered or required by the United States government, or any other government (including court-ordered treatment).
- Charges resulting from war or service connected injuries or diseases.
- Charges associated with any treatment for weight reduction.
- Charges for hearing aids or the examination and fitting of hearing aids.
- Charges to the extent that they are recovered from any person or organization other than an insurer of the patient.
- Charges for cosmetic treatment and/or surgery for purposes other than breast reconstruction following a mastectomy, correction of damages caused by accidental injury, or for correction of a birth defect, providing that the patient was covered under this Plan on the date of the accident or date of birth and is still eligible as of the date of the cosmetic treatment or surgery. NOTE: SURGERY GENERALLY CONSIDERED COSMETIC IN NATURE (EVEN THOUGH FOR MEDICAL REASONS) REQUIRES PRIOR APPROVAL FROM THE FUND.

Charges for the diagnosis and treatment of dislocations, strains, sprains or misplacements of the skeletal structure (pertaining to the skeleton) or musculature (the system of muscles), except for the first fifteen (15) visits with a physician in any calendar year or when requiring the administration of a general anesthesia, an opening or cutting operation, or confinement in a hospital.

Charges for orthotic shoe inserts (unless specifically covered under your Summary of Benefits Schedule).

Charges for immunizations and vaccines (unless specifically covered under the Horizon Blue Cross HMO Program)

Charges for eye exercises, psychological testing, and learning disabilities, school or DOT physicals.

Charges for Counseling (including marriage counseling) or group therapy. See definition of these terms in the following section for some exceptions.

Charges for treatment of temporomandibular joint dysfunction in excess of any coverage under the Fund's Dental Benefit Plan.

Charges for sex change operations.

Charges for penile prosthetic devices.

Charges for the surgical correction of myopia.

Charges for oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.

Charges for treatment of infertility, including, but not limited to, in-vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and/or reversal of a sterilization procedure.

Charges for any other medical, dental, vision, or pharmacy service except as provided in your appropriate Summary of Benefits Schedule.

Also, benefits will only be paid in accordance with provisions of the Fund's various Plans. For example, Vision Care is provided for under its Vision Care Plan and will not be provided under any other provision of the Plan unless specifically included in such other Plan provision.

**GENERAL PROVISIONS AND DEFINITIONS**  
**(in addition to those set forth in the Horizon Blue Cross PPO booklet)**

**Accidental Bodily Injury:** For an injury to be considered an accident, the injury must have resulted from some external, violent and unforeseen happening.

**Actual Charges:** Shall mean covered charges up to the Usual, Customary and Reasonable charges as defined in this Section, and never to exceed the payment the provider of service accepted as payment in full from any other source.

**Assignment:** The Member or his/her Spouse have the right to authorize the Fund to pay a Family Member's benefits directly to the physician or hospital who provided the Family Member with covered care and treatment. Except for this, however, you may not assign, alienate, anticipate or commute any benefits which a Family Member is entitled to receive from the Plan and, further, except as may be prescribed by law, none of your benefits shall be subject to any attachments or garnishments of or for your debts and/or contracts, etc., except for recovery of overpayments made on a Family Member's behalf by the Fund, as described under the HOW SOON SHOULD YOU FILE YOUR CLAIM paragraph in the How To File a Claim section of this Booklet.

**Automobile Insurance:** Where an injury is caused by an accident that is covered by a State-required Automobile Insurance Law, the coverage under this Plan is secondary and the automobile insurance or Assigned Claims Plan is responsible to pay the covered charges for that injury first. The Plan will then cover the balance of the covered charges that were not covered by the automobile insurance, up to the maximum benefit level set forth in the Summary of Benefits Schedule insert.

Special additional exclusions apply in the case of No-Fault insurance policies that are governed by the New Jersey No-Fault Law, as amended by the New Jersey Insurance Freedom of Choice and Cost Containment Act. Participants, dependents and beneficiaries who are injured in the course of an automobile accident and who are also covered by an automobile insurance policy governed by the New Jersey No-Fault Law, as amended by the New Jersey Automobile Insurance Freedom of Choice and Cost Containment Act, may only be reimbursed under the Plan by the Fund up to a maximum of \$1,000 per accident for Covered Expenses and, in the case of an eligible member, only up to a Weekly Disability maximum of \$62.50 per week up to the Plan maximum of twenty-six (26) weeks.

**Benefit Period:** Benefit Period shall mean the Plan Year which begins on January 1 and ends on December 31 of each year.

**Claim Forms:** The Fund, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such are not furnished within 30 days after the giving of notice, the claimant shall be deemed to have complied with the requirements of the Fund for submitting proof.

**Claim Review Procedure:** See "Your Rights and Protections under ERISA" in this Booklet.

**Collective Bargaining Agreement:** As a requirement of which the employer is obligated to make contributions to the Fund on behalf of the employees covered by that Collective Bargaining Agreement.

**Contributing Employer:** An employer whose signed Collective Bargaining Agreement requires the employer to make contributions to the Fund on behalf of the employees covered by the terms of that Collective Bargaining Agreement.

**Coordination of Benefits (C.O.B.):** The Teamsters Health and Welfare Fund's Plan provides for Coordination of Benefits. This means that should a Family Member be entitled to any medical, dental, vision, disability or pharmacy benefits from another source, benefits under this Plan may be reduced to an amount, which together with all such other coverage under any other plan or policy, will not exceed 100% of any Usual, Customary and Reasonable item of expense covered under this Plan or any other such plan. The Fund has special rules for coordinating benefits with respect to automobile insurance. These rules are explained under the heading "Automobile Insurance" which is defined earlier in this section. In all other cases in which a Family Member, on whose behalf a claim is submitted, is covered under one or more group plans for health benefits in addition to the

Fund's Plan, benefits will be coordinated so that the member may receive up to 100% of the Reasonable and Customary Charges in accordance with the following priorities of payment:

If the other plan providing benefits for a person covered under the Fund's Plan does not have a coordination of benefits or duplication of benefits provision, benefits payable for covered expenses under the other plan will be paid in full before any benefits are paid by the Fund's Plan.

If the other plan providing benefits for a person covered under the Fund's Plan does have a coordination or non-duplication provision, the following rules will apply for determining whether the Fund or the other plan will provide primary coverage. For the purposes of these rules, the plan which provides "primary coverage" shall be obligated to provide benefits to the fullest extent of its coverage before any other plan is obligated to cover the benefits in question. The plan which provides "secondary coverage" shall not be obligated to provide benefits until the "primary coverage" is exhausted.

*Member of the Fund:* The Fund will provide primary coverage for Members of the Fund, and (in each case) the other plan will provide secondary coverage for such Members. This provision will not apply to pensioners under age 65 who are gainfully employed and covered by a plan provided by their employer; such individuals are covered by paragraph 4 below.

*Dependent Spouses:* In each case, the other plan will provide primary coverage for the dependent spouse, and the Fund will provide secondary coverage for the dependent spouse. A spouse who (i) works full-time (defined as regularly scheduled to work 32 or more hours per week), and (ii) who is eligible to participate in group health coverage sponsored by his/her employer must enroll in that coverage except if the spouse must pay 100% of the premium for such coverage. If the spouse is required to enroll in such coverage, but does not, the Fund will provide secondary coverage and only to the extent as if the other coverage was in effect as of the date services were rendered to the patient/spouse.

*Dependent Children:*

If a dependent child is gainfully employed and is covered by another plan as a result of that employment, then no coverage is available under the Fund's plan for such dependent child.

If paragraph 3(a) above is not applicable and the member and the child's other parent are married to each other and not separated, then the "birthday rule" shall apply. Under the birthday rule, the Fund will provide primary coverage if the member's birthday occurs before the spouse's birthday during the calendar year. For example, if the member was born in June and the spouse in September, then the Fund will provide primary coverage and the spouse's plan will provide secondary coverage. On the other hand, if the spouse's birthday occurred earlier in the calendar year than the member's birthday, then the spouse's plan will provide primary coverage and the Fund will provide secondary coverage. If the member and the spouse have the same birthday in the calendar year, then provision (5) below will apply.

If paragraph 3(a) above is not applicable and the member and the child's other parent are either separated or divorced from each other, then the following rules shall apply.

If there is a court order which establishes or apportions the parents' respective obligations to provide for the medical, dental or other health care expenses of any such child, then benefits will be apportioned in accordance with the provisions of the court order, provided that such court order cannot grant benefits which are not otherwise provided by the Fund.

In the absence of such a court order establishing such financial responsibility, the following shall be the order of payment of benefits for such dependent child:

**Parents Separated or Divorced - Not Remarried**

1. Plan covering Parent with Custody
2. Plan covering Parent without Custody

**Parents Separated or Divorced and Remarried**

1. Plan covering Parent with Custody
2. Plan covering Step-Parent with Custody
3. Plan covering Parent without Custody



The Fund's Plan will not provide any benefit if the person for whom the claim is made is a pensioner, or the dependent of a pensioner who is gainfully employed and his employer provides him with health insurance or the person for whom the claim is made is not a member, or an eligible dependent of a member.

If the rules set forth above do not establish the order of benefit payment, the plan which covered the person for whom the claim is made for the longer period of time shall be considered the primary source of benefits.

**Medicare Coverage-** For Covered Expenses incurred by Members and/or Dependents age 65 through 69 years, except for dependents age 65 through 69 of Members over age 69, the coverage provided by the Fund is primary. In those cases where the Member is actively at work, the Fund's coverage is primary. In all other situations, Medicare coverage is primary and the Fund is secondary.

Under no circumstances will the Fund pay any benefits as the primary plan when a member or the dependent of a member has elected to make the Fund the primary plan by waving coverage under any other plan. This provision shall be effective regardless of whether the dependent waived enrollment in such other plan (when required to enroll in circumstances described in paragraph g. below) or, if enrolled, sought or secured services outside of the required network of providers of such other plan.

If a group plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed a benefit payment.

Benefits otherwise payable under the Fund's Plan shall be reduced in accordance with the above priorities of payment to the extent necessary so that the sum of such reduced benefits payable under all group plans shall not exceed the total of the Usual, Customary and Reasonable charges for the service provided.

If a dependent spouse is employed full time (defined as being regularly scheduled to work 32 or more hours each week) and is eligible to enjoy group coverage through his/her employer at less than 100% of the cost to him/her, the spouse must enroll for such coverage (single coverage only). Furthermore, if such coverage exists for the spouse, the spouse may not waive coverage in lieu of a salary increase or other financial remuneration.

**Counseling:** It is not a covered benefit unless it is performed by a physician as defined in this Booklet. In addition, the counseling must be related to the patient being treated for a mental illness and/or functional nervous disorder, drug abuse and alcoholism. The counseling must also be performed in a non-group setting, unless the other participants are Family Members, in which case the Fund would still only provide a single individual benefit allowance per session.

**Covered Expenses:** Only actual charges for an item or service which is specifically listed as a covered benefit under a provision of the Plan which is covered by your specific Summary of Benefits Schedule which accompanies this Booklet.

**Deductible:** A specified amount of Covered Expenses for the Covered Services that is incurred by the Covered Person before the Fund will assume any liability.

**Dependent:** (See Eligibility Provisions in the front of this Booklet.)

**Family Member:** (See Eligibility Provisions in the front of this Booklet.)

**Fraud:** No benefits under this Plan will be paid if the person on whose account, or by whom the benefit is claimed, or the provider of service attempts to perpetrate a fraud upon or misrepresents a fact to the Fund with respect to any such claim. In the case of such conduct, the Board of Trustees, may, in its sole and exclusive discretion, pay no further benefits to the member, dependent or beneficiary involved as to the particular claim or as to any other claims arising during a period of not more than one year after the discovery of such fraud, attempted fraud or misrepresentation. The Fund shall have the right to fully recover any amounts, with interest, improperly paid by the Fund by reason of fraud, attempted fraud or misrepresentation of fact by a member, dependent, beneficiary or provider of service and to pursue all other legal remedies. The Board of Trustees shall have the right to finally

determine whether or not a fraud has been attempted or committed upon the Fund or if a misrepresentation of fact has been made, and its decision shall be final, conclusive and binding upon all persons.

**Fund:** The Teamsters Health and Welfare Fund of Philadelphia and Vicinity.

**Group Therapy:** Is not covered unless the only other participants in the "group" are other Family Members. In addition the therapy must be performed by a physician as defined in this Booklet and be related to treatment of a mental illness, a functional nervous disorder, drug abuse or alcoholism. Regardless of the number of Family Members participating in the therapy session, only a single individual allowance will be made per session.

**Hospitals:** An acute care institution which meets the following requirements:

Is licensed as a Hospital by the State in which it is located, and the primary function of the institution is providing inpatient medical care and treatment through medical diagnostic and major surgical facilities on its premises under the supervision of a staff of physicians, and with 24 hour a day nursing service, and

Is not owned or operated by the United States Government or by a State (or political subdivision thereof) unless there is an unconditional requirement that persons receiving care must pay for such care.

However, "Hospital" does not include a Nursing Home or an institution, or part of one, used primarily as a facility for convalescence, rehabilitation, treatment of mental illness or functional nervous disorders, a place for the aged, a rest home, a place for alcoholics, or place for drug addicts.

**Inpatient:** An individual who, while confined in a Hospital or Special Care Facility, is assigned to a bed in any department of the institution other than its outpatient department and for whom a charge for room and board is made.

**Legend Drugs:** Drugs, biologicals, and compounded prescriptions which, by Federal Law can be dispensed only pursuant to a prescription, and are required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

**Maternity Coverage:** Maternity coverage under the Plan available to female members and the female spouses of male members. Under federal law, the Fund may not restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Fund may not, under federal law, require that a provider obtain authorization from the Fund for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Medically Appropriate or Medically Necessary:** Means services or supplies that are:

appropriate for the symptoms and diagnosis or treatment of the Family Member's condition, illness, disease or injury; and

required for the diagnosis, or the direct care and treatment of the Family Member's condition, illness, disease or injury; and

in accordance with standards of good medical practice as generally recognized and accepted by the medical community; and

not primarily for the convenience of either the Family Member's family or a provider of medical services; and

the most efficient and economical supply or level of service that can safely be provided to the Family Member. When applied to hospitalization, this further means that the Family Member

requires acute care as a bed patient due to the nature of the services rendered or the Family Member's conditions, and the Family Member cannot receive safe and adequate care in some other setting without adversely affecting the Family Member's condition or quality of medical care.

**Medicare:** To the extent permitted by law, Medicare benefits will be taken into account for any Member or Dependent while they are eligible to apply for Medicare, whether or not they actually apply. The Fund will determine a Family Member's benefit allowance, if any, based upon the applicable Medicare statutes and regulations.

**Member (or Eligible Member):** An individual who has satisfied the eligibility requirements based on contributions made on his/her behalf by his Employer to the Fund and has qualified for the benefit program. Members include the following types of employees: (1) an employee covered by a collective bargaining agreement which requires his/her employer to contribute to the Fund on his/her behalf, (2) an employee of a Labor Union or trade association which contributes to the Fund on his/her behalf and (3) an employee of the Fund or the Teamsters Pension Trust Fund of Philadelphia and Vicinity who has contributions paid to the Fund on his/her behalf.

The masculine pronoun whenever used shall include the feminine pronoun and the singular shall include the plural where appropriate.

**Participating Local Union:** A union with whom any of the contributing employers have entered into a signed Collective Bargaining Agreement, as a requirement of which, the employer is obligated to make contributions to the Fund on behalf of the employees covered by that Collective Bargaining Agreement.

**Physical Examination:** The Fund reserves the right to examine at its own expense and as often as necessary, any person whose injury or sickness is the basis of a claim and, in the case of any death claim, to have an autopsy made.

**Physician:** Means a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a doctor of chiropractic medicine (D.C.), a doctor of dental surgery (D.D.S.), a doctor of dental medicine (D.M.D.), a doctor of podiatric medicine (D.P.M.), and optometrist (O.D.). A clinical psychologist (Ph.D., M.S., or M.A. or L.S.W.), when providing treatment for mental illness or functional nervous disorders, shall also be considered a physician.

**Plan:** Means this Booklet, the Horizon PPO or Horizon Blue Cross HMO booklet, the applicable Summary of Benefits Schedule and any modifications thereto published by the Teamsters Health and Welfare Fund of Philadelphia and Vicinity duly adopted by the Fund's Board of Trustees in accordance with their authority set forth in the Agreement and Declaration of Trust establishing the Fund. Additionally, the Trustees of the Fund, by unanimous action, may terminate, suspend, withdraw, amend or modify the benefits available under the Fund, in whole or in part, at any time and without any prior notice. Any such termination, suspension, withdrawal, amendment or modification of benefits shall not require the consent of any employer, union, Member or Dependent, nor shall such action require individual notice to any such person or organization .

**Prescription:** A written order of a physician or where permitted by law, an oral order of a physician, for legend drugs to the extent that such order is within the scope of such physician's license.

**Special Care Facility:** An institute other than a Hospital (as defined in this Booklet) which:

specializes in physical rehabilitation of injured or sick patients, or

specializes in the diagnosis and treatment of mental illness or functional nervous disorders, or

specializes in the diagnosis and treatment of alcoholism, drug addiction or mental and nervous disorders.

In addition, to qualify as a Special Care Facility, an institution must be:

legally licensed to give medical treatment, and  
operated under the supervision of a physician, and

offer nursing service by registered graduated nurses or licensed practical nurses.

However, the term "Special Care Facility" does not include an institution or part of one that is used mainly as a facility for rest, convalescence, or for the aged.

**Spouse:** Means either your lawful wife or your lawful husband. The status of spouse shall be determined exclusively with reference to the laws of the Commonwealth of Pennsylvania regardless of the residence or domicile of the parties involved. Additionally, whether you are "separated" from your spouse will be determined with reference to the laws of the Commonwealth of Pennsylvania regardless of the residence or domicile of the parties involved.

**Subrogation/Reimbursement of Benefits:** The following rule applies to any situation in which the Fund makes any full or partial payment to or on behalf of a Member or Dependent (other than for death benefits) who subsequently recovers from any other source additional payments or benefits in any way related to the accident, illness, or treatment for which the Fund made full or partial payment. Upon any such subsequent recovery by or on behalf of a participant or beneficiary, from any person or persons, party or parties, insurance company, firm, corporation, or government agency, whether by suit, judgment, settlement, compromise, or otherwise, the Fund, with or without the signing of a subrogation agreement, shall be entitled to immediate reimbursement to the extent of benefits paid to or on behalf of the Member or Dependent. The Fund shall be first reimbursed fully by or on behalf of such Member or Dependent to the extent of benefits paid from the monies paid by any person or persons, party or parties, insurance company, firm, corporation, or government agency and the balance of monies, if any, then remaining from such subsequent recovery shall be retained by or on behalf of the Member or Dependent. The Member and/or Dependent shall hold, as a fiduciary in constructive trust for the benefit of the Fund, any monies so recovered that are subject to the Fund's subrogation/reimbursement lien or these provisions.

All Members and Dependents are obligated to cooperate with the Fund in its efforts to enforce its subrogation rights and to refrain from any actions which interfere with those efforts. This duty of cooperation includes (but is not limited to) the obligation to sign a subrogation agreement in a form prescribed by the Fund. The Fund shall have the right to take all appropriate actions necessary to enforce its subrogation rights in the event that a Member or Dependent refuses to sign a subrogation agreement, refuses to reimburse the Fund in accordance with the Fund's subrogation rights, or takes any other action inconsistent with the Fund's subrogation rights. In such situations, the Fund's options shall include, without limitation, the right in appropriate cases to deny benefits to an individual who refuses to sign a subrogation agreement; to institute legal actions to recover sums wrongfully withheld or to obtain other relief; and/or to offset wrongfully withheld sums against future benefit payments otherwise owed the individual who retains such sums. The Fund may pay counsel fees in an amount not to exceed 20% in order to protect the Fund's subrogation interests.

**Summary of Benefits Schedule:** This is the Insert which accompanies this Booklet, and contains the actual allowances for your various benefits. In addition, you will also find a partial listing of covered dental allowances in this Insert. You may write the Fund office to learn the allowance of any covered procedure not listed. The maximum allowance may not exceed the fee actually charged for the procedure.

**Totally Disabled:**

*For Member:* You are prevented from engaging in your customary occupation solely because of injury or disease and are performing no work of any kind for pay or profit.

*For Dependent:* Your dependent is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health solely because of injury or disease.

**Usual, Customary and Reasonable Allowance (or "UCR"):** The benefit allowance for a procedure or service performed by a Physician or other medical service provider, taking into account the most consistent charge by an individual physician or provider of service to patients for a given service, the range of usual charges for a given service billed by most physicians or providers of service with similar training and experience within a given area, and the complexity of treatment of the particular case.

## **EMPLOYEE RETIREMENT INCOME SECURITY ACT ("ERISA")**

### **IMPORTANT INFORMATION REQUIRED BY ERISA**

The Plan Year starts on January 1 and ends on December 31, and consists of an entire calendar year for the purposes of accounting and preparing the reporting and disclosure information which must be submitted to the United States Department of Labor and other regulatory bodies.

The Plan is maintained by more than ten Collective Bargaining Agreements which are between the Teamsters Locals 107, 115, 312, 326, 331, 384, 463, 470, 500, 623, 628, 676 and 929 and various employer associations that have entered into labor contracts with these Local Unions. Other groups participate in the benefit program by reason of Participation Agreements.

The Plan is funded through employer contributions, the amount of which is specified in the Collective Bargaining Agreement between your employer and your Local Union.

Benefits provided under the Plan, other than death benefits, are self-insured and paid directly from the corpus of the Trust Fund. The Trustees retain the right to amend the Plan of Benefits set forth in this booklet to the fullest extent provided by law.

Your Collective Bargaining Agreement may be reviewed at the Fund office.

Upon written request, the Administrator will furnish you with information as to whether a particular employer participates in the Plan and, if so, his address.

This Plan provides comprehensive Hospitalization, Surgical, Medical, Dental, Vision, Death and Dismemberment, Short-term Weekly Disability and Prescription Drug Benefits. Please refer to the Table of Contents and the Summary of Benefits Schedule for more information concerning the benefits provided under this Plan.

### **IMPORTANT INFORMATION REQUIRED BY ERISA**

As a participant in the Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, provided that all Plan participants shall be entitled to:

#### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, if any, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, insurance contracts, if any, Collective Bargaining Agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

#### **Continue Group Health Plan Coverage**

Continued health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of creditable

coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subjected to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. **The Fund's Plan does not contain any exclusions for preexisting conditions.**

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforcing Your Rights**

If your claim for a benefit under this Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these fees. If you lose, the court may order you to pay these costs and fees. For example: If it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

**USE AND DISCLOSURE OF HEALTH INFORMATION**

The Fund may use your health information, that is, information that constitutes “protected health information” as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Fund has established a policy to guard against unnecessary disclosure of your health information. Please note that, under the Privacy Rule, “protected health information” does not include information relating to weekly disability or life insurance benefits.

IN ADDITION TO OTHER USES AND DISCLOSURES PERMITTED UNDER HIPAA, THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

**To Make or Obtain Payment.** The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other trust funds, health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other the Funds to coordinate payment of benefits.

**To Conduct Health Care Operations.** The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Member Service activities relating to claim eligibility and payment. Benefit eligibility of a family member may be disclosed to the Member or spouse (or, in the case of a non-mentally handicapped dependent child over the age of 18, to that dependent child). Limited information (such as whether a claim has been received or paid) regarding your claims may be disclosed, upon appropriate authentication, to your spouse, unless you advise us that no information should be released to your spouse except upon an express written authorization. Claims information relating to dependent children under the age of 18 may be disclosed to the parent or legal guardian of that child. Claims information relating to covered dependents over the age of 18 may be disclosed only to that dependent, unless the dependent authorizes the disclosure of claims information to someone else, including the parent or legal guardian of that dependent. Claims information relating to a mentally handicapped dependent child over the age of 18 may be disclosed to the parent or legal guardian of that child.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.

- Business management and general administrative activities of the Fund, including customer service and resolution of internal grievances.

For example, The Fund may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

**For Treatment Alternatives.** The Fund may use and disclose your health information to Fund consultants to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Distribution of Health-Related Benefits and Services.** The Fund may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

**For Disclosure to the Plan Sponsor.** The Fund may disclose your health information to the plan sponsor (the Fund's Board of Trustees) for plan administration functions performed by the plan sponsor on behalf of the Fund. The Fund also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other the Funds or modify, amend or terminate the plan.

**When Legally Required.** The Fund will disclose your health information when it is required to do so by any federal, state or local law.

**To Conduct Health Oversight Activities.** The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

**In Connection With Judicial and Administrative Proceedings.** As permitted or required by state law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Fund makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purposes.** As permitted or required by state law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

**In the Event of a Serious Threat to Health or Safety.** The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions.** In certain circumstances, federal regulations require the Fund use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

**For Worker's Compensation.** The Fund may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

## **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than as stated above, the Fund will not disclose your health information other than upon your written authorization. An authorization must contain certain language and, for that reason, the Fund has developed an appropriate form that is available in the Fund office or on the Fund's web site. Such authorizations



are limited by the event (such as a claim) and by time. Blanket authorizations for general disclosures are not permitted under HIPAA's Privacy Rule. If you authorize the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

## **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You have the following rights regarding your health information that The Fund maintains:

**Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request. If you wish to make a request for restrictions, please contact the Fund's Privacy Officer whose name and address appears at the end of this Notice.

**Right to Receive Confidential Communications.** You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The Fund will attempt to honor your reasonable requests for confidential communications.

**Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

**Right to Amend Your Health Information.** If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

**Right to an Accounting.** You have the right to request a list of disclosures of your health information made by the Fund for any reason other than for (1) treatment, payment or health care operations, (2) disclosures made under circumstances described in this Notice, or (3) disclosures which you authorized. The request must be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

**Right to a Paper Copy of this Notice.** You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact Fund's Privacy Officer whose name and address appears at the end of this Notice. ***You also may obtain a copy of the current version of the Fund's Notice at its web site, [www.teamsterfunds.com](http://www.teamsterfunds.com).***

## **DUTIES OF THE FUND**

The Fund is required by law to maintain the privacy of your health information as set forth herein and to provide to you a Notice of its duties and privacy practices. The Fund is required to abide by the terms of this

Privacy Policy, which may be amended from time to time. The Fund reserves the right to change the terms of this Privacy Policy and to make the new Policy provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice of Privacy Practices and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Section. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

### **CONTACT PERSON**

The Fund has designated William J. Einhorn, the Fund's Administrator as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at the following:

Privacy Officer  
Teamsters Health & Welfare Fund of Philadelphia and Vicinity  
6981 N. Park Drive, Suite 400  
Pennsauken, NJ 08109  
(856) 382-2400 ext. 2470  
(fax) (856) 382-2401

**IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER IDENTIFIED ABOVE.**

## CLAIM REVIEW / CLAIM APPEAL PROCEDURE

### HERE IS YOUR PROCEDURE FOR HAVING A CLAIM REVIEWED (Claims Review/Claim Appeal Procedure for Claims filed on or after January 1, 2003.)

- a. **Statement of Intent.** The Trustees intend to establish and to maintain reasonable claim procedures as required by law.
- b. **Precertification or Preauthorization Contact.** A Claimant who wishes to precertify or preauthorize a form of treatment as required by this Plan should contact Horizon Blue Cross ("HORIZON BLUE CROSS") at the telephone number found on the reverse side of the member's identification card.
- c. **Authorized Representative.** A Claimant for benefits under this Plan may appoint an authorized representative to act on the Claimant's behalf in pursuing a claim or an appeal from an adverse benefit determination. Any person who wishes to be recognized by the Plan as the authorized representative of a Claimant should contact the Fund office.
- d. **Filing of Claims.** Any participant, former participant, dependent or beneficiary (designated or contingent) under the Plan ("Claimant"), may file a written claim for benefits with the Trustees through the Fund office.
- e. **Notification on Denial of Claim.** In the event of an adverse benefit determination, the Plan or HORIZON BLUE CROSS will send the Claimant a written notification containing specific reasons for the adverse benefit determination. The written notification will contain specific reference to pertinent Plan provisions on which the adverse benefit determination is based. In addition, the written notification will contain a description of any additional material or information necessary for the Claimant to perfect the claim, as well as an explanation of why such material or information is necessary. Furthermore, the notification shall provide appropriate information as to the steps to be taken if the Claimant wishes to seek review of the adverse benefit determination.
- f. **Time Frames.** The following time frames will apply to benefit determinations by the Plan:
  - (1) **Urgent Care Claims.** In the case of a claim involving urgent care, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant has failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan or HORIZON BLUE CROSS shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Paragraph e of this section. The Plan or HORIZON BLUE CROSS shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the Claimant to provide the specified additional information.
  - (2) **Concurrent Care Decision.** If the Plan or HORIZON BLUE CROSS has approved an ongoing course of treatment to be provided over a period of time or a number of treatments --
    - (a) Any reduction or termination by the Plan or HORIZON BLUE CROSS of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan or HORIZON BLUE CROSS shall notify the Claimant in accordance with Paragraph e of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and to obtain a determination on review that the adverse benefit determination before the benefit is reduced or terminated.
    - (b) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments concerning a claim involving urgent care shall be decided as soon as possible, taking into

account medical exigencies, and the Plan or HORIZON BLUE CROSS shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Paragraph e of this section, and appeal shall be governed by Paragraph g(5)(a), (b) or (c) of this section, as appropriate.

- (3) **Pre-Service Claims.** In the case of a pre-service claim, the Plan or HORIZON BLUE CROSS shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan or HORIZON BLUE CROSS. This period may be extended one time by the Plan or HORIZON BLUE CROSS for up to 15 days, provided the Plan or HORIZON BLUE CROSS both determines that such an extension is necessary due to matters beyond the control of the Plan or HORIZON BLUE CROSS, and notifies the Claimant prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan or HORIZON BLUE CROSS expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide this specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Paragraph e of this section.
- (4) **Post-Service Claims.** In the case of a post-service claim, the Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan or HORIZON BLUE CROSS for up to 15 days, provided that the Plan or HORIZON BLUE CROSS both determines that such an extension is necessary due to matters beyond the control of the Plan or HORIZON BLUE CROSS and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan or HORIZON BLUE CROSS expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
- (5) **Disability Claims.** In the case of a claim for disability benefits under this Plan, the Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

#### g. **Right of Review**

- (1) **Full and Fair Review.** A Claimant who receives an adverse benefit determination with respect to any claim shall have the right to a full and fair review of that determination as required by law. For purposes of this Plan, an "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a Claimant's eligibility to participate in the Plan, and including a failure to provide or

make payment (in whole or in part) for a benefit resulting from the application of any utilization review as well as a failure to cover an item or service for which benefits are otherwise provided because the service is determined to be experimental or investigational or not medically necessary or appropriate.

- (2) **Time Frame for Seeking Review of an Adverse Benefit Determination.** A Claimant may institute review of an adverse benefit determination within 180 days of the Claimant's receipt of notification of that determination. Such a review should be initiated in writing, addressed to the Fund office.
- (3) The following procedures shall apply to any review sought by a Claimant concerning an adverse benefit determination under this Plan:
  - (a) The Claimant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.
  - (b) The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits. Whether a document, record or other information is relevant to a claim shall be governed by the following: The document shall be "relevant" if it was relied upon in making the benefit determination, submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination or demonstrates compliance with the administrative process and safeguards required herein or by applicable law.
  - (c) The review of the adverse benefit determination shall take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
  - (d) Review of the adverse benefit determination shall be give deference to the adverse benefit determination and will be conducted by an appropriate fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject to the appeal nor the subordinate of any such individual.
  - (e) If the adverse benefit determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, then the appropriate Plan fiduciary shall consult with a health care professional who has the appropriate training and experience in the relevant field.
  - (f) The review process shall identify the medical or vocational expert, if any, whose advise was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.
  - (g) If a health care professional was consulted in connection with the adverse benefit determination, that person shall not be consulted in connection with the review of the adverse benefit determination.
  - (h) In the case of a claim involving urgent care, there shall be provided an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's adverse benefit determination on review, shall be transmitted between the Plan or HORIZON BLUE CROSS and the Claimant or Claimant's authorized representative by telephone, facsimile or other available similarly expeditious methods.
- (4) **Right to Hearing Before Trustees' Appeals Committee.** The Trustees' Appeal Committee will consist of two (2) Trustees designated by the Plan's Board of Trustees. A Claimant or Claimant's authorized representative may appear before this committee to present any evidence or argument in support of the claim review.

- (5) **Content of Claim Review Determination.** Each claim review determination shall be signed by at least two (2) Trustees authorized by the full Board of Trustees to resolve such claim review. The content of each determination will include: the specific reason or reasons for the adverse benefit determination; reference to the specific Plan provision on which the adverse benefit determination is based; and a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined by Paragraph g(3)(b) of this section.
- (6) **Time Frames for Claim Review Determination.** The following time frames shall apply to any rulings upon a requested claim review:
- (a) **Urgent Care Claims.** In the case of a claim involving urgent care, the Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.
- (b) **Pre-Service Claims.** In the case of a pre-service claim, the Plan shall notify the Claimant in accordance with Paragraph e of this section, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Plan of the Claimant's request for review of the adverse benefit determination period.
- (c) **Post-Service Claims.** In the case of a post-service claim, the ruling on the claim review shall not be made later than the date of the Trustees' Meeting that immediately follows the Plan's receipt of the request for review, unless the request for review was filed within 30 days preceding the date of such Meeting. In such a case, a benefit determination may be made no later than the date of the second Trustees' Meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension for processing, a benefit determination shall be rendered not later than the third Trustees' Meeting following the Plan's receipt of the claim review. If such an extension of time for review is required because of special circumstances, the Plan shall notify the Claimant in writing of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.
- (d) **Disability Claims.** In the case of a claim for disability benefits under this Plan, a ruling on the claim review shall be made not later than the date of the Meeting of the Trustees that immediately follows the Plan's receipt of the claim review, unless the claim review is filed within 30 days preceding the date of such Meeting. In such case, a benefit determination may be made by not later than the date of the second Meeting following the Plan's receipt of the request for review. If the special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third Meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for a review is required because of special circumstances, the Plan shall notify the Claimant, in writing, of the extension, describing the special circumstances and the date by which the benefit determination shall be made prior to commencement of the extension period. The Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the benefit determination, as soon as possible, but not later than 5 days after the benefit determination is made.
- (7) **Furnishing Documents.** In the case of an adverse benefit determination on review, the Plan shall provide such access to, and copies of, documents, records and other information as appropriate and required by law.
- (8) **Definitions.** The following definitions shall apply herein:

- (a) A claim involving "urgent care" means any claim for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- (b) "Pre-service claim" means any claim in which receipt of the benefit is conditioned, in whole or in part, upon precertification or preauthorization by the Plan.
- (c) The term "post-service claim" means any claim that is not a pre-service claim.

January 1, 2008

## SUMMARY OF BENEFITS SCHEDULE

### Composite Contribution Rate

Benefits are effective 60 days after effective date of rate.

### **TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA AND VICINITY**

www.teamsterfunds.com  
6981 N. Park Drive, Suite 400  
Pennsauken, NJ 08109  
(856) 382-2400

**NATIONWIDE**  
1-800-523-2846

### **PLAN SPONSOR**

Board of Trustees of the Teamsters Health & Welfare Fund  
of Philadelphia and Vicinity  
6981 N. Park Drive, Suite 400  
Pennsauken, NJ 08109

### **BOARD OF TRUSTEES**

The Board of Trustees represents labor and management and are responsible for governing the entire operation of the Fund.

#### **LABOR TRUSTEES**

Paul Cardullo, President  
I.B.T. Local 929  
4345 Frankford Avenue  
Philadelphia, PA 19124

William T. Hamilton, President  
I.B.T. Local 107  
2845 Southampton Road  
Philadelphia, PA 19154

Anthony F. Volpe, Secretary/Treasurer  
I.B.T. Local 470  
3565 Sepviva Street  
Philadelphia, PA 19134

#### **MANAGEMENT TRUSTEES**

Kenneth F. Leedy  
c/o Transport Employers Association  
56 Main Street, Second Floor  
Camillus, NY 13031

Bob Schaeffer, Jr., Executive Director  
Transport Employers Association  
56 Main Street, Second Floor  
Camillus, NY 13031

Tom J. Ventura, Vice-President  
YRC Worldwide, Inc.  
10990 Roe Avenue  
Overland Park, KS 66211



**ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS**

(Legal process may also be served upon a Trustee)

William J. Einhorn  
6981 N. Park Drive, Suite 400  
Pennsauken, NJ 08109  
(856) 382-2400

**LEGAL COUNSEL**

Stevens & Lee  
29th Floor, 1818 Market Street  
Philadelphia, PA 19103

Freedman & Lorry, P.C.  
1601 Market Street, 2nd Floor  
Philadelphia, PA 19103

**AUDITOR**

BondBeebe  
4600 East-West Highway Suite 900  
Bethesda MD 20814-3423

**PRESCRIPTION DRUG  
PROGRAM**

Express Scripts, Inc.  
P.O. Box 66583  
St. Louis, MO 63166

**INVESTMENT MANAGER**

SEI Investments  
One Freedom Valley Drive  
Oaks, PA 19456

The Health & Welfare Fund Covers Employees  
Represented by these Teamsters Locals

Local 107	Local 463
Local 115	Local 470
Local 312	Local 500
Local 326	Local 623
Local 331	Local 628
Local 384	Local 676
	Local 929

The only person authorized to advise you of your rights under this Plan is William J. Einhorn, Administrator, or his specific designee.

Reliance upon information from any other source is at your own risk.

## ELIGIBILITY

A member of the Teamsters Health and Welfare Fund of Philadelphia and Vicinity will become and remain eligible for the Benefit Program in accordance with the following "Qualifying Schedule."

## QUALIFYING SCHEDULE

Depending upon the terms of your Collective Bargaining Agreement, a different eligibility schedule could apply to you. If your Employer is required to make contributions to the Fund on your behalf in the form of a **monthly premium** (rather than a stated amount per hour or day), then you will be eligible for benefits during the month in which the premium is due to be paid by your Employer. Otherwise, the following Qualifying Schedule shall apply:

If an Employer is required to make contributions to the Fund in a stated amount per hour or per day on behalf of a member for at least:

<b>15 days during the month of:</b>	<b>OR</b>	<b>180 days during the months of:</b>	<b>Such member will be eligible for benefits during the month of:</b>
November		December through November	January
December		January through December	February
January		February through January	March
February		March through February	April
March		April through March	May
April		May through April	June
May		June through May	July
June		July through June	August
July		August through July	September
August		September through August	October
September		October through September	November
October		November through October	December

Note: The eligibility requirement for benefit months occurring prior to October 2007 is equal to 18 days in the qualifying month or 216 days in the qualifying year and 15 days in the qualifying month or 180 days in the qualifying year for benefit months occurring prior to March 2006.

## DEPENDENT ELIGIBILITY

Eligibility for benefits for each of your dependents will be determined on the same basis as for you, except where noted.

## BENEFITS

### DEATH BENEFITS

Member.....	\$20,000.00
Death Benefit continued in force on member in the event of total disability.....	\$3,000.00
Spouse.....	\$1,500.00
Child -- In accordance with age as follows:	
Over 14 days, but less than six months.....	\$300.00
Six months, but less than two years.....	\$600.00
Two years, but less than three years .....	\$1,200.00
Three years, but less than 19 years (23 years if in full-time attendance at an accredited secondary school, college or university) or a child over 19 who has a mental or physical disability as described in your Benefit Book.....	\$1,500.00

### ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Member Only -- Principal Sum.....	\$20,000.00
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### WEEKLY DISABILITY (Loss of Time) BENEFIT -- Member Only

Per Week.....	\$250.00
Per Work Day.....	\$50.00

**NOTE: If you work for a New Jersey employer covered under the New Jersey Disability Law, you will receive a benefit equal to ½ of the disability payment indicated above.**

#### Commencement of Benefit:

Accident or from first day of hospitalization.....	First Work Day
Sickness or pregnancy.....	Sixth Work Day
Maximum period payable.....	26 Weeks

### PRESCRIPTION DRUGS (Cash Copayments Per Prescription)

Generic Drugs.....	\$3.00
Formulary Drugs (Preferred) .....	\$10.00
Non-Formulary Drugs (Non-Preferred) .....	50% with a min. copay of \$30 and max. copay of \$40

**Note: Some drugs may require pre-certification and are subject to a step therapy program Maintenance Drugs are available through Express Scripts Home Delivery (90 day supply with one copayment). To be eligible, patient must have been taking the maintenance medication for a minimum of three (3) consecutive months. A listing of covered maintenance drugs is available on the Fund's web site, [www.teamsterfunds.com](http://www.teamsterfunds.com), or at the Fund office.**

### VISION BENEFITS

This benefit is administered through both closed and open panels of eye doctors. Benefits are payable only if you are eligible at the time the vision service is performed. The Vision Care Benefits are as follows:

Eye Examination (one every 24 months).....	\$40.00
Frames (one pair every 24 months).....	\$27.00
Lenses (one pair every 24 months)	
Single Vision.....	\$ 33.00
Bifocal.....	\$ 37.00
Trifocal.....	\$ 42.00
Lenticular.....	\$115.00

**NOTE: The closed panel doctors will ordinarily accept the Fund's allowances as payment in full. A list of these doctors may be obtained from the Fund office or on the Fund's web site -- [www.teamsterfunds.com](http://www.teamsterfunds.com).**

**BEHAVIORAL HEALTH / SUBSTANCE ABUSE BENEFITS**

	In Network	Out-of-Network
<b>Psychiatric Care:</b>  Inpatient; Lifetime maximum of 50 days (in or out-of-network combined)  Outpatient	100%, up to 30 days per Benefit Period  100% of allowance, max of 30 visits per Benefit Period	80% of allowance, up to 20 days per Benefit Period  80% of allowance, max of 20 visits per Benefit Period
<b>Alcohol/Drug Abuse Treatment:</b>  Inpatient Detoxification – 7 days per admission; lifetime maximum of 4 confinements  Residential Care – 30 days per Benefit Period; Lifetime maximum of 90 days  Outpatient care – 30 full session visits; Lifetime maximum of 120 visits	100%  100%  100%	80% of allowance  80% of allowance  80% of allowance

You must contact Total Care Network at 1-800-298-2299 to coordinate Behavioral Health/Substance Abuse services

**ORTHOTICS**

Benefits are provided for orthotic shoe inserts once every twenty-four (24) months with a limit of \$100.00 per foot. Claims for these items should be filed directly with the Fund office.

## DENTAL EXPENSE BENEFITS

This benefit is administered through both closed and open panels of dentists. Benefits are payable only if you are eligible at the time each procedure is performed.

Family Member Calendar Year Maximum..... \$2,000.00  
(*This maximum does not include any orthodontia payments*)

Orthodontia -- Family member Lifetime Maximum..... \$3,300.00  
(*Available only for dependent children between the ages of 10 and 18, inclusive.*)

**NOTE: The closed panel dentists will ordinarily accept the Fund's allowances as payment in full. A list of these doctors may be obtained from the Fund office or on the Fund's web site -- [www.teamsterfunds.com](http://www.teamsterfunds.com).**

## SCHEDULE OF DENTAL BENEFITS

The Fund has set allowances for all covered dental procedures. A complete listing of those covered procedures and allowances may be obtained at the Fund office or from the Fund's web site -- [www.teamsterfunds.com](http://www.teamsterfunds.com). The maximum allowances may not exceed the fee actually charged for the procedure. No payment will be made until the required Dental Claim Form has been completed by the attending dentist and approved by the Fund. This Table of Allowances will apply to all. For any procedure which has an allowance that is different from Members or Dependents over the age of 14 and for Dependent Children between the ages of 0 and 14, the description indicates "adult" or "child."

Benefit payment will be calculated with reference to the dental allowances set by the Fund's Trustees, less any applicable patient copayment. Patient copayments apply to the following types of dental procedures:

Preventative services (Yearly and periodic exams, xrays, cleanings)	\$0
Restorative services (Amalgam and composite fillings, etc.)	\$0
Fixed Prosthodontics (Crowns and bridges)	\$30 per tooth
Removable Prosthodontics (Full or partial dentures)	\$50 per unit
Periodontal surgery	\$257 per quadrant
Endodontic surgery (root canal, etc.)	\$25 per tooth
Oral surgery	\$25 per tooth
Orthodontic care	\$100 per case.

## SUMMARY OF PPO MEDICAL BENEFITS

For members who are enrolled in the Fund's PPO benefit program, the following schedule of medical benefits shall apply. Those members should refer to the separate Horizon Blue Cross/Blue Shield Member Handbook appended to this document. That booklet explains the medical, hospital and surgical program under which you would enjoy coverage. If you did not receive a copy and are enrolled in this program, contact the Fund office at 1-800-523-2846.

**Benefit Period** Calendar Year

**Program Deductible**  
(Covered Person's Liability)

(Preferred Care) \$225/person

(Non-Preferred Care) \$450 per person per benefit period.

This deductible applies to all services, except emergency care service, medical foods, pediatric immunizations, routine gynecological examination, pap smear and routine mammogram.

### **Family Deductible**

(Non-Preferred Care)

The family deductible amount is equal to 2 times the individual deductible. In each benefit period, it will be applied for all family members covered under a family coverage. A deductible will not be applied to any covered individual family member once that covered individual has satisfied the individual deductible, or the family deductible has been satisfied for all covered family members combined.

### **Deductible Carryover**

Expenses incurred for covered expenses in the last three months of a benefit period which were applied to that benefit period's deductible will be applied to the deductible of the next benefit period.

**Coinsurance**  
(Covered Person's Liability)

(Preferred Care) 10%

(Non-Preferred Care) 20% for covered services; 50% for outpatient mental health/psychiatric visits; except coinsurance does not apply to emergency care services. For alcohol and drug abuse services, in the first instance or course of treatment, no deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness.

**Out-of-Pocket Limit**

(Preferred Care) \$500 per person  
(Non-Preferred Care) \$1,500 per person

When a covered person reaches the co-insurance out-of-pocket limit in one benefit period, the coinsurance percentage will be reduced to 0% for the balance of that benefit period. The dollar amounts specified shall not include any expense incurred for inpatient/out-patient mental health/psychiatric services, any deductible, penalty or copayment amount.

**Lifetime Maximum**

(Preferred Care/Non-Preferred Care) \$2,000,000 per lifetime, per covered person for preferred and non-preferred covered services

**Reinstatement**

(Preferred Care/Non-Preferred Care) Amounts applied to a covered person's lifetime maximum are not restorable.

## SUMMARY OF PPO MEDICAL BENEFITS

For members who are enrolled in the Fund's PPO benefit program, the following schedule of medical benefits shall apply. Those members should refer to the separate Horizon Blue Cross/Blue Shield Member Handbook appended to this document. That booklet explains the medical, hospital and surgical program under which you would enjoy coverage. If you did not receive a copy and are enrolled in this program, contact the Fund office at 1-800-523-2846.

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Calendar Year

### Program Deductible

(Covered Person's Liability)

(Preferred Care)

\$225/person

(Non-Preferred Care)

\$450 per person per benefit period.

This deductible applies to all services, except emergency care service, medical foods, pediatric immunizations, routine gynecological examination, pap smear and routine mammogram.

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The family deductible amount is equal to 2 times the individual deductible. In each benefit period, it will be applied for all family members covered under a family coverage. A deductible will not be applied to any covered individual family member once that covered individual has satisfied the individual deductible, or the family deductible has been satisfied for all covered family members combined.

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**Coinsurance**

(Covered Person's Liability)

(Preferred Care)

10%

(Non-Preferred Care)

20% for covered services; 50% for outpatient mental health/psychiatric visits; except coinsurance does not apply to emergency care services. For alcohol and drug abuse services, in the first instance or course of treatment, no deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness.

**Out-of-Pocket Limit**

(Preferred Care)

\$500 per person

(Non-Preferred Care)

\$1,500 per person

When a covered person reaches the co-insurance out-of-pocket limit in one benefit period, the coinsurance percentage will be reduced to 0% for the balance of that benefit period. The dollar amounts specified shall not include any expense incurred for inpatient/out-patient mental health/psychiatric services, any deductible, penalty or copayment amount.

**Lifetime Maximum**

(Preferred Care/Non-Preferred Care)

\$2,000,000 per lifetime, per covered person for preferred and non-preferred covered services

**Reinstatement**

(Preferred Care/Non-Preferred Care)

Amounts applied to a covered person's lifetime maximum are not restorable.

**SCHEDULE OF SERVICES**

<b><u>SERVICES</u></b>	<b><u>PREFERRED</u></b>	<b><u>NON-PREFERRED</u></b> <b><u>(% of Allowable Charge)</u></b>
<b>HOSPITAL</b>		
<p><b>Inpatient Services:</b> Maximum of 365 days for preferred services; 70 days maximum for non-preferred services per illness</p> <p>The non-preferred days maximum is part of, not separate from, the preferred days maximum.</p>	90%	80%
<b>Outpatient Services</b>	90%	80%
<b>EMERGENCY CARE</b>		
<p>Services within two (2) days of emergency certification of services must take place within two (2) business days of service, or as soon as reasonably possible, as determined by the Fund.</p>	100%, less \$100 copayment, waived if admitted	100%, less \$100 copayment, waived, if admitted
<p>Follow-up emergency room care within 14 days of initial treatment.</p>	100%, less \$100 copayment	100%, less \$100 copayment
<b>SURGICAL SERVICES</b>		
<p>If more than one surgical procedure is performed by the same professional provider during the same operative session, the Fund shall pay for the highest paying procedure and no allowance for additional procedures except where the Fund deems that an additional allowance is warranted.</p>	90%	80%

<b><u>SERVICES</u></b>	<b><u>PREFERRED</u></b>	<b><u>NON-PREFERRED (% of Allowable Charge)</u></b>
<b>ASSISTANT SURGEON</b>	90%	80%
<p>If more than one surgical procedure is performed by the same professional provider during the same operative session, the Fund shall pay the charge for the highest paying procedure and no allowance for additional procedures except where the Fund deems that an additional allowance is warranted.</p>		
<b>ANESTHESIA</b>	90%	80%
<p>Services administered by a nurse anesthetist not employed by a professional provider are paid at 50%.</p>		
<b>SECOND SURGICAL OPINION</b> Voluntary	90%	80%
<b>MEDICAL CARE</b>		
Inpatient Care Concurrent Care (Inpatient consultations are limited to 1 consultation per consultant per confinement).	90%	80%
<b>DIAGNOSTIC SERVICES - OUTPATIENT</b>		
X-ray: Radiology, Ultrasound and Nuclear Medicine, ECG, EEG, Other.	90%	80%
Laboratory, Pathology	First \$100 per benefit period payable @ 100%; 90% thereafter	80%

<b><u>SERVICES</u></b>	<b><u>PREFERRED</u></b>	<b><u>NON-PREFERRED (% of Allowable Charge)</u></b>
Allergy Testing	90%	80%
<b>THERAPY - OUTPATIENT</b>		
Radiation Therapy, Chemotherapy and Dialysis Therapy	90%	80%
Infusion Therapy	90%	80%
Respiratory Therapy	100%, less \$25 copayment per session	80%
Cardiac Rehabilitation Therapy 18 Preferred/Non-Preferred sessions per benefit period.	100%, less \$25 copayment per session	80%
Pulmonary Rehabilitation Therapy 12 Preferred/Non-Preferred sessions per benefit period.	100%, less \$25 copayment per session	80%
Physical Occupational, Speech Therapy	100%, less \$25 copayment per session	80%
<b>RESTORATIVE SERVICES</b> (Chiropractic services limited to 15 sessions per benefit period)	100%, less \$25 copayment per session	80%
<b>MATERNITY SERVICES</b>		
Obstetrical/Maternity Care <i>(Member or Spouse only)</i>	100% after \$25 copayment for 1st visit	80%
Abortions (only to avert the death of the mother)	90%	80%
Newborn Care (from the date of birth to mother's discharge from the hospital)	90%	80%

**SERVICES****PREFERRED****NON-PREFERRED  
(% of Allowable Charge)**

**SKILLED NURSING  
FACILITY CARE (SNF)**  
(Hospital day limit maximum  
applies)

90%

80%

Physician visit limits per benefit  
period: Two visits during first  
week of confinement and one  
visit per week for each  
consecutive week of confinement  
thereafter.

90%

80%

**DURABLE MEDICAL/  
SURGICAL EQUIPMENT**

Pre-certification is required for  
non-preferred supplies including  
all rentals and for purchase of  
items with a billed amount that  
exceeds \$500.

(Orthotics are covered once every  
24 months, with a benefit limit of  
\$100 per foot appliance)

90%

80%

**PROSTHETICS**

90%

80%

Pre-certification of non-preferred  
supplies is required for items with  
a billed amount that exceeds  
\$500 in value.

**HOME HEALTH CARE**

90%

80%

**HOSPICE CARE**

90%

80%

Respite Care - maximum of  
seven (7) days every six (6)  
months.

**AMBULANCE**

90%

80%

**MEDICAL FOODS AND  
NUTRITIONAL FORMULAS**

90%

80%

(Deductibles do not apply to  
Medical Foods benefits.)

**SERVICES****PREFERRED****NON-PREFERRED  
(% of Allowable Charge)****TRANSPLANT SERVICES**

Coverage for charges of the donor is secondary to any other coverage the donor enjoys and is subject to a benefit maximum of \$25,000 per transplant..

90%

80%

**OUTPATIENT PRIVATE  
DUTY NURSING**

90%

80%

**PRIMARY CARE**

Home, office, outpatient visits and outpatient consultation with primary care physician

100%, less \$15  
copayment per visit

80%

Pediatric immunizations (copayments, deductibles and maximum amounts do not apply to this benefit).

100%

80%

Adult Preventive Care with primary care physician

100%, less \$15  
copayment per visit

80%

Specialist

100%, less \$25  
copayment per visit

80%

Routine Gynecological Exam and Pap Smears (copayments, deductibles and maximum amounts do not apply to this benefit).

100%

80%

Screening Mammogram (copayments, deductibles and maximum amounts do not apply to this benefit).

100%

80%

Therapeutic Injections

100%, less \$15  
copayment per visit

80%

Allergy Extract/Injections

100%

80%

## COVERED SERVICES LIMITATION

Services	Limitations
Inpatient Admissions/Services Mental Health/Psychiatric Services Alcohol, Drug Abuse and Dependency Skilled Nursing Facility Care Transplant Services	Failure to precertify non-preferred services will result in a \$1,000 reduction in benefits payable for selected services
Outpatient Services Surgical Services Home Health Care Hospice Care Private Duty Nursing	Failure to obtain pre-procedure certification for non-preferred services will result in a 20% reduction in benefits payable for selected services.
Disease Management Program	Failure to participate in the program will result in the assessment of a yearly penalty deductible of \$500 in addition to all other applicable deductible, co-insurance and copayment provisions

### Lifetime Medical Benefit Maximum

Benefits under the program are subject to an overall \$2 Million per patient lifetime medical maximum for all hospital, medical and surgical benefits. The calculation of benefits paid shall begin from the patient's first participation in the Fund and shall include all medical benefits paid on behalf of the patient regardless of which medical benefit program (traditional, PPO medical or HMO medical) under which the patient was or is enrolled.

## NOTES



**THE PREFERRED PROVIDER ORGANIZATION**

**HEALTH BENEFITS PROGRAM**

Horizon Blue Cross/Blue Shield of New Jersey  
(Hereafter called "the Claims Administrator")

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## INTRODUCTION

This booklet has been prepared so that you may become acquainted with the Preferred Provider organization health care plan offered by your Fund. Coverage under your Fund's plan is available to active Members who are eligible for the Coverage and enrolled in it. The Preferred Provider Organization health care coverage described in this booklet is subject to the terms and conditions of the Fund coverage administered by Horizon Blue Cross/Blue Shield of New Jersey.

Benefits will not be available for services to a greater extent or for a longer period than is Medically Appropriate/Medically Necessary, as determined by the Claims Administrator. The amount of benefits for any Covered Service will not exceed the amount charged by the health care provider, and will not be greater than any maximum amount or limit described or referred to in this booklet.

### **SPECIAL NOTE FOR PART-TIME EMPLOYEES:**

**If you are or become a part-time employee, as determined by the Health & Welfare Fund, the benefits described in this booklet are limited to you, the employee. Contact the Fund if you are unsure as to your status as a fulltime or part-time employee. NO COVERAGE IS PROVIDED FOR THE SPOUSE OR DEPENDENT CHILDREN OF A PART-TIME EMPLOYEE.**

### **IMPORTANT NOTICES:**

#### **REGARDING EXPERIMENTAL/INVESTIGATIONAL TREATMENT:**

The Claims Administrator does not cover treatment it determines to be experimental/ Investigational in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Claims Administrator acknowledges that situations exist when a Covered Person and his or her Physician agree to utilize Experimental/Investigational treatment. If a Covered Person receives Experimental/ Investigational treatment, the Covered Person shall be responsible for the cost of the treatment. A Covered Person or his or her Physician should contact the Claims Administrator to determine whether a treatment is considered Experimental/ Investigational. The term "Experimental/Investigational" is defined in the ***Defined Terms*** section.

#### **REGARDING TREATMENT WHICH IS NOT MEDICALLY APPROPRIATE/MEDICALLY NECESSARY:**

The Claims Administrator only covers treatment which it determines Medically Appropriate/ Medically Necessary. A Member/Contracting Provider accepts the Claims Administrator's decision and contractually is not permitted to bill the Covered Person for treatment which the Claims Administrator determines is not Medically Appropriate/Medically Necessary unless the Member/Contracting Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by the Claims Administrator, and that the Covered Person will be financially responsible for such services. A Non-Member/Non-Contracting Provider, however, is not obligated to accept the Claims Administrator's determination and the Covered Person may not be reimbursed for treatment which the Claims Administrator determines is not Medically Appropriate/Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Member/Non-Contracting Provider. You can avoid these charges simply by choosing a Member/Contracting Provider for your care. The term "Medically Appropriate/Medically Necessary" is defined in the Defined Terms section.

#### **REGARDING TREATMENT FOR COSMETIC PURPOSES:**

The Claims Administrator does not cover treatment which it determines is for cosmetic purposes because it is not necessitated as part of the Medically Appropriate/Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Claims Administrator acknowledges that situations exist when a Covered Person and his or her Physician decide to pursue a course of treatment for cosmetic purposes. In such cases, the Covered Person is responsible for the cost of the treatment. A Covered Person or his or her Physician should contact the Claims Administrator to determine whether treatment is for cosmetic purposes. The exclusion for services and operations for cosmetic purposes is detailed in the ***What Is Not Covered*** section.

## **REGARDING COVERAGE FOR EMERGING TECHNOLOGY:**

While the Claims Administrator does not cover treatment it determines to be Experimental/Investigational, it routinely performs technology assessments in order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The Claims Administrator uses the technology assessment process to assure that new drugs, procedures or devices ("emerging technology") are safe and effective before approving them as Covered Services. When new technology becomes available or at the request of a practitioner or Covered Person, the Claims Administrator researches all scientific information available from these expert sources. Following this analysis, the Claims Administrator makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A Covered Person or his or her Provider should contact the Claims Administrator to determine whether a proposed treatment is considered "emerging technology".

## **REGARDING USE OF NON-PREFERRED PROVIDERS:**

To receive the maximum benefits available under this program, the Covered Person must obtain Covered Services from Preferred Providers that participate in the PPO Network or in the Blue Card PPO Program. While this PPO program has an extensive network, it may not contain every provider that a Covered Person needs. The Covered Person may obtain Covered Services from Participating Professional Providers or Member Facility Providers (Participating Providers) who are not part of the PPO Network but have agreed to accept contracted rates as payment in full and will not balance bill. However, those services will be subject to Non-Preferred "Out-of-Network" Coinsurance and Deductibles. In addition, the PPO program allows a Covered Person to obtain Covered Services from Non-Preferred, Non-Participating Providers. If a Covered Person uses a Non-Preferred, Non-Participating Provider, the Covered Person will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles, Coinsurance and the balance of the provider's bill. This is true whether a Non-Preferred, Non-Participating Provider is used by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a provider.

The Claims Administrator may approve Covered Services provided by a Non-Preferred Provider subject to Preferred "In-Network" cost-sharing, if such cost-sharing is applicable to the program (Copayments, Coinsurance and Deductibles), if the Covered Person has: (1) first sought and received care from a Preferred Provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the Non-Preferred Provider requested; (2) been advised by the Preferred Provider that there are no Preferred Providers that can provide the requested Covered Services; and (3) obtained authorization from the Claims Administrator prior to receiving care. The Claims Administrator reserves the right to make the final determination whether there is a Preferred Provider that can provide the Covered Services. If the Claims Administrator approves the use of a Non-Preferred, Non-Participating Provider, the Covered Person will not be responsible for the difference between the provider's billed charges and the Claims Administrator's payment to the Provider. Applicable program terms including Medical Necessity/ Appropriateness and precertification will apply.

**REMEMBER: Whenever a Provider suggests a new treatment option that may fall under the category of "Experimental/Investigational", "cosmetic", or "emerging technology", the Covered Person, or his or her Provider, should contact the Claims Administrator for a coverage determination. That way the Covered Person and the Provider will know in advance if the treatment will be covered by the Claims Administrator.**

**In the event the treatment is not covered by the Claims Administrator, the Covered Person can make an informed decision about whether to pursue alternative treatment options or be financially responsible for the non-covered service. For more information on when to contact the Claims Administrator for coverage determinations, please see the Precertification and Prenotification requirements in the *Managed Care* section.**

## DEFINED TERMS

The terms below have the following meaning when describing the benefits within this Booklet. They will be helpful to you in fully understanding your benefits.

**ACCESSIBILITY** – the extent to which a member of a Managed Care Organization can obtain from a Preferred Provider available Covered Services at the time they are needed. Accessibility to a Preferred Provider refers to both telephone access and ease of scheduling an appointment.

**ACCIDENTAL INJURY** – bodily injury which results from an accident directly and independently of all other causes.

**ACCREDITED EDUCATIONAL INSTITUTION** – a publicly or privately operated academic institution of higher learning which: (a) provides recognized course or courses of instruction and leads to the conferment of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and (b) is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education. The definition may include, but is not limited to, colleges and universities, and technical or specialized schools.

**ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE** – Complementary and alternative medicine, as defined by the National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM), is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications: (a) alternative medical systems (e.g., homeopathy, naturopathy, Ayurveda, traditional Chinese medicine); (b) mind-body interventions which include a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms (e.g., meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance); (c) biologically based therapies using natural substances, such as herbs, foods, vitamins or nutritional supplements to prevent and treat illness (e.g., diets, macrobiotics, megavitamin therapy); (d) manipulative and bodybased methods (e.g., massage, equestrian/hippotherapy); and (e) energy therapies, involving the use of energy fields. The energy therapies are of two types: (1) Biofield therapies - intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi Gong, Reiki, and therapeutic touch. (2) Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

**AMBULATORY SURGICAL FACILITY** – a Facility Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health care, Inc., or by the Claims Administrator and which:

- A. has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;
- B. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- C. does not provide Inpatient accommodations; and
- D. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

**ANCILLARY PROVIDER** – an individual or entity that provides services, supplies or equipment (such as, but not limited to, Home Infusion Therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the coverage.

**ANESTHESIA** – consists of the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

**APPEAL** – A request by a Covered Person, or the Covered Person’s representative or Provider, acting on the Covered Person’s behalf upon written consent, to change a previous decision made by the Claims Administrator.

- A. Administrative Appeal – an appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding coverage terms such as contract exclusions and non-covered benefits. Administrative appeal may present issues related to Medical Necessity or Medical Appropriateness, but these are not the primary issues that affect the outcome of the appeal.
- B. Medical Necessity Appeal – request for the Claims Administrator to change its decision, based primarily on Medical Necessity and Appropriateness, to deny or limit the provision of a Covered Service.
- C. Expedited Appeal – a faster review of a Medical Necessity Appeal, conducted when the Claims Administrator determines that a delay in decision making would seriously jeopardize the Covered Person’s life, health, or ability to regain maximum function.

**APPLICANT AND MEMBER** – you, the Member who applies for coverage under the Plan.

**APPLICATION AND APPLICATION CARD** – the request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the Claims Administrator.

**ATTENTION DEFICIT DISORDER** – a disease characterized by developmentally inappropriate inattention, impulsiveness and hyperactivity.

**BENEFIT PERIOD** – the specified period of time as shown in the Schedule of Benefits during which charges for Covered Services must be Incurred in order to be eligible for payment by the Claims Administrator. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

**BIRTH CENTER** – a Facility Provider approved by the Claims Administrator which (1) is licensed as required in the state where it is situated, (2) is primarily organized and staffed to provide maternity care, and (3) is under the supervision of a Physician or a licensed certified nurse midwife.

**CASE MANAGEMENT** – Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the Covered Person to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve Covered Person outcomes. Case Management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

**CERTIFIED REGISTERED NURSE** – a certified registered nurse anesthetist, certified registered nurse practitioner, certified enteral therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility or by an anesthesiology group.

**COINSURANCE** – a type of cost-sharing in which the Covered Person assumes a percentage of the Covered Expense for Covered Services (such as 10 percent).

**COMPLAINT** – any expression of dissatisfaction, verbal or written, by a Covered Person.

## **COMPLICATIONS OF PREGNANCY** –

- (a) conditions requiring medical treatment prior or subsequent to the termination of pregnancy whose diagnoses are distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, disease of the vascular, hemopoietic, nervous, or endocrine systems, and similar medical and surgical conditions of comparable severity; but will not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy, not constituting a classifiable distinct complication of pregnancy; and
- (b) hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.
- (c) Conditions requiring medical treatment after the termination of pregnancy whose diagnoses are distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy.

**COPAYMENT** – a type of cost-sharing in which the Covered Person pays a flat dollar amount each time a Covered Service is provided (such as a \$15 or \$25 Copayment per office visit). Copayments, if any, are identified in the Schedule of Benefits.

**COVERED EXPENSE** – refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

- (a) With respect to services rendered by providers with which your local Blue Cross and Blue Shield Plan has negotiated a special pricing arrangement, Covered Expense is the amount payable to the provider under the special pricing arrangement.
- (b) (i) With respect to services rendered by Facility and Ancillary Providers with which your local Blue Cross and Blue Shield Plan has not negotiated a special pricing arrangement, Covered Expense is the lesser of the: (1) Provider's charges, (2) Medicare Allowable Payment, or (3) Reasonable and Customary Charge for the Covered Services.
- (ii) With respect to services rendered by Professional Providers with which your local Blue Cross and Blue Shield Plan has not negotiated a special pricing arrangement, Covered Expense means the amount as determined by the Claims Administrator's lowest network fee schedule that the Claims Administrator would have paid to a Preferred Professional Provider in the Claims Administrator's local network for the same service, or the charge whichever is less.

**COVERED PERSON** – an enrolled Member or his Eligible Dependents who have satisfied the specifications of the Schedule of Eligibility. A Covered Person does not mean any person who is eligible for Medicare except as specifically stated in this booklet.

**COVERED SERVICE** – a service or supply specified in this booklet for which benefits will be provided by the Claims Administrator.

**CUSTODIAL CARE (DOMICILIARY CARE)** – provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.



**DAY REHABILITATION PROGRAM** – is a level of Outpatient care consisting of four (4) to seven (7) hours of daily rehabilitative therapies and other medical services five (5) days per week. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy, and Speech Therapy, as otherwise defined in this Plan and other medical services such as nursing services, psychological therapy and Case Management services. Day Rehabilitation sessions also include a combination of one-to-one and group therapy. The Covered Person returns home each evening and for the entire weekend.

**DEDUCTIBLE** – a specified amount of Covered Expenses for the Covered Services that is incurred by the Covered Person before the Claims Administrator will assume any liability.

**DURABLE MEDICAL EQUIPMENT** – is equipment which meets the following criteria:

- A. it is durable and can withstand repeated use;
- B. it is medical equipment, meaning it is primarily and customarily used to serve a medical purpose;
- C. it generally is not useful to a person in the absence of an illness or injury; and
- D. it is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to: diabetic supplies, canes, crutches, walkers, commode chairs, home oxygen equipment, hospital beds, traction equipment and wheelchairs.

**EFFECTIVE DATE** – according to the Eligibility Section, the date on which coverage for a Covered Person begins under your Preferred Provider Organization Plan. All coverage begins at 12:01 a.m. on the date reflected on the records of the Claims Administrator.

**EMERGENCY** – The sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- A. Placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy;
- B. Serious impairment to bodily functions; or
- C. Serious dysfunction of any bodily organ or part.

**EMERGENCY CARE** – Covered Services and supplies provided by a Hospital or Facility Provider and/or Professional Provider to a Covered Person in or for an Emergency on an Outpatient basis in a Hospital Emergency Room or Outpatient Emergency Facility.

**ENTERAL NUTRITION** – the provision of nutritional requirements through a tube into the stomach or small intestine.

**EXPERIMENTAL/INVESTIGATIONAL SERVICES** – a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

- A. Is the subject of ongoing Phase I or Phase II Clinical Trials;
- B. Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;

- D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or
- E. Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia:

- o The American Hospital Formulary Service Drug Information, or
- o The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental/Investigational.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigational if it meets all of the criteria listed below:

- A. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.
- B. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
- C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.
- E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

**FACILITY PROVIDER** – an institution or entity licensed, where required, to provide care. Such facilities include:

- Ambulatory Surgical Facility
- Birth Center
- Free Standing Dialysis Facility
- Free Standing Ambulatory Care Facility
- Home Health Care Agency
- Hospice
- Hospital
- Rehabilitation Hospital
- Short Procedure Unit
- Skilled Nursing Facility

**FAMILY COVERAGE** – for you and one or more of your Dependents.

**FREE STANDING AMBULATORY CARE FACILITY** – a Facility Provider, other than a Hospital, which provides treatment or services on an Outpatient or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of a Physician.

This facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

**FREE STANDING DIALYSIS FACILITY** – a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the Claims Administrator, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

**FUND or (ENROLLED FUND)** – a Fund of Members which has been accepted by the Claims Administrator, consisting of all those active Applicants whose charges are remitted by the Applicant's Agent together with all the Members, listed on the Application Cards or amendments thereof, who have been accepted by the Claims Administrator.

**HEARING AID** – a Prosthetic that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of (a) a microphone to pick up sound, (b) an amplifier to increase the sound, (c) a receiver to transmit the sound to the ear, and (d) a battery for power. A hearing aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a hearing aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles: (a) behind-the-ear, (b) in-the-ear, (c) in-the-canal, (d) completely-in-the-canal, and (e) implantable (can be partial or complete). A Hearing Aid is not a cochlear implant.

**HOME HEALTH CARE AGENCY** - a Facility Provider, approved by the Claims Administrator, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient's home in accordance with an approved home health care Plan of Treatment.

**HOSPICE** – a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

**HOSPITAL** – a short-term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the Claims Administrator and which:

- A. is a duly licensed institution;
- B. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
- C. has organized departments of medicine;
- D. provides 24-hour nursing service by or under the supervision of Registered Nurses;
- E. is not, other than incidentally, a: Skilled Nursing Facility; nursing home; Custodial Care home; health resort, spa or sanitarium; place for rest; place for aged; place for treatment of Mental Illness; place for treatment of Alcohol or Drug Abuse; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of Hospice care.

**IDENTIFICATION CARD** – the currently effective card issued to you by the Claims Administrator which must be presented when a Covered Service is requested.

**IMMEDIATE FAMILY** – the Member's spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law.

**INCURRED** – a charge shall be considered incurred on the date you or your Covered Dependent receives the service or supply for which the charge is made.

**INDEPENDENT CLINICAL LABORATORY** – a laboratory that performs clinical pathology procedure and that is not affiliated or associated with a Hospital, Physician or Facility Provider.

**INPATIENT ADMISSION or (INPATIENT)** – your actual entry into a Hospital, extended care facility or Facility Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility or Facility Provider and for whom a room and board charge is made; the Inpatient Admission shall continue until such time as you are actually discharged from the facility.

**LICENSED PRACTICAL NURSE (LPN)** – a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

**LIMITING AGE FOR DEPENDENTS** – the age at which a Dependent child shall be removed from the Member's coverage. The Limiting Age for covered, unmarried children is shown in the Eligibility Under the Plan section.

**MAINTENANCE** – Continuation of care and management of the patient when the maximum therapeutic value of a Medically Appropriate/Medically Necessary treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, the provision of Covered Services for a condition ceases to be of therapeutic value and is no longer Medically Appropriate/Medically Necessary. This includes Maintenance services that seek to prevent disease, promote health and prolong and enhance the quality of life.

**MANAGED CARE ORGANIZATION (MCO)** – a generic term for any organization that manages and controls medical service. It includes HMOs, PPOs, managed indemnity insurance programs and managed BCBS programs.

**MAXIMUM** – a limit on the amount of Covered Services that you may receive. The Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less deductibles, coinsurance and Copayment amounts paid by Covered Persons for the Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Claims Administrator to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

- A. Benefit Maximum - the greatest amount of a specific Covered Service that a Covered Person may receive.
- B. Lifetime Maximum - the greatest amount of Covered Services that a Covered Person may receive in his lifetime.

**MEDICAL CARE** – services rendered by a Professional Provider within the scope of his license for the treatment of an illness or injury.

**MEDICAL FOODS** – liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

**MEDICALLY APPROPRIATE/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS/MEDICAL NECESSITY)** – an intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by the Claims Administrator's medical director or physician designee, it meets all of the following criteria:

- A. ***It is a "Health Intervention"***. A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human

variation. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. **It is the most appropriate supply or level of service, considering potential benefits and harms to the Covered Person.**

C. **It is known to be “effective” in improving “health outcomes”**

Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a “new” or “existing” intervention.

- i. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

“Scientific Evidence” consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

- ii. Existing interventions: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion.

For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for determinations of Medical Appropriateness/Medical Necessity.

If no Scientific Evidence is available, professional standards of care should be considered.

If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion.

Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence.

Existing interventions can meet the contractual definition of Medical Appropriateness/Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. **It is cost-effective for this condition compared to alternative interventions, including no intervention.**

“Cost effective” does not necessarily mean lowest price. An intervention is considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this definition of Medical Appropriateness/Medical Necessity. An intervention is covered if: (a) it is a Covered Service; (b) it is not excluded from your coverage; and (c) it is Medically Appropriate/Medically Necessary.

**MEDICARE** – the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

**MEDICARE ALLOWABLE PAYMENT** – means the payment amount, as determined by the Medicare program, for a Covered Service or supply.

**MEMBER** – an individual of the Fund who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the Identification Card is issued.

**MEMBER FACILITY PROVIDER** – a Facility Provider that is not part of the Preferred Provider Organization Network but is approved by and has a contractual relationship with the Claims Administrator for the provision of services to Covered Persons.

**NON-MEMBER FACILITY PROVIDER** – a Facility Provider that does not have a contractual relationship with the Claims Administrator or your local Blue Cross or Blue Shield Plan for the provision of services to Covered Persons.

**NON-PARTICIPATING PROFESSIONAL PROVIDER** – a Professional Provider who has not agreed to accept a rate of reimbursement determined by a contract with the Claims Administrator or your local Blue Cross or Blue Shield Plan for the provision of Covered Services to Covered Persons.

**NON-PREFERRED ANCILLARY PROVIDER** – an Ancillary Provider that is not a member of a BlueCard PPO Network or any other Blue Cross or Blue Shield Preferred Provider Network.

**NON-PREFERRED FACILITY PROVIDER** – a Facility Provider that is not a member of a BlueCard PPO Network or any other Blue Cross or Blue Shield Preferred Provider Network.

**NON-PREFERRED PROFESSIONAL PROVIDER** – a Professional Provider who is not a member of a BlueCard PPO Network or any other Blue Cross or Blue Shield Preferred Provider Network.

**NON-PREFERRED PROVIDER** – a Facility Provider, Professional Provider or Ancillary Provider that is not a member of a BlueCard PPO Network or any other Blue Cross or Blue Shield Preferred Provider Network.

**NUTRITIONAL FORMULA** – liquid nutritional products which are formulated to supplement or replace normal food products.

**OUT-OF-POCKET LIMIT** – a specified dollar amount of Coinsurance expense Incurred by a Covered Person for Covered Services in a Benefit Period. Such expense does not include any Deductible, penalties, Inpatient or Outpatient mental health services, or Copayment amounts. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the Schedule of Benefits.

**OUTPATIENT CARE** – medical, nursing, counseling or therapeutic treatment provided to a Covered Person who does not require an overnight stay in a Hospital or other inpatient facility.

**OUTPATIENT DIABETIC EDUCATION PROGRAM** – an outpatient diabetic education program provided by a Preferred Facility Provider which has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

**PARTICIPATING PROFESSIONAL PROVIDER** – a Professional Provider who has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

**PENALTY** – a type of cost-sharing in which the Covered Person is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified in the Schedule of Benefits and explained in detail in the Managed Care section.

**PERVASIVE DEVELOPMENTAL DISORDERS (PDD)** – disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests and activities. Examples are Asperger's syndrome and childhood disintegrative disorder.

**PHYSICIAN** – a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs.

**PLAN ADMINISTRATOR** – the person or entity that has discretionary authority or responsibility to control and manage the operation and administration of this Plan, as provided in the documents establishing this Plan, in accordance with Employee Retirement Income Security Act (ERISA). **THE CLAIMS ADMINISTRATOR IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE FUND.**

**PLAN OF TREATMENT** – a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan of Treatment should be limited in scope and extent to that care which is Medically Appropriate/Medically Necessary for the Covered Person's diagnosis and condition.

**PRECERTIFICATION (or PRECERTIFY)** – prior assessment by the Claims Administrator or a designated agent that proposed services, such as hospitalization, are Medically Appropriate/Medically Necessary for a particular patient and covered by the patient's Preferred Provider Organization plan. Payment for services depends on whether the patient and the category of service are covered under the individual's plan of coverage.

**PREFERRED ANCILLARY PROVIDER** – an Ancillary Provider that is a member of a BlueCard PPO Network and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

**PREFERRED FACILITY PROVIDER** – a Facility Provider that is a member of a BlueCard PPO Network and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Covered Persons.

**PREFERRED PROFESSIONAL PROVIDER** – a Professional Provider who is a member of a BlueCard PPO Network and has agreed to a rate of reimbursement determined by contract for "in-network" Covered Services rendered to a Covered Person.

**PREFERRED PROVIDER** – a Facility Provider, Professional Provider or Ancillary Provider that is a member of a BlueCard PPO Network, authorized to perform specific "in-network" Covered Services at the Preferred level of benefits.

**PREFERRED PROVIDER ORGANIZATION (PPO)** – a type of managed care plan that offers the freedom to choose a physician like a traditional health care plan and provides the physician visits and preventive benefits normally associated with an HMO (Health Maintenance Organization). In a PPO, an individual is not required to select a primary care physician to coordinate care, and is not required to obtain referrals to see specialists.

**PRENOTIFICATION (or PRENOTIFY)** – the requirement that a Covered Person provide prior notice to the Claims Administrator that proposed services, such as maternity care, are scheduled to be performed. Payment for services depends on whether the Covered Person and the category of service are covered under this Plan.

**PRIMARY CARE SERVICES** – basic, routine medical care traditionally provided to individuals with common illnesses and injuries and chronic illnesses.

**PRIMARY CARE PROVIDER** – a Professional Provider as listed in the Preferred Provider Organization Network directory under "Primary Care Physicians" (General Practice, Family Practice or Internal Medicine), "Obstetricians/Gynecologists" or "Pediatricians".

**PRIVATE DUTY NURSING** – Medically Appropriate/Medically Necessary Outpatient continuous skilled nursing services provided to a Covered Person by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

**PROFESSIONAL PROVIDER** – a person or practitioner licensed where required and performing services within the scope of such licensure. The Professional Providers are:

- |                                    |                                    |
|------------------------------------|------------------------------------|
| A. Audiologist                     | G. Optometrist                     |
| B. Certified Registered Nurse      | H. Physical Therapist              |
| C. Chiropractor                    | I. Physician                       |
| D. Dentist                         | J. Podiatrist                      |
| E. Independent Clinical Laboratory | K. Speech-language Pathologist     |
| F. Nurse Midwife                   | L. Teacher of the hearing impaired |

**PROSTHETICS** – devices (except dental prosthetics), which replace all or part of: (1) an absent body organ including contiguous tissue; or (2) the function of a permanently inoperative or malfunctioning body organ.

**PROVIDER** – a Facility Provider, Professional Provider or Ancillary Provider, licensed where required.

**QUALIFYING CLINICAL TRIAL** – the systematic, intensive investigation or evaluation of a drug, biological product, device, medical treatment, therapy or procedure that meets all of the following criteria:

- A. Investigates a service that falls within a benefit category of this Contract;
- B. Is not specifically excluded from coverage;
- C. Has a therapeutic intent upon enrolled patients with diagnosed disease;
- D. Is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available Reliable Evidence;
- E. Does not duplicate existing studies;
- F. Is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial;
- G. Is designed and conducted according to appropriate standards of scientific integrity;
- H. Complies with Federal regulations relating to the protection of human subjects;
- I. Has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;
- J. Is: (1) funded by, or supported by centers or cooperative groups that are funded by: the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA); or (2) conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA;
- K. Is conducted by a Preferred Professional Provider, and conducted in a Preferred Facility Provider. If there is no comparable Clinical Trial (as defined above) being conducted by a Preferred Provider, the Claims Administrator will consider a Clinical Trial being conducted by a Non-Preferred Provider as covered. In the absence of meeting the criteria listed above, the Clinical Trial must be approved by the Claims Administrator as a Qualifying Clinical Trial.

**REASONABLE AND CUSTOMARY** – means the amount that is the usual or customary charge for the service or supply as determined by the Claims Administrator. The chosen standard is an amount which is most often charged by other providers for similar services or supplies within the same geographic area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply. If no comparison exists, the Claims Administrator determines what is reasonable by the severity and/or complexity of the patient's condition for which the service or supply is provided.

**REGISTERED NURSE (R.N.)** – a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.



**REHABILITATION HOSPITAL** – a Facility Provider, approved by the Claims Administrator and licensed by the appropriate regulatory agency, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

**RELIABLE EVIDENCE** – only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

**RESTORATIVE SERVICES** – courses of treatments prescribed or provided by Professional Providers to restore loss of function of a body part. Restorative services generally involve neuromuscular training as a course of treatments over weeks or months. Examples of restorative services include, but are not limited to:

- A. Manipulative treatment of functional loss from back disorder
- B. Therapy treatment of functional loss following foot surgery
- C. Orthoptic/Pleoptic therapy

**ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS** – Routine costs include: (a) Covered Services under this Contract that would typically be provided absent a Qualifying Clinical Trial; (b) services and supplies required solely for the provision of the Experimental/Investigational drug, biological product, device, medical treatment or procedure; (c) the clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications; and (d) the services and supplies required for the diagnosis or treatment of complications.

Routine costs do not include the Experimental/Investigational drug, biological product, device, medical treatment or procedure itself, the services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Qualifying Clinical Trial.

**SEVERE SYSTEMIC PROTEIN ALLERGY** – means allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

**SHORT PROCEDURE UNIT** – a unit which is approved by the Claims Administrator and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient stay in the absence of a Short Procedure Unit.

**SKILLED NURSING FACILITY** – an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol or Drug Abuse, which:

- A. is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- B. is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
- C. is otherwise acceptable to the Claims Administrator.

**SPECIALIST SERVICES** – all Professional Provider services providing medical or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

**SURGERY** – the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered surgery.

**THERAPY SERVICE** – the following services or supplies prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Covered Person:

- A. **CARDIAC REHABILITATION THERAPY** - Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.
- B. **CHEMOTHERAPY** - The treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.
- C. **DIALYSIS** - The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.
- D. **INFUSION THERAPY** - Treatment including, but not limited to infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.
- E. **OCCUPATIONAL THERAPY** - Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational therapy also includes medically prescribed treatment concerned with improving the Covered Person's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.
- F. **PHYSICAL THERAPY** - Medically prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.
- G. **PULMONARY REHABILITATION THERAPY** - Multidisciplinary treatment which combines physical therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.
- H. **RADIATION THERAPY** - The treatment of disease by X-Ray, gamma ray, accelerated particles, mesons, neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.
- I. **RESPIRATORY THERAPY** - Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.
- J. **SPEECH THERAPY** - Medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

**TOTAL DISABILITY** – means that you, due to illness or injury, cannot perform any duty of your occupation or any occupation for which you are, or may be, suited by education, training and experience, and you are not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Totally Disabled person must be under the regular care of a Physician.

**URGENT CARE** – Medically Appropriate/Medically Necessary Covered Services provided in order to treat an unexpected illness or Accidental Injury that is not life-or limb-threatening. Such Covered Services must be required in order to prevent a serious deterioration in the Covered Person's health if treatment were delayed.

## YOUR PREFERRED PROVIDER ORGANIZATION PLAN

Your Preferred Provider Network Plan (the Plan) is a program, which allows you to maximize your health care benefits by utilizing the Preferred Providers in your local PPO Network. These Providers are called "Preferred Providers" in this Booklet. You may think of them as "In-Network Providers". Preferred Providers are doctors, hospitals and other health care professionals and institutions that are part of your local BlueCard PPO Network, authorized to perform specific "in-network" Covered Services at the Preferred level of benefits.

When you receive health care through a Provider that is a member of your local BlueCard PPO Network, you are assured of little, if any, out-of-pocket expenses, and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

To locate a BlueCard PPO network provider go to [www.bluecares.com](http://www.bluecares.com) or call 1-800-810-BLUE (2583). The Claims Administrator covers only care that is Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient Department.

Some of the services you receive through this Plan must be pre-certified before you receive them, to determine whether they are Medically Appropriate/Medically Necessary. Failure to precertify Covered Services, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews Medical Appropriateness/Medical Necessity of certain procedures/admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. The latest innovations in health care enable doctors to provide services, once provided exclusively in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor's office.

When you need to seek medical treatment that requires Precertification, you must ask your Provider to initiate the Precertification process. The precertification number is listed on the back of your Identification Card. The provider should give your name, facility's name, diagnosis, and procedure or reason for admission. Failure to precertify required services will result in a reduction of benefits payable to you.

If the request for Precertification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

### HOW TO FILE A CLAIM

Most BlueCard PPO providers will file claims for you. Simply present your Identification Card at the time the services are provided. You may call 1-800-810-BLUE (2583) for assistance in finding BlueCard PPO Preferred Providers. When you receive care from a Non-Preferred Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call the number listed on the back of your Identification Card, and a claim form will be sent to you. Fill out the claim form and return it with your itemized bills to Horizon Blue Cross/Blue Shield of New Jersey at the address listed on the claim form no later than 20 days after completion of the Covered Services.

The itemized bill should contain the following information:

- (1) patient's name and address;
- (2) date of service;
- (3) type of service and diagnosis;
- (4) itemized charges;
- (5) provider's complete name and address.

An expense will be considered Incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 20-day period, your benefits will not be reduced, but in no event will the Claims Administrator be required to accept the claim more than two years after the end of the Benefit Period in which the Covered Services are rendered.

## **PAYMENT OF PROVIDERS**

Covered Person or the Provider may submit bills directly to the Claims Administrator, and, to the extent that benefits and indemnity are payable within the terms and conditions of this coverage, reimbursement will be furnished as detailed below. The Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits for Covered Services are based on the rate of reimbursement as defined under "Covered Expense" in the Defined Terms section of this Booklet.

### **Facility Providers**

#### **Preferred Facility Providers**

Preferred Facility Providers are members of the Preferred Provider Organization Network or a BlueCard PPO Network and have a contractual arrangement for the provision of services to Covered Persons. Benefits will be provided as specified in the Schedule of Benefits for services which have been performed by a Preferred Facility Provider. The Claims Administrator will compensate Preferred Facility Providers in accordance with the contracts entered into between such Providers and the Claims Administrator. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

#### **Non-Preferred Facility Providers**

Non-Preferred Facility Providers include facilities that are not part of the Preferred Provider Organization's Network, a BlueCard PPO Network, or any other Blue Cross or Blue Shield Preferred Provider Network. The Claims Administrator may have a contractual arrangement with a facility even if it is not part of its Preferred Organization Network. Non-Preferred Member Facility Providers that have contracts with the Claims Administrator will be compensated in accordance with the contracts entered into between such Providers and the Claims Administrator.

A Non-Preferred Non-Member Facility Provider is a Facility Provider which does not belong to your local Preferred Provider Organization Network, nor does it have a contract with the Claims Administrator or any other Blue Cross or Blue Shield Preferred Provider Network. The Claims Administrator will provide benefits at a Non-Preferred Non-Member Provider at the Non-Preferred coinsurance level specified in the Schedule of Benefits.

If the Claims Administrator determines that Covered Services were for Emergency Care as defined herein, the Covered Person normally will not be subject to the cost sharing penalties that would ordinarily be applicable to Non-Preferred services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Claims Administrator. The Claims Administrator will provide benefits for the Covered Expenses incurred for certain medical services when rendered incident to hospitalization, as described herein. If charges for such services are included in a bill from a Preferred Facility Provider or a Member Facility Provider, payment shall be made to such Facility Provider subject to any existing agreement between the Facility Provider and the Claims Administrator.

Once Covered Services are rendered by a Facility Provider, the Plan will not honor a Covered Person's request not to pay for claims submitted by the Facility Provider. The Covered Person will have no liability to any person because of its rejection of the request.

### **Professional Providers**

The Claims Administrator is authorized by the Covered Person to make payment directly to the Preferred and Participating Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Most Preferred and Participating Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Most Preferred and Participating Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this program. However, not all Preferred and Participating Professional Providers have agreed to hold members harmless from balance bills. The Covered Person is responsible within 60 days of the date in which the Claims Administrator finalizes such services to pay, or make arrangements to pay, such amounts to the Preferred and Participating Professional Provider.

Benefit amounts, as specified in the Schedule of Benefits of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to the Claims Administrator for determination. The decision of the Claims Administrator shall be final.

### **Non-Preferred Professional Provider Reimbursement**

When Covered Services are performed by a Non-Preferred Professional Provider, the Claims Administrator will make payment to the Covered Person, subject to any applicable Coinsurance or other cost sharing penalty on services by Non-Preferred Professional Providers. When a Covered Person seeks care from a Non-Preferred Participating Professional Provider, payment will be made in accordance with the rate of reimbursement determined by the contract between the Professional Provider and the Claims Administrator. When a Covered Person seeks care from a Non-Preferred, Non-Participating Professional Provider, payment will be the amount as determined by the Claims Administrator's lowest network fee schedule that the Claims Administrator would have paid to a Preferred Professional Provider for the same service or the charge, whichever is less. Accordingly, when a Covered Person seeks care from Non-Preferred, Non-Participating Professional Providers, any difference between the Non-Preferred Professional Provider's charge and the Claims Administrator's payment shall be the personal responsibility of the Covered Person.

If the Claims Administrator determines that services were performed during an emergency, the Covered Person will not be subject to the cost-sharing features ordinarily applicable to Covered Services rendered by Non-Preferred Professional Providers.

Once Covered Services are rendered by a Professional Provider, the Claims Administrator will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. The Claims Administrator will have no liability to any person because of its rejection of the request.

### **Ancillary Providers**

#### **Preferred Ancillary Providers**

Preferred Ancillary Providers include members of your local Preferred Provider Organization's Network or any other BlueCard PPO Network. Benefits will be provided as specified in the Schedule of Benefits for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Ancillary Provider.

## **Non-Preferred Ancillary Providers**

Non-Preferred Ancillary Providers are not members of the Preferred Provider Organization's Network or any other BlueCard PPO Network. Benefits will be provided to the Covered Person at the Non-Preferred coinsurance level specified in the Schedule of Benefits. The Covered Person will be penalized by the application of higher cost sharing as detailed in the Schedule of Benefits.

## **Assignment of Benefits to Providers**

The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the Group Contract, as required by law.

## **BLUECARD PPO PROGRAM**

When you obtain health care services through BlueCard outside the geographic area Horizon Blue Cross/Blue Shield of New Jersey ("HORIZON") serves, the amount you pay for Covered Services is calculated on the lower of:

- o The billed charges for your Covered Services, or
- o The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Plan") passes on to us.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating a Covered Person's liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, HORIZON would then calculate your liability for any covered health care services in accordance with the applicable Host Blue state statute in effect at the time you received your care.

## **DEDUCTIBLE**

You must pay a portion of your covered medical expenses before the Carrier begins to pay for benefits. A Deductible must be met each Benefit Period before payment will be made for Covered Services. See the Schedule of Benefits section for the Deductible amount and the services to which the Deductible is applicable.

Expenses incurred for Preferred and Non-Preferred Services in the last three (3) months of a Benefit Period which were applied to that year's Preferred and Non-Preferred Deductible will be applied to the Deductible for the next Benefit Period.

No more than two times the individual Deductible under one Family Coverage must be satisfied in each Benefit Period. However, no family member may contribute more than the individual Deductible amount.

## **COINSURANCE**

Coinsurance is a percentage of the Covered Expenses that must be paid by you or your covered Dependents; it is applied after the Deductible, if any, is met. Coinsurance is applied to most Covered Services, when they are received from some Preferred Providers and most Non-Preferred Providers. Refer to the Schedule of Benefits for specific Coinsurance amounts.

### **Limits on Coinsurance Liability**

There is a Maximum placed on the amount of Coinsurance which you are required to pay each Benefit Period. This Maximum is called your "Out-of-Pocket Coinsurance Limit ". See the Schedule of Benefits section for the Outof-Pocket Coinsurance Limit amounts.

For each Covered Person, when the Preferred and Non-Preferred Out-of-Pocket Limit is reached, the Claims Administrator will pay 100% of the Covered Expenses for Preferred and Non-Preferred services incurred during the balance of the Benefit Period.

Out-of-Pocket expenses incurred for Non-Preferred Covered Services do not count toward the Preferred Out-of-Pocket Limit.

### **LIFETIME MAXIMUM**

There is a Lifetime maximum for all Preferred and Non-Preferred services. Benefits will cease after benefits for the Preferred and Non-Preferred care exceed the individual Lifetime Maximum. The calculation of benefits paid shall begin from the Covered Person's first participation in the Fund and shall include all medical benefits paid on behalf of the Covered Person regardless of which medical benefit program (Traditional, PPO medical or HMO medical) under which the Covered Person was or is enrolled.

See the Schedule of Benefits for the Lifetime Maximum amount.

Amounts applied to the Covered Person's Lifetime Maximum are not restorable.

## ELIGIBILITY UNDER THE PLAN

### Who Is Eligible and When?

**Effective Date:** The date the Fund agrees that all Eligible Persons may apply and become covered for the benefits as set forth in the Fund Contract and described in this booklet. If a person becomes an eligible person after the Fund's Effective Date, that date becomes the Effective Date.

### **ELIGIBLE PERSON**

You are eligible to be covered under this PPO Plan if you are determined by the Fund as eligible to apply for coverage and sign the Application.

Eligibility shall not be affected by your physical condition and determination of eligibility for the coverage by the Fund shall be final and binding.

### **SPECIAL NOTE FOR PART-TIME EMPLOYEES:**

**If you are or become a part-time employee, as determined by the Health & Welfare Fund, the benefits described in this booklet are limited to you, the employee. Contact the Fund if you are unsure as to your status as a full-time or part-time employee.**

### **ELIGIBLE DEPENDENT**

If you are a Full-Time Employee, your family is eligible for coverage (Dependent coverage) when you are eligible for Member coverage. No coverage is provided for the spouse or Dependent children of a Part-time Employee.

An Eligible Dependent is defined as your spouse under a legally valid existing marriage, provided you are not separated as defined by the Fund's benefit plan, your unmarried child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is your responsibility under the terms of a qualified release or court order. The limiting age for covered, unmarried children is to the date on which they reach age 19; or if a student is enrolled full-time in an Accredited Educational Institution, the limiting age is not beyond the date on which they reach age 23 or the date of graduation, whichever first occurs.

Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on you for over half of their support. The Plan may require proof of your eligibility under the prior Claims Administrator's plan and also from time to time under this Plan.

The newborn child(ren) of you or your spouse shall be entitled to the benefits provided by the Plan from the date of birth for a period of 31 days. Coverage of newborn children within such 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the 31 day period, you must enroll the newborn child within such 31 days. To continue coverage beyond 31 days for a newborn child, who does not otherwise qualify for coverage as a Dependent, you must apply within 31 days after the birth of the newborn and the appropriate rate must be paid when billed.

A newly acquired Dependent shall be eligible for coverage under the Plan on the date the Dependent is acquired provided that you apply to the Claims Administrator for addition of the Dependent within 31 days after the Dependent is acquired and you make timely payment of the appropriate rate. If Application is made later than 31 days after the Dependent is acquired, coverage shall become effective on the first billing date following 30 days after your Application is accepted by the Claims Administrator.

A Dependent child of a custodial parent covered under the Fund coverage may be enrolled under the terms of a qualified medical release or court order, as required by law.



## YOUR PREFERRED PROVIDER ORGANIZATION BENEFITS

All Inpatient Hospital Admissions, other than a maternity admission or an admission for a Medical Emergency, and certain other services as described in this section below must receive precertification in accordance with the requirements contained in the Managed Care section of this booklet. Admissions for a Medical Emergency must be reviewed within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Claims Administrator.

The services described below may be provided by either a Preferred or Non-Preferred Provider. However, the Covered Person will maximize the benefits available when services are provided by a Provider that belongs to your Preferred Provider Organization's Network or another Blue Cross and Blue Shield Plan's BlueCard PPO Network (a Preferred or "In-Network" Provider) that has a contract with the Claims Administrator or another Blue Cross or Blue Shield Plan to provide services and supplies to the Covered Person. To locate a BlueCard PPO Network Provider go to [www.bcbs.com](http://www.bcbs.com) or call 1-800-810-BLUE (2583).

### PRIMARY AND PREVENTIVE CARE SERVICES

A Covered Person is entitled to benefits for Primary Care and "Preventive Care" Covered Services when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the **Schedule of Benefits**.

"Preventive Care" services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when the Covered Person has no symptoms of disease. Services performed to treat an illness or injury are not covered as Preventive Care under this benefit.

The Claims Administrator periodically reviews the schedule of Covered Services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of Covered Services are subject to change. The Claims Administrator reserves the right to modify the schedule at any time after written notice of the change has been given to the Covered Person.

#### A. Office Visits

Medical care visits for the examination, diagnosis and treatment of an illness or injury by a Primary Care Provider. For the purpose of this benefit, "Office Visits" include medical care visits to a Provider's office, medical care visits by a Provider to a Covered Person's residence, or medical care consultations by a Provider on an Outpatient basis.

#### B. Pediatric Preventive Care

Pediatric Preventive Care includes the following:

1. **Physical Examination, Routine History, Routine Diagnostic Tests.** Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, is limited to Covered Persons under eighteen (18) years of age in accordance with the schedule shown below. When a range is given (i.e., 2-3 months), the dash indicates that coverage is available for one service from two (2) months through three (3) months of age.

Twenty-four (24) examinations up to age seventeen (17) – according to each of the following age groupings:

- o Eight (8) exams between the ages of 0-24 months within the following age ranges:

0-1 month	9-11 months
2-3 months	12-14 months
4-5 months	15-17 months
6-8 months	18-24 months

- One (1) exam every calendar year between two (2) and seventeen (17) years of age
2. **Blood Lead Screening.** This blood test detects elevated lead levels in the blood. Children are covered for:
    - One (1) test between 9-12 months of age
    - One (1) test at twenty-four (24) months of age
  3. **Hemoglobin/Hematocrit.** This blood test measures the size, shape, number and content of red blood cells. Children are covered for:
    - One (1) test between 0-12 months of age
    - One (1) test between one (1) and four (4) years of age
    - One (1) test between five (5) and twelve (12) years of age
    - One (1) test between thirteen (13) and seventeen (17) years of age
  4. **Rubella Titer Test.** The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the child has ever been immunized. Children are covered for one (1) test and immunization between eleven (11) and seventeen (17) years of age.
  5. **Urinalysis.** This test detects numerous abnormalities. Children are covered for:
    - One (1) test every 365 days between 0-24 months of age
    - One (1) test every calendar year between two (2) and seventeen (17) years of age

### C. Pediatric Immunizations

Coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the Standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control) U.S. Department of Health and Human Services. Benefits are limited to Covered Persons under twenty-one (21) years of age.

Effective December 1, 2006, coverage will be provided, with a patient copayment of \$35.00 per injection for the series of injections for immunization, including the immunizing agents, for the Human Papillomavirus (HPV) Vaccine for female participants between the ages of eleven (11) and twenty-six (26).

### D. Adult Preventive Care

1. **Physical Examination, Routine History.** Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Covered Persons eighteen (18) years of age or older in accordance with the following schedule:
  - One (1) examination every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
  - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
  - One (1) examination every calendar year, beginning at forty (40) years of age
2. **Adult Tetanus Toxoid (TD).** This immunization provides immunity against tetanus and diphtheria.
  - One (1) test every ten (10) calendar years, beginning at eighteen (18) years of age
3. **Blood Cholesterol Test.** This blood test measures the total serum cholesterol level. High blood cholesterol is one of the risk factors that leads to coronary artery disease.

- One (1) test every four (4) calendar years between eighteen (18) and thirty-nine (39) years of age
  - One (1) examination every calendar year, beginning at forty (40) years of age
4. **Complete Blood Count (CBC)**. This blood test checks the red and white blood cell levels, hemoglobin and hematocrit.
    - One (1) test every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
    - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
    - One (1) test every calendar year, beginning at forty (40) years of age
  5. **Fecal Occult Blood Test**. This test checks for the presence of blood in the feces which is an early indicator of colorectal cancer.
    - One (1) test every calendar year, beginning at fifty (50) years of age
  6. **Flexible Sigmoidoscopy**. This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.
    - One (1) test every three (3) calendar years, beginning at fifty (50) years of age
  7. **Influenza Vaccine**. This vaccine provides immunization against influenza type A and B viruses.
    - One (1) vaccine every calendar year, beginning at eighteen (18) years of age
  8. **Pneumococcal Vaccine**. This vaccine provides immunization against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.
    - One (1) vaccine every five (5) calendar years, beginning at sixty-four (64) years of age
  9. **Prostate Specific Antigen (PSA)**. This blood test may be used to detect tumors of the prostate.
    - One (1) test every calendar year, beginning at fifty (50) years of age
  10. **Routine Colonoscopy**. This test detects colorectal cancer by use of a flexible fiberoptic colonoscope.
    - One (1) test every ten (10) calendar years, beginning at fifty (50) years of age
  11. **Rubella Titer Test**. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the adult has ever been immunized.
    - One (1) test and immunization between eighteen (18) and forty-nine (49) years of age
  12. **Thyroid Function Test**. This test detects hyperthyroidism and hypothyroidism.
    - One (1) series of tests every calendar year, beginning at eighteen (18) years of age
  13. **Urinalysis**. This test detects numerous abnormalities.
    - One (1) test every calendar year, beginning at eighteen (18) years of age
  14. **Varicella Vaccine**. This vaccine is recommended for women of childbearing age who have not been previously exposed to the chicken pox virus.
    - One (1) immunization for women between eighteen (18) and forty-nine (49) years of age
  15. **Osteoporosis Screening (Bone Mineral Density Testing or BMDT)**. Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test

determines the amount of mineral in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

- o One screening test every two calendar years beginning at age 65

16. **Fasting Blood Glucose Test.** This test is used for detection of diabetes.

- o One (1) test every three (3) years, beginning at age forty-five (45).

17. **Abdominal Aortic Aneurysm Screening.** One (1) test per lifetime is recommended for men with a smoking history.

- o One (1) ultrasound for men between sixty-five (65) and seventy-five (75) years of age.

#### **E. Routine Gynecological Examination, Pap Smear**

Female Covered Persons are covered for one (1) routine gynecological examination each calendar year, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

#### **F. Mammograms**

Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992.

#### **G. High Risk Immunizations**

- o Benefits are payable for certain immunizations provided to Covered Persons determined to be at "high risk" as determined by the Claims Administrator.

#### **H. Therapeutic Injections**

- o Therapeutic injections required in the treatment of an injury or illness.

#### **I. Allergy Injections**

- o Benefits are provided for allergy extracts and allergy injections.

The Claims Administrator periodically reviews the schedule of covered services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of services is subject to change.

Therefore, the Claims Administrator reserves the right to modify this schedule from time to time.

### **INPATIENT SERVICES**

A Covered Person is entitled to benefits for Covered Services while an Inpatient in a Facility Provider, when deemed Medically Appropriate/Medically Necessary and billed for by a Facility Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

All Inpatient Admissions, other than an Emergency admission, must be precertified by the Claims Administrator in accordance with the requirements contained in the Managed Care section of this booklet. Emergency admissions must be reviewed within 2 business days of the admission or as soon as reasonably possible. A concurrent

review is required for any continued length of stay beyond what has been Pre-Certified by the Claims Administrator.

## **A. HOSPITAL SERVICES**

### **ROOM AND BOARD**

Benefits will be paid for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

- a. an average semi-private room, as designated by the Hospital; or a private room, when designated by the Claims Administrator as semi-private for the purposes of this coverage in Hospitals having primarily private rooms;
- b. a private room, when Medically Appropriate/Medically Necessary;
- c. a Special Care Unit, such as Intensive or Coronary Care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
- d. a bed in a general ward; and
- e. nursery facilities.

Benefits are provided for up to the number of days specified in the Schedule of Benefits.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one day.

Days available under this coverage shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided: (1) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (2) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

### **ANCILLARY SERVICES**

Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including but not limited to the following:

- a. meals, including special meals or dietary services as required by the patient's condition;
- b. use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
- c. casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
- d. oxygen and oxygen therapy;
- e. administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as may be provided within this coverage;
- f. anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
- g. Physical Therapy, Cardiac Rehabilitation Therapy, Respiratory Therapy, hydrotherapy, Speech Therapy, and/or Occupational Therapy when administered by a person who is appropriately licensed and authorized to perform such services;
- h. Radiation Therapy;

- i. Chemotherapy;
- j. all drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals;
- k. use of Special Care Units, including but not limited to, Intensive or Coronary Care; and
- l. Preadmission testing.

Subject to the Exclusions, conditions and limitations of this coverage, a Covered Person is entitled to benefits for Covered Services when: (1) deemed Medically Appropriate/Medically Necessary and (2) billed for by a Provider.

## **B. MEDICAL CARE**

Medical Care provided by the Professional Provider in charge of the case to a Covered Person who is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery, pregnancy, Radiation Therapy, or Mental Illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

### 1. Concurrent Care

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations or Medical Care routinely performed in the pre-or post-operative or pre-or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

### 2. Consultations

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by Facility Provider's rules and regulations. Benefits are limited to one (1) consultation per consultant during any inpatient confinement.

## **C. SKILLED NURSING FACILITY**

Benefits are provided for a Skilled Nursing Facility, when Medically Appropriate/Medically Necessary as determined by the Claims Administrator, up to the Maximum days specified in the Schedule of Benefits. The Covered Person must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Facility. For maximum benefits, admission to a Skilled Nursing Facility must be pre-certified as an Inpatient admission in accordance with the Managed Care section of this booklet.

Medically Necessary Professional Provider visits in a Skilled Nursing Facility are provided as shown in the Schedule of Benefits.

No benefits are payable:

- 1. when confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person;
- 2. for the treatment of alcohol and drug addiction, and Mental Illness; or
- 3. after the Covered Person has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine custodial care.

## **INPATIENT/OUTPATIENT BENEFITS**

A Covered Person is entitled to benefits for Covered Services either while an Inpatient in a Facility Provider or on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

### **A. BLOOD**

Benefits shall be payable for the administration of Blood and Blood processing from donors. Benefits shall be payable for autologous Blood drawing, storage or transfusion - i.e., an individual having his own Blood drawn and stored for personal use, such as self-donation in advance of planned Surgery.

Benefits shall be payable for whole Blood, Blood plasma and Blood derivatives, which are not classified as drugs in the official formularies and which have not been replaced by a donor.

### **B. HOSPICE SERVICES**

When the Covered Person's attending Physician certifies that the Covered Person has a terminal illness with a medical prognosis of six (6) months or less and when the Covered Person elects to receive care primarily to relieve pain, the Covered Person shall be eligible for Hospice benefits. Hospice Care is primarily comfort care, including pain relief, physical care, counseling and other services that will help the Covered Person cope with a terminal illness rather than cure it. Hospice Care provides services to make the Covered Person as comfortable and pain-free as possible. When a Covered Person elects to receive Hospice Care, benefits for treatment provided to cure the terminal illness are no longer provided. However, the Covered Person may elect to revoke the election of Hospice Care at any time.

Respite Care: When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the Covered Person's home. Up to seven (7) days of such care every six (6) months will be covered. Benefits for Covered Hospice Services shall be provided until the earlier of the Covered Person's death or discharge from Hospice Care.

Special Hospice Services Exclusions: No Hospice Care benefits will be provided for:

1. Services and supplies for which there is no charge;
2. Research studies directed to life lengthening methods of treatment;
3. Services or expenses incurred in regard to the Covered Person's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property);
4. Care provided by family members, relatives, and friends; and
5. Private Duty Nursing care.

## **C. MATERNITY/OB-GYN/FAMILY SERVICES**

### **1. Maternity/Obstetrical Care**

Services rendered in the care and management of a pregnancy for a Member or spouse are a Covered Expense under this Plan as specified in the *Schedule of Benefits*.

Prenotification of maternity care should occur within one (1) month of the first prenatal visit to the Physician or midwife. Benefits are payable for: (1) facility services provided by a Hospital or Birth Center; and (2) professional services performed by a Professional Provider or certified nurse midwife.

Benefits payable for a delivery shall include pre- and post-natal care. Maternity care Inpatient benefits will be provided for forty-eight (48) hours for vaginal deliveries and ninety-six (96) hours for cesarean deliveries, except where otherwise approved by the Claims Administrator as provided for in the *Managed Care* section.

In the event of early post-partum discharge from an Inpatient Admission, benefits are provided for Home Health Care as provided for in the Home Health Care subsection.

Under this program, coverage for pregnancy for Dependent daughters shall include only those services which are provided for conditions classified as Complications of Pregnancy.

### **2. Therapeutic Abortions**

Facility services provided by a Hospital or Birth Center and services performed by a Professional Provider for the voluntary termination of a pregnancy by a Member or Member's spouse are a Covered Expense: (a) when necessary to avert the death of the mother, and (b) for termination of pregnancy related to either rape or incest.

### **3. Newborn Care**

For Full-Time Employees, the newborn child of a Member or Dependent Spouse shall be entitled to benefits provided by this Plan from the date of birth up to a maximum of thirty-one (31) days. Such coverage within the thirty-one (31) days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery. Coverage for a newborn may be continued beyond thirty-one (31) days under conditions specified in the *Eligibility Under this Plan* section.

For Part-Time Employees, coverage for newborns is limited to routine nursery care from the date of birth to Member's discharge from the hospital, when billed as a part of the Member's claim.

## **D. BEHAVIORAL HEALTH SERVICES**

Coverage for Behavioral Health services (including treatment of psychiatric conditions and alcohol and drug abuse), is not provided under your PPO benefit program, and the Claims Administrator plays no role in the administration of Behavior Health services for the Fund. Behavioral Health services are provided through the Fund's Behavioral Health program administrator, which is not affiliated with the Claims Administrator. The details of your benefits for Behavioral Health services appear in the "Behavioral Health" section of the Fund's Summary Plan Description.

## **E. ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS**

Benefits are provided for Routine Costs Associated With Participation in a Qualifying Clinical Trial (see the Defined Terms section). To ensure coverage, the Claims Administrator must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial.



## F. SURGICAL SERVICES

Surgery benefits will be provided for services rendered by a Professional Provider and/or Facility Provider for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. Also covered is (1) the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and (2) coverage for the following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Coverage is also provided for: (a) the initial and subsequent insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (b) the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

**Failure to obtain preprocedure certification for these services will result in a 20% reduction of the benefits payable for surgical services.**

Covered surgical procedures shall include routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

### 1. Hospital Admission for Dental Procedures or Dental Surgery

Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Appropriate/ Medically Necessary to ensure the patient's health. Coverage for such hospitalization does not imply coverage of the dental procedures or Surgery performed during such a confinement. Only oral surgical procedures specifically identified as covered under the "Oral Surgery" terms of this Plan will be covered during such a confinement.

### 2. Oral Surgery

Benefits will be payable for Covered Services provided by a Professional Provider and/or Facility Provider for:

- a. Orthognathic surgery – surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
  - (1) The initial treatment of Accidental Injury/trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.
  - (2) In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
  - (3) In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.
- b. Other oral surgery – defined as surgery on or involving the teeth, mouth, tongue, lips, gums and contiguous structures. Benefits will be provided only for:
  - (1) Surgical removal of impacted teeth which are partially or completely covered by bone.
  - (2) The surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
  - (3) Surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

### 3. Assistant at Surgery

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery.

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Claims Administrator. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

### 4. Anesthesia

Administration of Anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider.

### 5. Second Surgical Opinion (Voluntary)

Consultations for Surgery to determine the Medical Necessity of an elective surgical procedure. Elective Surgery is that Surgery which is not of an emergency or life threatening nature.

Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery.

One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation.

In such instances the Covered Person will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

## G. TRANSPLANT SERVICES

When a Covered Person is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Inpatient and Outpatient transplants which are beyond the Experimental or Investigative stage.

Inpatient and Outpatient transplants require pre-certification with the following exceptions: transplantation of cornea or skin. Benefits are also provided for those services to the Covered Person which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow or tissue and the processing of Blood provided to a Covered Person.

- (a) When both the recipient and the donor are Covered Persons, each is entitled to the benefits of this coverage. Benefits for the donor will be charged against the recipient's coverage under this coverage.
- (b) When only the recipient is a Covered Person, only the recipient is entitled to this coverage.
- (c) When only the donor is a Covered Person, the donor is not entitled to the benefits of this coverage.
- (d) If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

**Failure to precertify Inpatient transplants will result in a \$1,000 reduction in benefits payable for these services.**

**Failure to precertify Outpatient transplants will result in a 20% reduction in benefits payable for these services.**

## **OUTPATIENT BENEFITS**

A Covered Person is entitled to benefits for Covered Services on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

### **A. AMBULANCE**

Ambulance services, which are Medically Appropriate/Medically Necessary as determined by the Claims Administrator, for local transportation in a specially designed and equipped vehicle used only to transport the sick or injured are a Covered Expense. All Non-Preferred, non-emergency ambulance services must be pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet.

The Ambulance must be transporting the Covered Person:

- a. from a Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital;
- b. between Hospital and Skilled Nursing Facility or between Hospitals.
- c. If there is no Hospital in the local area that can provide services Medically Appropriate/Medically Necessary for the Covered Person's condition, then ambulance service means transportation to the closest Hospital outside the local area that can provide the necessary service.
- d. Air or sea ambulance transportation benefits are payable only if the Claims Administrator determines that the patient's condition, and the distance to the nearest facility able to treat the patient's condition, justify the use of air instead of another means of transportation.

**Failure to precertify Non-Emergency services will result in a 20% reduction in benefits payable for these services.**

### **B. DAY REHABILITATION PROGRAM**

Subject to the limits shown in the Schedule of Benefits, benefits will be provided for a Medically Appropriate/Medically Necessary Day Rehabilitation Program when provided by a Facility Provider under the following conditions:

1. The Covered Person requires intensive Therapy services, such as Physical, Occupational and/or Speech Therapy five (5) days per week for 4-7 hours per day;
2. The Covered Person has the ability to communicate (verbally or non-verbally) his/her needs; the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;
3. The Covered Person is willing to participate in a Day Rehabilitation Program; and
4. The Covered Person's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

### **C. DIABETIC EDUCATION PROGRAM**

Benefits are provided for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a Professional Provider legally authorized to prescribe such items under law.

The attending Physician must certify that a Covered Person requires diabetic education on an Outpatient basis under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) a significant change in

the patient's symptoms or condition; or (3) the introduction of new medication or a therapeutic process in the treatment or management of the patient's symptoms or condition.

Outpatient diabetic education services will be covered when provided by a Preferred Facility Provider or a Preferred Ancillary Provider. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Claims Administrator. These requirements are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Covered services include Outpatient sessions that include, but may not be limited to, the following information:

1. initial assessment of the patient's needs;
2. family involvement and/or social support;
3. psychological adjustment for the patient;
4. general facts/overview on diabetes;
5. nutrition including its impact on blood glucose levels;
6. exercise and activity;
7. medications;
8. monitoring and use of the monitoring results;
9. prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
10. use of community resources; and
11. pregnancy and gestational diabetes, if applicable.

#### **D. DIABETIC EQUIPMENT AND SUPPLIES**

Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance or precertification requirements applicable to Durable Medical Equipment benefits

##### **1. Diabetic Equipment**

- a. blood glucose monitors\*;
- b. insulin pumps\*;
- c. insulin infusion devices\*; and
- d. orthotics and podiatric appliances for the prevention of complications associated with diabetes\*.

\*Precertification is required for the purchase of equipment that exceeds \$500 of the billed amount. The applicable Deductible, Copayment and/or Coinsurance amounts will apply to this benefit.

##### **2. Diabetic Supplies**

Insulin, oral agents and other Diabetic Supplies are covered under the Fund's free-standing prescription drug program.

#### **E. DIAGNOSTIC SERVICES**

The following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:

- a. Diagnostic X-ray, consisting of radiology, ultrasound, and nuclear medicine;
- b. Diagnostic laboratory and pathology tests.
- c. Diagnostic medical procedures consisting of ECG, EEG, and other diagnostic medical procedures approved by the Claims Administrator.
- d. Allergy testing, consisting of percutaneous, intracutaneous and patch tests.

**Preprocedure certification is required for the following diagnostic procedures: Preferred and Non-Preferred Operative and Diagnostic Endoscopies, MRI, MRA, CAT Scan and PET Scan, as described in the Managed Care Section. Failure to precertify Non-Preferred Services will result in a 20% reduction in benefits.**

The Claims Administrator reserves the right to modify the diagnostic procedures that are subject to precertification after written notice has been given to the Fund.

## **F. DURABLE MEDICAL EQUIPMENT**

Precertification is required on the rental of any Durable Medical Equipment and the purchase of all Durable Medical Equipment that exceed the amount shown on the Schedule of Benefits.

### **Durable Medical Equipment**

Benefits will be provided for the rental (but not to exceed the total allowance of purchase) or, at the option of the Claims Administrator, the purchase of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use, when determined to be Medically Appropriate/Medically Necessary by the Claims Administrator.

Although an item may be classified as Durable Medical Equipment, it may not be covered in every instance. Therefore, precertification is required on the rental of any Durable Medical Equipment and the purchase of all Durable Medical Equipment that exceeds the amount shown in the Schedule of Benefits.

Durable Medical Equipment, as defined in the "Defined Terms" section of this booklet, includes equipment that meets the criteria of (a) – (d) below.

- (a) It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature are not considered "durable". (For examples, see (d) under "Exclusions" below).
- (b) It customarily and primarily serves a medical purpose.
- (c) It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the patient's illness, injury, or to the improvement of a malformed body part.
- (d) It is appropriate for home use.

Orthotics, when prescribed as Medically Necessary/Medically Appropriate, are covered with the limitations set forth in the Summary of Benefits Schedule

### **Exclusions:**

Examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

- (a) Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems; bed-wetting alarms; and ramps;
- (b) Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants;
- (c) Equipment inappropriate for home use. This is an item that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, translift chairs and traction units;
- (d) Non-reusable supplies other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME. Items not

covered include, but are not limited to: incontinence pads, lambs wool pads, ace bandages, antiembolism stockings; catheters (non-urinary), face masks (surgical), disposable gloves, disposable sheets and bags, and irrigating kits;

- (e) Equipment that is not primarily medical in nature. Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" in nature. This is true even though the item may have some medically related use. Such items include but are not limited to ear plugs, exercise equipment, ice pack, speech teaching machines, strollers, feeding chairs, silverware/utensils; toileting systems; electronically-controlled heating and cooling units for pain relief; toilet seats; bathtub lifts; stairglides; and elevators.
- (f) Equipment with features of a medical nature which are not required by the patient's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medically Appropriate/Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.
- (g) Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider;
- (h) Services not primarily billed for by a Provider such as delivery, set-up and service activities and installation and labor of rented or purchased equipment; and
- (i) Modifications to vehicles, dwellings and other structures. This includes (i) any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability; or (ii) any modification made to a vehicle, dwelling or other structure to accommodate a DME item, such as a wheelchair.

Replacement and Repair: The Claims Administrator will provide benefits for the replacement of Durable Medical Equipment: (a) when there has been a change in the Covered Person's condition that requires the replacement, (b) if the equipment breaks because it is defective, or (c) it breaks because it has exceeded its life expectancy, as determined by the manufacturer. If an item breaks and is under warranty, unless it is a rental item, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

The Claims Administrator will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment, replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning. A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage. The Claims Administrator will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

## **G. EMERGENCY CARE SERVICES**

Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility within two days of the Emergency are provided by the Claims Administrator at the Preferred level of benefits, regardless of whether the patient is treated by a Preferred or Non-Preferred Provider. If Emergency Services are required, whether the Covered Person is located in or outside the PPO Network service area, call 911 or seek treatment immediately at the emergency department of the closest Hospital or Outpatient Emergency Facility.

Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency. Outpatient follow-up care provided in a Medically Appropriate/Medically Necessary setting (in Emergency Room, other Outpatient Emergency Facility or physician's office) are also covered if received within 14 days of the initial Outpatient Emergency Care, as specified above.

Examples of an Emergency include heart attack, loss of consciousness or respiration, cardiovascular accident, convulsions, severe Accidental Injury, and other acute medical conditions as determined by the Claims Administrator. Should any dispute arise as to whether an Emergency existed or as to the duration of an emergency, the determination by the Claims Administrator shall be final.

## H. HOME HEALTH CARE

Benefits will be provided for the services listed below when performed by a licensed Home Health Care Agency. Home Health Care services must be pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet.

- Professional services of appropriately licensed and certified individuals;
- Intermittent Skilled Nursing Care;
- Physical Therapy;
- Speech Therapy;
- Well mother/well baby care following release from an inpatient maternity stay.
- Care within 48 hours following release from an Inpatient admission when the discharge occurs within 48 hours following a mastectomy.

With respect to well mother/well baby care following early release from an inpatient maternity stay, Home Health Care services must be provided within 48 hours if discharge occurs earlier than 48 hours of a vaginal delivery or 96 hours of a cesarean delivery. No Deductible, Copayment or Coinsurance shall apply to these benefits when they are provided after an early discharge from the inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include occupational therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Claims Administrator.

Home health care benefits will be provided only when prescribed by the Covered Person's attending Physician in a written Plan of Treatment and approved by the Claims Administrator as Medically Appropriate/Medically Necessary.

**HOME** – means a Covered Person's place of residence (e.g. private residence/domicile, assisted living facility, long-term care facility, skilled nursing facility (SNF)) at a custodial level of care.

**HOMEBOUND** – means there exists a normal inability to leave Home due to severe restrictions on the Covered Person's mobility and when leaving the Home: (a) would involve a considerable and taxing effort by the Covered Person; and (b) the Covered Person is unable to use transportation without another's assistance. A child, unlicensed driver or an individual who cannot drive will not automatically be considered Homebound but must meet both requirements (a) and (b).

**Precertification must be performed in accordance with the Managed Care section of the booklet. Failure to precertify these services will result in a 20% reduction in benefits payable.**

There is no requirement that the Covered Person be previously confined in a Hospital or Skilled Nursing Facility prior to receiving home health care.

With the exception of home health care provided to a Covered Person immediately following an Inpatient release for maternity care, the Covered Person must be homebound in order to be eligible to receive home health care benefits. This means that leaving the home could be harmful to such person, would involve a considerable and taxing effort, and that the Covered Person is unable to use transportation without another's assistance.

### EXCLUSIONS

No Home Health Care benefits will be provided for services and supplies in connection with home health services for the following:

- custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
- rental or purchase of Durable Medical Equipment;

- rental or purchase of medical appliances (e.g. braces) and prosthetic devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices;
- prescription drugs;
- services provided by a member of the patient's Immediate Family or the Immediate family of the patient's spouse;
- patient's transportation, including services provided by voluntary ambulance associations for which the patient is not obligated to pay;
- emergency or non-emergency Ambulance services;
- visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
- services provided to individuals (other than a Covered Person released from an inpatient maternity stay), who are not essentially homebound for medical reasons; and
- visits by any Provider personnel solely for the purpose of assessing an individual's condition and determining whether or not the individual requires and qualifies for home health services and will or will not be provided services by the Provider.

#### **I. MEDICAL FOODS AND NUTRITIONAL FORMULAS**

Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Coverage is provided when administered on an outpatient basis either orally or through a tube. Benefits are exempt from Deductible requirements.

Benefits are also payable for Nutritional Formulas when: (1) they are the sole source of nutrition for an individual (more than 75% of estimated basal caloric requirement) and the Nutritional Formula is given by way of a tube into the alimentary tract, or (2) the Nutritional Formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, refractory to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

Benefits are payable for Medical Foods and Nutritional Formulas when provided through a Durable Medical Equipment Supplier or in connection with Infusion Therapy as provided for in this coverage.

#### **J. NON-SURGICAL DENTAL SERVICES**

Benefits will be provided only for the initial treatment of Accidental Injury/trauma (i.e., fractured facial bones and fractured jaws), in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound, Natural Teeth, including the first caps, crowns, bridges and dentures (but not including dental implants), required for the initial treatment for the Accidental Injury/trauma. Also covered is the preparation of the jaws and gums required for initial replacement of Sound, Natural Teeth. (Sound, Natural Teeth are teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental injury/trauma). Injury as a result of chewing or biting is not considered an Accidental Injury. (See the exclusion of dental services in the What Is Not Covered section for more information on what dental services are not covered);

#### **K. PRIVATE DUTY NURSING SERVICES**

Benefits will be provided as specified in the Schedule of Benefits for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician. All nursing services must be Medically Appropriate/Medically Necessary as determined by the Claims Administrator and pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet.

Benefits are not payable for:

- (a) nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication;
- (b) services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's immediate family; and



- (c) services provided by a home health aide or a nurse's aide.

## **L. PROSTHETICS**

Expenses incurred for prosthetic devices (except dental prostheses) required as a result of illness or injury. Expenses for prosthetic devices are subject to medical review by the Claims Administrator to determine eligibility and Medical Appropriateness/Medical Necessity.

Such expenses may include, but not be limited to:

- a. the purchase, fitting, necessary adjustments and repairs of prosthetic devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and
- b. the supplies and replacement of parts necessary for the proper functioning of the prosthetic device;
- c. breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prosthetics inserted during reconstructive surgery incident and subsequent to mastectomy.

Coverage limitations on external breast prostheses are as follows:

- (i) Post mastectomy, four bras per calendar year are covered;
  - (ii) The useful lifetime expectancy for silicone breast prostheses is (2) two years ;
  - (iii) The lifetime expectancy of fabric, foam or fiber-filled breast prostheses is (6) six months; and
- d. Benefits are provided for the following visual Prosthetics when Medically Appropriate/Medically Necessary and prescribed for one of the following conditions:
    - (1) Initial contact lenses prescribed for treatment of infantile glaucoma;
    - (2) Initial pinhole glasses prescribed for use after surgery for detached retina;
    - (3) Initial corneal or scleral lenses prescribed (i) in connection with the treatment of keratoconus; or (ii) to reduce a corneal irregularity other than astigmatism;
    - (4) Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
    - (5) Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of (i) Accidental Injury; (ii) trauma, or (iii) ocular surgery.

Benefits are not provided for

- (1) Lenses which do not require a prescription;
- (2) Any lens customization such as, but not limited to tinting, oversize or progressive lenses, antireflective coatings, UV lenses or coatings, scratch resistance coatings, mirror coatings, or polarization;
- (3) Deluxe frames;
- (4) Eyeglass accessories, such as cases, cleaning solution and equipment.

The repair and replacement provisions do not apply to this item d.

Benefits are not payable for: (a) wigs (except for cranial prostheses for chemotherapy patients, limited to \$450 per lifetime) or (b) eyeglasses except as specified in Item d. above.

### **Repair and Replacement**

Benefits for replacement of a prosthetic device or its parts will be provided: (a) when there has been a significant change in the Covered Person's medical condition that requires the replacement; (b) if the prostheses breaks because it is defective; (c) if the prostheses breaks because it has exceeded its life expectancy, as determined by the manufacturer; or (d) for a Dependent child due to the normal growth process when Medically Necessary.

The Claims Administrator will provide benefits to repair prosthetic devices when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of a prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning.

A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Claims Administrator will not provide benefits for repairs and replacements needed because the prosthetic was abused or misplaced. If a prosthetic device breaks and is under warranty, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

#### **M. RESTORATIVE SERVICES**

Benefits shall be provided for Restorative Services, subject to the benefit period maximums set forth in the Schedule of Benefits, when performed by a Professional Provider in order to restore loss of function of a body part. Restorative Services are any services, other than those specifically detailed under "Therapy Services", provided in accordance with a specific plan of treatment related to the Covered Person's condition which generally involve neuromuscular training as a course of treatments over weeks or months. Examples of Restorative Services include, but are not limited to, manipulative treatment of functional loss from back disorder, therapy treatment of functional loss following foot surgery, and orthoptic/pleoptic therapy.

#### **N. SPECIALIST OFFICE VISIT**

Benefits will be provided for Specialist Service medical care provided in the office by a Provider other than a Primary Care Physician. For the purpose of this benefit, "in the office" includes medical care visits to a Provider's office, medical care visits by a Provider to a Covered Person's residence, or medical care consultations by a Provider on an Outpatient basis.

#### **O. THERAPY SERVICES**

Benefits shall be provided, subject to the Benefit Period Maximums specified in the Schedule of Benefits, for the following services prescribed by a Physician and performed by a Professional Provider, a registered, licensed therapist, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person.

##### **Cardiac Rehabilitation Therapy**

Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise. Benefits are provided up to the number of visits specified in the Schedule of Benefits.

##### **Chemotherapy**

Chemotherapy means the treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetic and other related biotech products. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes).

The cost of drugs, approved by the Federal Food and Drug Administration and only for those uses for which such drugs have been specifically approved by the Federal Food and Drug Administration (FDA) as antineoplastic agents is covered, provided they are administered as described in this paragraph.

##### **Dialysis**

The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).

Benefits will not be provided to the extent that benefits are payable by Medicare for persons who are Medicare eligible on the basis of end stage renal disease (ESRD) and for whom Medicare must pay as primary Claims Administrator.

Effective January 1, 2007, the second paragraph under "Dialysis" is removed.

### **Infusion Therapy**

Treatment includes, but is not limited to, infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.

### **Occupational Therapy**

Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist. Benefits are provided up to the number of visits specified in the Schedule of Benefits.

### **Physical Therapy**

Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

### **Pulmonary Rehabilitation Therapy**

Includes treatment through a multidisciplinary program which combines Physical Therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status for Chronic Obstructive Pulmonary Disease (COPD). COPD may include, but is not limited to, diagnosis such as emphysema, chronic bronchitis, asthmatic bronchitis, pre-lung transplant and cystic fibrosis. Benefits are provided up to the number of sessions specified in the Schedule of Benefits.

### **Radiation Therapy**

The treatment of disease by X-ray, radium, or radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.

### **Respiratory Therapy**

Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.

### **Speech Therapy**

Includes treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

**Preprocedure certification is required for the Infusion Therapy Services as described in the Managed Care section of this booklet. Failure to precertify these services will result in a 20% reduction in benefits payable for these services.**

## WHAT IS NOT COVERED

Except as specifically provided in this booklet, no benefits will be provided for services, supplies or charges:

- Which are not Medically Appropriate/Medically Necessary as determined by the Claims Administrator for the diagnosis or treatment of illness or injury;
- Which are Experimental/Investigational, except, as approved by the Claims Administrator, Routine Costs associated with a Qualifying Clinical Trial that meets the definition of a Qualifying Clinical Trial under this coverage;
- Which were Incurred prior to the Covered Person's Effective Date of coverage;
- Which were or are Incurred after the date of termination of the Covered Person's coverage except as provided in the General Information section of this booklet;
- For any loss sustained or expenses Incurred during military service while on active duty; or as a result of enemy action or act of war, whether declared or undeclared.
- For which a Covered Person would have no legal obligation to pay;
- Received from a dental or medical department maintained by or on behalf of a Fund, a mutual benefit association, labor union, trust, or similar person or Fund;
- Paid or payable by Medicare when Medicare is primary. For purposes of this Plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
- For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;
- To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;
- For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- For drugs or medicines for which the Covered Person has coverage under a free-standing prescription drug program provided through the Enrolled Fund;
- Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider" "Facility Provider" or "Ancillary Provider" except as otherwise indicated under the subsections entitled: (a) "Therapy Services" (that identifies covered therapy services as provided by licensed therapists), and (b) "Ambulance Services", as described under section entitled "**PREFERRED PROVIDER NETWORK PROGRAM BENEFITS**";
- Rendered by a member of the Covered Person's Immediate Family;
- Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a hospital or university;
- For ambulance services except as specifically provided under this coverage;
- For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are

payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for and defined in the subsection entitled SURGICAL SERVICES in the Your Preferred Provider Organization Benefits section of this booklet;

- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For marriage counseling;
- For Custodial Care, domiciliary care or rest cures;
- For equipment costs related to services performed on high cost technological equipment as defined by the Claims Administrator, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by the Claims Administrator;
- For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this booklet. Services not covered include, but are not limited to, apicoectomy (dental root resection) prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated;
- For dental implants for any reason;
- For dentures, unless for the initial treatment of an Accidental Injury/trauma;
- For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
- For injury as a result of chewing or biting (neither is considered an Accidental Injury); ○ For treatment of temporomandibular joint syndrome(TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;
- For palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For supportive devices of the foot, except for orthotic appliances that are covered as set forth in the Summary of Benefits Schedule;
- For Hearing Aids, including cochlear electromagnetic hearing devices and/or implants, and hearing examinations or tests for the prescription or fitting of Hearing Aids. Services and supplies related to these items are not covered;
- For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such surgery;
- For assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
- For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;
- For treatment of obesity, except for surgical treatment of obesity when: (a) the Claims Administrator determines the surgery is Medically Appropriate/Medically Necessary, and (b) the surgery is not a repeat, reversal or revision of any previous obesity surgery. The exclusion of coverage for a repeat, reversal or

revision of a previous obesity surgery does not apply when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person;

- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, wigs ( except for cranial prostheses for chemotherapy patients, as set forth in this booklet), chairlifts, stairglides, elevators, spa or health club memberships, whirlpool, sauna, hot tub or equivalent device, whether or not recommended by a Provider;
- For wigs (except for cranial prostheses for chemotherapy patients, as set forth in this booklet);
- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;
- For correction of myopia or hyperopia by means of corneal microsurgery, such as Lasik, keratomileusis, keratophakia, and radial keratotomy and all related services;
- For preventive services except as specifically provided for under the subsection entitled "Primary and Preventive Care Services" of the Your Preferred Provider Organization Benefits section of this booklet;
- For weight reduction;
- For premarital blood tests;
- For diagnostic screening examinations, except for mammograms and preventive care as provided in the subsection entitled "Primary and Preventive Care Services" of Your Preferred Provider Organization Benefits section of this booklet;
- For Alternative Therapies/complementary medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, naturopathy, hypnotherapy, bioenergetic therapy, Qi Gong, Ayurvedic therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;
- For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;
- For immunizations required for employment purposes, or for travel;
- For care in a nursing home, home for the aged, convalescent home, school, institution for retarded children, Custodial Care in a Skilled Nursing Facility;
- For counseling or consultation with a patient's relatives or Hospital charges for a patient's relatives or guests;
- For medical supplies such as but not limited to thermometers, ovulation kits, and early pregnancy or home pregnancy testing kits;
- For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, and (c) with end-stage renal disease receiving home dialysis;
- As described under "Durable Medical Equipment" in the Your Preferred Provider Organization Benefits section of this booklet: for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by the patient's condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;

- For prescription drugs;
- For amino acid supplements, appetite suppressants or nutritional supplements. Coverage does not include basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the subsection entitled "Medical Foods and Nutritional Formulas" in the section entitled Your Preferred Provider Organization Benefits;
- For Inpatient Private Duty Nursing services;
- For any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;
- For charges incurred for expenses in excess of Benefit Maximums as specified in the Schedule of Benefits;
- For research studies;
- For Maintenance of chronic conditions;
- For Cognitive Rehabilitation Therapy; (Cognitive Rehabilitation Therapy is a therapeutic approach designed to improve cognitive functioning after central nervous system injury or trauma. It includes therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning and problem solving. It utilizes tasks designed to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for the impaired neurologic system);
- For elective abortions, except (a) to avert the death of the mother, and (b) to terminate a pregnancy that is the result of either rape or incest;
- For maternity benefits for dependent daughters, except for treatment of complications of pregnancy as defined in this booklet;
- For the reversal of sterilization;
- For transplant donor services, except if both the donor and the recipient are members of the Fund or, if the donor is not a member of the Fund, in excess of \$25,000 per transplant of secondary coverage;
- For mental health/psychiatric services and treatment for alcohol and drug abuse and dependency. (These services may be covered under a separate program provided by the Fund);
- For oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.
- For penile prosthetic devices; and
- For any other service or treatment except as provided under the coverage.

## **GENERAL INFORMATION**

### **BENEFITS TO WHICH YOU ARE ENTITLED**

The liability of the Claims Administrator is limited to the benefits specified in this booklet. The Claims Administrator's determination of the benefit provisions applicable for the services rendered to you shall be conclusive.

### **TERMINATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP IN THE FUND**

When a Covered Person ceases to be an Eligible Member or Eligible Dependent, or the required contribution is not paid, the Covered Person's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this coverage are provided by and/or approved by the Claims Administrator before the Claims Administrator receives notice of the Covered Person's termination under the Fund Contract, the cost of such benefits will be the sole responsibility of the Covered Person. In that circumstance, the Claims Administrator will consider the effective date of termination of a Covered Person under the Fund Contract to be not more than 60 days before the first day of the month in which the Fund notified the Claims Administrator of such termination.

### **CONTINUATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP DUE TO TOTAL DISABILITY**

Your protection under this coverage may be extended after the date you cease to be a Covered Person under the coverage because of termination of employment or termination of membership in the Fund. It will be extended if, on that date, you are totally disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time you remain Totally Disabled from any such illness or injury, but not beyond three months if you cease to be a Covered Person because your coverage under the Fund Contract ends.

Coverage under this Plan will apply during an extension as if you were still a Covered Person, except any reinstatement of your Lifetime Maximum amount will not be allowed under the Reinstatement subsection as set forth in the Schedule of Benefits section of this booklet. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for you through the Claims Administrator by the Fund. Continuation of coverage is subject to payment of the applicable premium.

### **CONTINUATION OF INCAPACITATED CHILD**

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on you for over half of his support, you may apply to the Claims Administrator to continue coverage of such child under the Claims Administrator upon such terms and conditions as the Claims Administrator may determine. Coverage of such Dependent child shall terminate upon his or her marriage. Continuation of benefits under this provision will only apply if the child was eligible as a dependent and mental or physical incapacity commenced prior to age 19, or if such mental or physical incapacity occurred after age 19 while the child was covered as a full-time student.

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining 19 years of age. The disability must be certified by the attending physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over 19 years of age and joining the Claims Administrator for the first time, the handicapped child must have been covered under the prior Claims Administrator and submit proof from the prior Claims Administrator that the child was covered as a handicapped person.

### **WHEN YOU TERMINATE EMPLOYMENT - CONTINUATION OF COVERAGE PROVISIONS – COBRA**

For purposes of this subsection of your booklet, A "qualified beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for Fund health benefits under this Plan as:

- a. you, an active, covered Member;



- b. your spouse; or
- c. your Dependent child.

In addition, any child born to or placed for adoption with you during COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Plan during COBRA continuation, other than a child born to or placed for adoption with you during COBRA continuation, will not be a qualified beneficiary.

**If a Member Terminates Employment or Has a Reduction of Work Hours:** If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if:

- a. your termination of employment was not due to gross misconduct; and
- b. you are not entitled to Medicare.

The continuation will cover you and any other qualified beneficiary who loses coverage because of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the 'When Continuation Ends' paragraph of this subsection.

**Extra Continuation for Disabled Qualified Beneficiaries:** If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified beneficiary's health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within 60 days of that date, the qualified beneficiary and any other affected qualified beneficiaries may elect to extend the 18 month continuation period described above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Plan Administrator must be given written proof of Social Security's determination of the qualified beneficiary's disability before the earlier of:

- a. The end of the 18 month continuation period; and
- b. 60 days after the date the qualified beneficiary is determined to be disabled.

If, during the 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the United States Social Security Act, the qualified beneficiary must notify the Plan Administrator within 30 days of such determination, and continuation will end, as explained in the "When Continuation Ends" paragraph of this subsection.

**If a Member Dies:** If you die, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the 'When Continuation Ends' paragraph of this subsection.

**If a Member's Marriage Ends:** If your marriage ends due to divorce or if you and your spouse become separated, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the 'When Continuation Ends' paragraph of this subsection.

**If a Member Becomes Entitled to Medicare:** If you become entitled to Medicare after terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months from the date the initial 18 month continuation period started, subject to the 'When Continuation Ends' paragraph of this subsection.

If you become entitled to Medicare **before** terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified beneficiaries other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 18 months, but may be extended until 36 months from the date you became entitled to Medicare, subject to the 'When Continuation Ends' paragraph of this subsection.

**If a Dependent Loses Eligibility:** If your Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this booklet, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to 36 months, subject to the 'When Continuation Ends' paragraph of this subsection.

**Concurrent Continuations:** If your Dependent who is a qualified beneficiary elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above.

The 36 month continuation period starts on the date the initial 18 month continuation period started, and the two continuation periods will run concurrently.

**The Qualified Beneficiary's Responsibilities:** A person eligible for continuation under this subsection must notify the Plan Administrator, in writing, of:

- a. your divorce or separation from your spouse;
- b. your Dependent child's loss of dependent eligibility, as defined in this booklet; or
- c. Social Security Administration's determination of disability.

The notice must be given to the Plan Administrator within 60 days of any of these events.

In addition, a disabled qualified beneficiary must notify the Plan Administrator, in writing, of any final determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the Plan Administrator within 30 days of such final determination.

**The Fund's Responsibilities:** Your Fund must notify the Plan Administrator, in writing, of:

- a. your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
- b. your death;
- c. your entitlement to Medicare; or
- d. commencement of employer's bankruptcy proceedings.

The notice must be given to the Plan Administrator no later than 30 days of any of these events.

**The Plan Administrator's Responsibilities:** The Plan Administrator must notify the qualified beneficiary, in writing, of:

- a. his or her right to continue the group health benefits described in this booklet;
- b. the monthly premium he or she must pay to continue such benefits; and
- c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified beneficiary within 14 days of:

- a. the date the qualified beneficiary notifies the Plan Administrator, in writing, of your divorce or separation from your spouse, or your Dependent child's loss of eligibility; or
- b. the date the Fund notifies the Plan Administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare;

**The Fund's Liability:** Your Fund will be liable for the qualified beneficiary's continued group health benefits to the same extent as, and in the place of, the Plan, if:

- a. the Fund fails to remit a qualified beneficiary's timely premium payment to the Plan on time, thereby causing the qualified beneficiary's group health benefit to end; or
- b. the Plan Administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above.

**Election of Continuation:** To continue his or her group health benefits, the qualified beneficiary must give the Plan Administrator written notice that he or she elects to continue benefits under the coverage. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from the Plan Administrator as described above or 60 days of the date the qualified beneficiary's group health benefits end, if later. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Plan Administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the Plan Administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the Fund. An additional charge of two percent of the total premium charge may also be required by the Fund.

Qualified beneficiaries who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra 11 month continuation period.

If the qualified beneficiary fails to give the Plan Administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

**Grace in Payment in Premiums:** A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.

**When Continuation Ends:** A qualified beneficiary's continued group health benefits under this coverage ends on the first to occur of the following:

- a. with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- b. with respect to a disabled qualified beneficiary and his or her family members who are qualified beneficiaries who have elected an additional 11 months of continuation, the earlier of:
  - i the end of the 29 month period which starts on the date the group health benefits would otherwise end;  
or
  - ii the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act;
- c. with respect to continuation upon your death, your divorce or separation, or the end of your covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- d. with respect to your Dependent whose continuation is extended due to your entitlement to Medicare,
  - i after, your termination of employment or reduction of work hours, the end of the 36 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
  - ii before, your termination of employment or reduction of work hours where, during the 18-month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the 18 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than 36 months from the date you become entitled to Medicare.
- e. the date this coverage ends;

- f. the end of the period for which the last premium payment is made;
- g. the date he or she becomes covered under any other group health plan (as a Member or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
- h. the date he or she becomes entitled to Medicare.

**THE CLAIMS ADMINISTRATOR'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF YOUR BOOKLET.**

**THE CLAIMS ADMINISTRATOR IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE FUND.**

## **RELEASE OF INFORMATION**

Each Covered Person agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Plan may furnish to the Claims Administrator, upon its request, any information (including copies of records relating to the illness or injury).

In addition, the Claims Administrator may furnish similar information to other entities providing similar benefits at their request.

The Claims Administrator shall provide to the Fund at the Fund's request certain information regarding claims and charges submitted to the Claims Administrator. The parties understand that any information provided to the Fund will be adjusted by the Claims Administrator to prevent the disclosure of any information that is protected by applicable state or federal laws of any Member or other patient treated by said Providers. The Fund shall reimburse the Claims Administrator for the actual costs of preparing and providing said information.

The Claims Administrator may also furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Claims Administrator needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Covered Person who is unable to provide it, the Claims Administrator will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Covered Person.

## **CONSUMER RIGHTS**

Each Covered Person has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records, call Member Services at the toll-free number on your ID card.

## **LIMITATION OF ACTIONS**

No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than two years after the date Covered Services are rendered.

## **CLAIM FORMS**

The Claims Administrator will furnish to you or to the Fund Contractholder, for delivery to you, such claim forms as are required for filing proof of loss for Covered Services provided by Non-Preferred Providers.

## **TIMELY FILING**

The Claims Administrator will not be liable under the coverage unless proper notice is furnished to the Claims Administrator that Covered Services have been rendered to a Covered Person. Written notice must be given within 20 days after completion of the Covered Services. The notice must include the date and information required by the Claims Administrator to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Claims Administrator within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Claims Administrator be required to accept notice more than two years after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by Preferred Providers.

## **MEMBER/PROVIDER RELATIONSHIP**

- a. The choice of a Provider or choice of treatment by a Provider is solely yours.
- b. The Claims Administrator does not furnish Covered Services but only makes payment for Covered Services received by persons covered under the Claims Administrator. The Claims Administrator is not liable for any act or omission of any Provider. The Claims Administrator has no responsibility for a Provider's failure or refusal to render Covered Services to a Covered Person.

## **SUBROGATION**

In the event any service is provided or any payment is made to you or your covered Dependent under this Plan, the Claims Administrator shall be subrogated and succeed to your rights of recovery against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in your name. You or your covered Dependent shall execute and deliver such instruments and take such other reasonable action as the Claims Administrator may require to secure such rights. You or your covered Dependent may do nothing to prejudice the rights given the Claims Administrator without the Claims Administrator's consent.

You or your covered Dependent shall pay the Claims Administrator all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this Claims Administrator and as permitted by law.

The Claims Administrator's right of subrogation shall be unenforceable when prohibited by law.

## **COORDINATION OF BENEFITS**

This Plan's Coordination of Benefits provision is designed to conserve funds associated with health care.

### **1. Definitions**

In addition to the Definitions of this Plan for purposes of this Provision only:

"Plan" shall mean any Fund arrangement providing health care benefits or Covered Services through:

- a) individual, Fund, (except hospital indemnity plans of less than \$200), blanket (except student accident) or franchise insurance coverage;
- b) the Plan, health maintenance organization and other prepayment coverage;
- c) coverage under labor management trusted plans, union welfare plans, Fund organization plans, or Member benefit organization plans; and
- d) coverage under any tax supported or government program to the extent permitted by law.

### **2. Determination of Benefits**

Coordination of Benefits (COB) applies when a Member has health care coverage under any other group health care plan (Plan) for services covered under this Plan, or when the Member has coverage under any tax-supported or governmental program unless such program's benefits are, to the extent permitted by law, excess to those of any private insurance coverage. When COB applies, payments may be coordinated between HORIZON and the other Plan in order to avoid duplication of benefits.

Benefits under this Plan will be provided in full when HORIZON benefits are primary, that is, when HORIZON determines benefits first. If another Plan is primary, HORIZON will provide benefits as described below.

When a Member has group health care coverage under this Plan and another Plan, the following will apply to determine which coverage is primary:

- a) If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.

- b) If the other Plan includes rules for coordinating benefits:
- 1) The Plan covering the patient other than as a Dependent shall be primary.
  - 2) The Plan covering the patient as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be primary, unless the child's parents are separated or divorced and there is no joint custody agreement. If both parents have the same birthday, the Plan which covered the parent longer shall be primary. However, if the other Plan does not have the birthday rule as described herein, but instead has a rule based on the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall control unless the child's parents are separated or divorced.
  - 3) Except as provided in subparagraph (4) below, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:
    - i) First, the Plan covering the child as a Dependent of the parent with custody;
    - ii) then, the Plan of the spouse of the parent with custody of the child;
    - iii) finally, the Plan of the parent not having custody of the child.
  - 4) When there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child and the Plan covering the parent with such financial responsibility has actual knowledge of the court decree, benefits of that Plan are determined first.
  - 5) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above in 2 (b) (2).
- c) The Plan covering the patient as a Member who is neither laid off nor retired (or as that Member's Dependent) is primary to a Plan which covers that patient as a laid off or retired Member (or as that Member's Dependent). However, if the other Plan does not have the rule described immediately above and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
- d) If none of the above rules apply, the Plan which covered the Member longer shall be primary.

### 3. **Effect on Benefits**

When the HORIZON Plan is secondary, the benefits under this Plan will be reduced so that HORIZON will pay no more than the difference, if any, between the benefits provided under the other Plan for services covered under this Plan and the total Covered Services provided to the Member. Benefits payable under another Plan include benefits that would have been payable had the claim been duly made under the other Plan. In no event will a HORIZON payment exceed the amount that would have been payable under this Plan if HORIZON benefits were primary.

When the benefits are reduced under the Primary plan because a Member does not comply with the Plan provision, or does not maximize benefits available under the Primary Plan, the amount of such reduction will not be considered an allowable benefit. Examples of such provisions are those related to second surgical opinion penalties, and penalties and increased coinsurance related to precertification of admissions and services, Preferred Provider arrangements and other cost-sharing features.

Certain facts are needed to apply COB. HORIZON has the right to decide which facts are needed. HORIZON may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which HORIZON deems necessary for such purposes. Any person claiming benefits under this Plan shall furnish to HORIZON such information as may be necessary to implement this provision. HORIZON, however, shall not be required to determine the existence of any other Plan or the amount of benefits payable under any such Plan, and the payment of benefits under this Plan shall be affected by the benefits that would be payable under any and all other Plans only to the extent that HORIZON is furnished with information relative to such other Plans.

### **Right of Recovery**

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, HORIZON shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits provided under this Plan and, to the extent of such payments, HORIZON shall be fully discharged from liability under this Plan.

Whenever payments have been made by HORIZON in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, HORIZON shall have the right to recover such payments to the extent of such excess from among one or more of the following, as HORIZON shall determine:

1. the person HORIZON has paid or for whom they have paid;
2. insurance companies; or
3. any other organizations.

You, on your own behalf and on behalf of your Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is reasonably necessary to secure such rights to HORIZON.



## MANAGED CARE

### A. UTILIZATION REVIEW PROCESS

A basic condition of Horizon Blue Cross/Blue Shield of New Jersey's ("the Claims Administrator") benefit plan coverage is that in order for a health care service to be covered or payable, the services must be Medically Appropriate/Medically Necessary. To assist the Claims Administrator in making coverage determinations for requested health care services, the Claims Administrator uses established Horizon Medical Policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person's benefit plan is called utilization review.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by the Claims Administrator to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by the Claims Administrator based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed it is called a Precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The Claims Administrator follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review and evaluation for coverage approval using the Claims Administrator's Medical Policies, established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director employed by the Claims Administrator may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable benefit plan policies and procedures, taking into consideration the individual Covered Person's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a Medical Director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and Covered Person in accordance with applicable law.

The Claims Administrator's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to the Claims Administrator's Medical Directors to discuss coverage of a case. Medical Directors and nurses are salaried, and contracted external physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The Claims Administrator does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

### B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

**The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medical Necessity coverage decisions:**

Clinical Decision Support Criteria: Clinical Decision Support Criteria is an externally validated and computer-based system used to assist the Claims Administrator in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist our clinical staff evaluating the Medical Appropriateness/Medical Necessity of coverage based on a Covered Person's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in the Claims Administrator's plan determinations for similar medical issues and requests, and reduces practice variation among the Claims Administrator's clinical staff to minimize subjective decision-making.

**Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following:**

- Some elective surgeries-settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery).
- Inpatient hospitalizations
- Inpatient Rehabilitation
- Home Health
- Durable Medical Equipment
- Skilled Nursing Facility

**Centers for Medicare and Medicaid Services (CMS) Guidelines:** A set of guidelines adopted and published by CMS for coverage of services by Medicare for Medicare Covered Persons.

**Horizon's Medical Policies:** Horizon maintains an internally developed set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services.

**Covered Services for which Horizon's Medical Policies are applied include, but are not limited to:**

- Ambulance
- Infusion
- Speech Therapy
- Occupational Therapy
- Durable Medical Equipment
- Review of potential cosmetic procedures

**Horizon Internally Developed Guidelines:** A set of guidelines developed specifically by HORIZON, as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting Horizon Medical Policies for coverage.

## **C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA**

The Claims Administrator delegates some of its utilization review process to the Claims Administrator's affiliate. That affiliate is a state licensed utilization review entity and is responsible for the Claims Administrator's utilization review process. In certain instances, the Claims Administrator has delegated certain utilization review activities, including Precertification review, concurrent review, and case management, to other entities with an expertise in medical management of a certain membership population (such as, Neonates/premature infants) or type of benefit or service (such as radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with the Claims Administrator's approval.

## **D. PRECERTIFICATION REVIEW**

When required, Precertification review evaluates the Medical Necessity, including the Medical Appropriateness of the setting, of proposed services for coverage under the Covered Person's benefit plan. Examples of these services include planned or elective inpatient admissions. For groups located in the PPO Network service area, Precertification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a PPO Network Provider. For Covered Person's located outside the

Claims Administrator's PPO Network who are accessing BlueCard Providers, the Covered Person is responsible for initiating or requesting the Provider to initiate the Precertification review. Where Precertification review is required, the Claims Administrator's coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

While the majority of services requiring Precertification review are reviewed for Medical Appropriateness of the requested procedure setting (e.g., Inpatient, Short Procedure Unit, or Outpatient setting), other elements of the Medical Appropriateness/Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing provider. Precertification review is not required for Emergency services and is not performed where an agreement with the Claims Administrator's local Preferred or Participating Provider does not require such review. The following are general examples of current Precertification review requirements under benefit plans; however, these requirements vary by benefit plan and state and are subject to change.

- Hysterectomy
- Nasal surgery procedures
- Bariatric surgery
- Potentially cosmetic or experimental/investigative procedures

The following information provides more specific information of this benefit plan's Precertification requirements.

## **1. INPATIENT PRE-ADMISSION REVIEW**

### **Preferred Inpatient Admissions**

In accordance with the criteria and procedures described above, Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified in accordance with the standards of the Claims Administrator as to the Medical Appropriateness/Medical Necessity of the admission. The Precertification requirements for Emergency admissions are set forth in the "Emergency Admission Review" subsection of this Managed Care section. A Preferred Hospital, Skilled Nursing Facility, or other Facility Provider in the PPO Network will verify the Precertification at or before the time of admission. However, the Covered Person, not the Hospital, Skilled Nursing Facility or other Facility Provider, is responsible to Precertify an Inpatient Admission under the BlueCard PPO Program. The Claims Administrator will not authorize the Hospital, Skilled Nursing Facility or other Facility Provider admission if Precertification is required and is not obtained in advance. For Covered Person's who reside in the Claims Administrator's local PPO Network service area, the Claims Administrator will hold the Covered Person harmless and the Covered Person will not be financially responsible for admissions to Hospitals, Skilled Nursing Facilities or other Facility Providers in the PPO Network which fail to conform to the pre-admission certification requirements unless: (a) the Provider provides prior written notice that the admission will not be paid by the Claims Administrator; and (b) the Covered Person acknowledges this fact in writing together with a request to be admitted which states that he will assume financial liability for such Facility Provider admission.

### **Non-Preferred Inpatient Admissions**

For a Non-Preferred Inpatient Admission and an Inpatient Admission to a BlueCard PPO Provider, the Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

- a. To obtain Precertification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact the Claims Administrator prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Claims Administrator will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Non-Preferred level shown in the Schedule of Benefits if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet.

- b. If such prior approval for a Medically Appropriate/Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the following amount will be deemed not to be Covered Services under this coverage: \$1,000 of allowable charges. Such Penalty, and any difference in what is covered by the Claims Administrator and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

- c. If Precertification is denied, the Covered Person, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, or Facility Provider will be so notified.

## **2. EMERGENCY ADMISSION REVIEW**

### **a. Preferred Admissions**

It is the responsibility of the Preferred Provider to notify the Claims Administrator of the In-Network Emergency admission.

### **b. Non-Preferred and BlueCard Provider Admissions**

1. Covered Persons are responsible for notifying the Claims Administrator of a Non-Preferred or BlueCard Provider Emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Claims Administrator.
2. Failure to initiate Emergency admission review will result in a \$1,000 reduction in Covered Expense for Non-Preferred services. Such penalty will be the sole responsibility of, and payable by, the Covered Person.
3. If the Covered Person elects to remain hospitalized after the Claims Administrator and the attending Physician have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

## **3. CONCURRENT AND RETROSPECTIVE REVIEW**

Concurrent review may be performed while services are being performed. This may occur during an Inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent Review is generally not performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with the Facility does not require such review.

### **Retrospective/Post Service Review:**

Retrospective review occurs after services have been provided. This may be for a variety of reasons, including the Claims Administrator not being notified of a Covered Person's admission until after discharge or where medical charts are unavailable at the time of concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, the Claims Administrator also may determine coverage of certain procedures and other benefits available to Covered Persons through prenotification as required by the Covered Person's benefit plan, and discharge planning.

**Pre-notification.** Pre-notification is advance notification to the Claims Administrator of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for Concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

**Discharge Planning.** Discharge Planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefits coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge Planning involves the Claims Administrator's authorization of covered post-Hospital services and identifying and referring Covered Persons to disease management or case management benefits.

**Selective Medical Review.** In addition to the foregoing requirements, the Claims Administrator reserves the right, under its utilization and quality management programs, to perform a medical review prior to, during or following the performance of certain Covered Services ("Selective Medical Review") that are otherwise not subject to review as described above. In addition, the Claims Administrator reserves the right to waive medical review for certain Covered Services for certain Providers, if the Claims Administrator determines that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services.

Coverage penalties are not applied to Covered Persons where required Selective Medical Review is not obtained by the Provider.

## **E. OTHER PRECERTIFICATION REQUIREMENTS**

Precertification is required by the Claims Administrator in advance for Home Health Care and certain surgical and diagnostic procedures. A complete list of Precertification requirements is shown in the "Services Requiring Precertification" subsection of this Managed Care section. When a Covered Person plans to receive any of these listed procedures, the Claims Administrator will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed in the "Services Requiring Precertification" subsection of this Managed Care section, that are performed during an Emergency, as determined by the Claims Administrator, do not require Precertification. However, the Claims Administrator should be notified within two (2) business days of Emergency services for such procedures, or as soon as reasonably possible, as determined by the Claims Administrator.

### **1. Preferred Care**

Preferred Providers in the PPO Network must contact the Claims Administrator to initiate Precertification. The Claims Administrator will verify the results of the Precertification with the Covered Person and with the Preferred Provider. If the Preferred Provider is a BlueCard PPO Provider, however, the Covered Person must initiate Precertification.

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment listed in the "Services Requiring Precertification" subsection of this Managed Care section, then benefits will be provided for Medically Appropriate/Medically Necessary treatment, subject to a Penalty.

For Preferred Providers in the PPO Network, the Claims Administrator will hold the Covered Person harmless and the Covered Person will not be financially responsible for this financial Penalty for the Preferred Provider's failure to comply with the Precertification requirements or determination, unless a Covered Person elects to receive the treatment after review and written notification that the procedure is not covered as Medically Appropriate/Medically Necessary. In which case benefits will not be provided and the Covered Person will be financially liable for non-covered charges.

### **2. Non-Preferred Care**

For Non-Preferred Care and care provided by BlueCard Providers, the Covered Person is responsible to have the Provider performing the service contact the Claims Administrator to initiate Precertification. The Claims Administrator will verify the results of the Precertification with the Covered Person and the Provider.

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment listed in the "Services Requiring Precertification" subsection of this Managed Care section, then benefits will be provided for Medically Appropriate/Medically Necessary treatment, but the Provider's charge less any applicable Coinsurance, Copayments, Deductibles shall be subject to a Penalty of 20% of allowable charges. Such Penalty, and any difference in what is covered by the Claims Administrator and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

## **F. SERVICES REQUIRING PRECERTIFICATION**

The following services must be Precertified whether Preferred (In-Network) or Non-Preferred (Out-of-Network), unless otherwise noted.

1. All Inpatient Admissions
  - a. Acute Rehabilitation
  - b. Hospice
  - c. Maternity (notification only)
  - d. Skilled Nursing Facility
  - e. Surgical/Non-Surgical (including Transplants)
2. Outpatient Services
  - a. Ambulance Services – non-Emergency
  - b. Birth Center (notification only)
  - c. Day Rehabilitation Program
  - d. Dental services as a result of Accidental Injury
  - e. Durable Medical Equipment (items over \$500 billed amount, including repairs and replacements, and all rentals)
  - f. Home Health Care
  - g. Outpatient Private Duty Nursing
  - h. Prosthetics (items over \$500 billed amount, including repairs and replacements)
  - i. PET Scan
  - j. MRI, MRA
3. Preferred and Non-Preferred Surgical and Diagnostic Services (Inpatient only)
  - a. Obesity Surgery
  - b. Orthognathic Surgery
  - c. Submucous Resection (Nasal Surgery)
  - d. Cataract Surgery
  - e. Hernia Repair
  - f. Operative and Diagnostic Endoscopies
  - g. Prostate Surgery
  - h. Spinal and Vertebral Surgery
4. Home based infusion therapy

## **G. OUT-OF-AREA CARE FOR DEPENDENT STUDENTS**

If an unmarried Dependent child is a full-time student in an Accredited Educational Institution located outside the area served by your local BlueCard PPO Network, the student may be eligible to receive Non-Preferred care at the Preferred level of benefits. Charges for treatment will be paid at the Preferred level of benefits when the

Dependent student receives care from Providers as described in the subsection entitled "BlueCard PPO Program" of the Your Preferred Provider Organization Plan section of this booklet. However, treatment provided by an educational facility's infirmary for sick/urgent care, for example, may also be paid at the Preferred level of benefits, but the Claims Administrator should be notified within 48 hours of treatment to insure covered services are treated as Preferred Services. Nothing in this provision will act to continue coverage of a Dependent child past the date when such child's coverage would otherwise be terminated under the Fund's coverage.

## RESOLVING PROBLEMS

For purposes of this section only, the term “Member” replaces the term “Covered Person”.

### Member Complaint Process

The Claims Administrator has a process for Members to express complaints. To register a complaint, Members should call the Member Services Department at the telephone number on the back of their identification card or write to the Claims Administrator at the following address:

Horizon Healthcare of New Jersey  
PO Box 820  
Newark, NJ 07101-0820

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member complaint, it will be investigated, and the Member will receive a response in writing within thirty (30) days.

### Member Appeal Process

**Filing an Appeal.** Procedures are available for the resolution of Member appeals. Member appeals may be filed within 180 days of the receipt of a decision from the Claims Administrator stating an adverse benefit determination.

An appeal occurs when the Member or, after obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form. Contact the Claims Administrator as directed below to obtain a “Member/Enrollee Authorization to Appeal by Provider or Other Representative” form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member, may request an appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

Appeals Dept, PP-14E  
Horizon BCBSNJ  
PO Box 420  
Newark, NJ 07101-0420

**Types of Member Appeals and Applicable Timeframes.** Following are the two types of Member appeals and the issues they address:

- **Medical Necessity Appeal Issues** – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity or Medical Appropriateness and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on the exclusions for experimental/investigative or cosmetic services.
- **Administrative Appeal Issues** – An appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Claims Administrator decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity and Medical Appropriateness, these are not the primary issues that affect the outcome of the appeal.

The timeframes described below for completing a review of each appeal depend on additional classifications:

Standard appeal timeframes apply to both pre-service appeals and post-service appeals that concern claims for non-urgent care.

- Pre-service appeal - An appeal for benefits that, under the terms of the Plan, must be pre-certified or preapproved (either in whole or in part) before medical care is obtained in order for coverage to be available.



- Post-service appeal - An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Member has already obtained do not qualify for review as expedited/urgent appeals.)

Expedited appeal timeframes apply to pre-service requests for urgent care.

- Expedited/Urgent appeal – An appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Claims Administrator will conduct an expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Member's life, health or ability to regain maximum function or would subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

**Information for the Appeal Review including Matched Specialist's Report.** At all appeal levels you may submit additional information pertaining to your case. You may specify the remedy or corrective action being sought. Upon request at any time during the appeal process, you or your authorized representative will be given access to, and copies of, documents, records, and other information relevant to the appeal that is provided to the appeal decision maker(s) for review. Input from a matched specialist is obtained for all Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

**Appeal Committee Composition and Role.** Each Appeals Committee described below designated by the Claims Administrator to review a standard internal first level Administrative Appeal or Medical Necessity Appeal will be comprised of employees of the Claims Administrator who have been designated to act as decision maker(s) on the appeal. The Committee decision maker(s) for any Administrative Appeal or Medical Necessity Appeal will not be those who made the adverse benefit determination at issue in the appeal and will not be subordinates of the person who made that determination. Each Committee will review all relevant information for the appeal, whether from the Member or his authorized representative or obtained from other sources during the investigation of the appeal issues.

**Right to Pursue Civil Action.** If you are enrolled in a group health plan that is subject to the requirements of Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of the Act after completing the Member Appeal processes described here.

**Changes in Participant Appeals Processes.** Please note that the Member Appeal processes described here may change due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve the Participant appeals processes, or to reflect decisions of Group and/or Plan Administrator regarding the administration of member appeal processes for this Plan.

## **STANDARD APPEALS**

There are two levels of appeal. The internal, standard appeal process for Administrative Appeals and Medical Necessity Appeals consists of two (2) internal levels of review—the first by the Claims Administrator and a second by the Plan Administrator. Further review, if any, is only available through the Plan Administrator. There is also an internal Expedited Complaint process available through the Plan Administrator in the event your condition involves an issue that may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed, as determined and validated by your Physician, if reviewed in standard Pre-service appeal timeframes.

Remember, no legal action can usually be taken until all of the Complaint appeal procedures have been followed.

## Level One Standard Appeal

An acknowledgement letter and description of the appeal process is mailed within five (5) business days of receipt of a Member appeal. The initial request for an appeal will be evaluated and the decision completed within the following timeframes for a standard appeal on an Administrative Appeal or Medical Necessity Appeal issue:

- Standard Pre-service Appeal – within 15 days of receipt of the appeal request
- Standard Post-service Appeal – within 30 days of receipt of the appeal request

You will be sent written notice of the first level decision within the timeframe stated above that applies to the appeal. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell you that relevant information is available, and describe how you can appeal to the next level. The first level appeal decision for a standard appeal is final unless you exercise your right to appeal the decision as described below.

## Level Two Standard Appeal

If you are not satisfied with the first level decision, you may file a request for a second level appeal within sixty (60) days. The appeal will be evaluated and the decision completed within the following timeframes for the second level review of a standard appeal on an Administrative or Medical Necessity appeal issue:

- Standard Pre-service Appeal – within 15 days of receipt of the appeal request
- Standard Post-service Appeal – within 30 days of receipt of the appeal request

**Under the appeal process in effect for this Plan, the Plan Administrator is responsible for the standard Second Level Administrative Appeal and Medical Necessity Appeal review processes. Once the request for a Second Level Standard Appeal is received, the Claims Administrator forwards the request and all appeal documents in its possession to the Plan Administrator. The Plan Administrator advises you or your authorized representative of the decision regarding your Second Level Standard Administrative Appeal or Medical Necessity Appeal and of any additional appeal rights that may be available for an external appeal.**

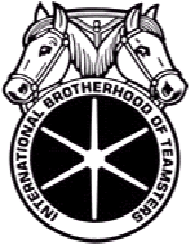
## EXPEDITED APPEALS

If your case involves a serious medical condition which you believe may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed while awaiting a standard appeal decision, you may ask to have your case reviewed in a quicker manner, as an expedited appeal. An expedited appeal consists of only one level of internal review for which the evaluation and decision must be completed within the following timeframe:

- Expedited Pre-service Appeals - within 72 hours of receipt of the appeal request.

To request an expedited appeal by the Plan Administrator, call Member Services at the toll free telephone number listed on the back of your ID card, or call, or fax the Member Appeals Department at 856-382-2416.

**Under the appeal process in effect for this Plan, the Plan Administrator is responsible for the Expedited Administrative Appeal and Expedited Medical Necessity Appeal review processes. Once the request for Expedited Appeal is received, the Claims Administrator forwards the request and all appeal documents in its possession to the Plan Administrator. The Plan Administrator advises you or your authorized representative of the decision regarding your Expedited Administrative Appeal or Medical Necessity Appeal and of any additional appeal rights that may be available for an external appeal.**



# Teamsters Health and Welfare Fund

*of Philadelphia and Vicinity*

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6981 NORTH PARK DRIVE, SUITE 400 • PENNSAUKEN, NJ 08109 • (856) 382-2400  
TOLL-FREE 1-800-523-2846 • FAX (856) 382-2401 • [www.teamsterfunds.com](http://www.teamsterfunds.com)

## **MEDICAL BENEFIT SELF-PAYMENT NOTICE (COBRA RIGHTS)**

### **THIS IS A VERY IMPORTANT NOTICE – YOU CAN LOSE MEDICAL BENEFITS IF YOU IGNORE THESE RULES**

You are receiving this notice because you have recently become covered under the Plan of Benefits of the Teamsters Health & Welfare Fund of Philadelphia and Vicinity (the "Plan"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Keep this notice in your permanent records.

#### **Introduction**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

**This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan office at the address at the top of this notice.

#### **COBRA Eligibility**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an **employee**, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Layoff; or
- Retirement.

If you are the **spouse of an employee**, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse is laid off;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse retires;
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both);
- You become separated from your spouse with the intent to abandon the marital relationship; or
- You become divorced from your spouse.

Your ***dependent children (basically children you claim on your tax return)*** will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee is laid off;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee retires;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child." (In many plans, coverage will stop at age 18 unless a child is a full-time student.)

**Notification**

**The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan office has been notified that a qualifying event has occurred.**

**Employer Notices**

The employer must notify the Plan office when the qualifying event is the end of employment or reduction of hours of employment, layoff, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both). The Plan office must be notified **within thirty (30) days of any of these qualifying events.**

**Employee or Dependent Notice**

**YOU OR YOUR DEPENDENT MUST NOTIFY THE PLAN OFFICE OF other qualifying events (divorce or separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child).** You can also notify the Plan office of qualifying events that your employer is suppose to report.

**YOU OR YOUR DEPENDENT MUST** notify the Plan office within sixty (60) days after the qualifying event occurs by completing the attached "Employee Notification" form. The name, address and phone number to contact is as follows:

**COBRA Department  
Teamsters Health & Welfare Fund  
of Philadelphia and Vicinity  
6981 North Park Drive, Suite 400  
Pennsauken, NJ 08109  
856-382-2400, ext. 2425**

The failure to provide timely notice can result in the loss of COBRA rights to purchase medical coverage. Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

## Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for **up to 36 months**.
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for **up to 18 months**.

The 18-month period of COBRA continuation coverage can be extended in two ways:

- Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and you notify the Plan office in a timely fashion, you and your entire family can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. You must make sure that the Plan office is notified of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan office at the address listed above and include the information or documentation listed on the enclosed Employee Qualifying Event Notice.

- Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can get up to an additional 18 months of COBRA continuation coverage, **for a maximum of 36 months**, if notice of the second qualifying event is properly given to the Plan. This extension is available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions about your COBRA continuation coverage, you should contact the Plan office at the following address and/or phone number:

COBRA Department  
Teamsters Health & Welfare Fund  
of Philadelphia and Vicinity  
6981 North Park Drive, Suite 400  
Pennsauken, NJ 08109  
856-382-2400, ext. 2425

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### Keep Your Plan Informed of Address Changes

**In order to protect your family's rights, you should keep the Plan office informed of any changes in the addresses of family members.** You should also keep a copy, for your records, of any notices you send to the Plan office.

**EMPLOYEE NOTIFICATION FORM FOR COBRA QUALIFYING EVENT**

**DUE DATE:** This form must be completed and delivered to the Plan within 60 days of a qualifying event for COBRA continuation coverage. If mailed, it need only be post-marked no later than 60 days after the qualifying event.

PLAN ADDRESS: Send the completed form to the Fund office at:

COBRA Department  
Teamsters Health and Welfare Fund of Philadelphia and Vicinity  
6981 North Park Drive, Suite 400  
Pennsauken, NJ 08109  
856-382-2400, ext. 2425

This notice is being used to inform the Plan that a qualifying event has occurred with respect to the following qualifying beneficiary:

Name [of person who may lose health coverage]: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Street [or mailing] Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Qualifying Event (check one or more):

- Divorce or separation
- Dependent is no longer eligible to be covered under the Plan
- Qualified beneficiary has been determined to be disabled by the Social Security Administration (please provide the Social Security Award )
- Disabled, qualified beneficiary has been determined to no longer be disabled (please provide the Social Security letter)
- Occurrence of a second qualifying event (check here and also check the box for the type of second qualifying event)
- Other (please provide a written explanation and documents). You can use this to report events that your employer may not report, such as:
  - Death of a covered employee
  - Termination of employment (other than by reason of gross misconduct)
  - A reduction in hours of employment for a covered employee
  - Medicare entitlement
  - Bankruptcy of employer (only with respect to retired employees)

Date that the qualifying event occurred: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Please provide any additional information or documentation concerning the qualifying event or determination of disability on the back of this form or separate attachment with the name of the qualifying beneficiary. You may return this form without documentation to make sure it is timely. You will need to follow up and provide the documentation as soon as practicable.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**BENEFICIARY NOTICE TO ADMINISTRATOR**

**DUE DATE:** This form must be completed and delivered to the Plan within 60 days of a qualifying event for COBRA continuation coverage. If mailed, it need only be post-marked no later than 60 days after the qualifying event.

PLAN ADDRESS: Send the completed form to the Fund office at:

COBRA Department  
Teamsters Health and Welfare Fund of Philadelphia and Vicinity  
6981 North Park Drive, Suite 400  
Pennsauken, NJ 08109  
856-382-2400, ext. 2425

1. Name of covered employee: \_\_\_\_\_
2. Social Security No./Employee ID/or employee date of birth: \_\_\_\_\_
3. Address: \_\_\_\_\_
4. Employee work location: \_\_\_\_\_
- Telephone No.: \_\_\_\_\_

5. Event reporting:
  - Employee's separation or divorce
  - Qualified beneficiary covered by Medicare during COBRA coverage
  - Death of employee
  - Dependent child ceased to be eligible dependent (due to dependent's marriage, attaining age 19/23 and is not full-time student)
  - Social Security determination of disability/termination of disability (please attach copy of the Social Security notice)

6. Date event occurred: \_\_\_\_\_

7. Please list the individual(s) to whom the event applies:

<b>Name</b>	<b>Relationship</b>	<b>S.S. No.</b>	<b>Date of Birth</b>	<b>to Employee</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If different from the employee's address, please provide the affected individual(s) address:

8. Completed by:

\_\_\_\_\_

Signature Print Name Relationship to Employee/  
Qualified Beneficiary

**Privacy Policy of the  
TEAMSTERS HEALTH & WELFARE AND PENSION TRUST FUNDS  
of Philadelphia and Vicinity**

The Trustees have adopted policies and procedures designed to protect your personal information from unauthorized use or disclosure. Towards that end:

Plan Administration has implemented physical, electronic and procedural safeguards to maintain the confidentiality and integrity of the personal information in our possession and to guard against unauthorized access. These measures include, among other things, procedures for controlling access to participants' files, building security programs and information technology security measures such as the use of passwords, encryption and firewalls, plus virus and use detection software.

Fund Administration continues to access new technology as it becomes available and to upgrade our physical and electronic security systems as appropriate.

The Fund's policy is to permit Fund employees and professionals engaged by the Fund to access your personal information only if they have a legitimate purpose for using such information, such as administering the Plan, reviewing and analyzing claims and claim denial appeals, and/or providing plan benefits to participants.

**Information Subject to the Policy**

The Fund collects information about you to help us provide Plan benefits to you and your eligible dependents, and to fulfill legal and regulatory requirements. Fund Administration considers all information about you in our possession to be personal information, even if you cease to be a Plan Participant. The personal information we collect may include, among other things:

- Identifying information, such as your name, age, address, phone number and social security number.
- Employment information.
- Personal health information.

Typically we collect this information on applications and other forms you complete, through conversations you may have with our administrative staff and health care professionals, and from reports and data provided to us by health service care providers.

**Sharing Information within the Fund Administrative Office**

Fund Administration shares personal information about you among our staff primarily to enable us to provide you with Plan benefits. It is also used to assure compliance with applicable laws and regulations.

**Sharing Information with Health Care Providers and Other Plan Professionals**

We share personal information about you, as required or permitted by law, with third parties, such as service providers who assist us in the day-to-day operations of our Plan. These third parties include: health care professionals, printing companies, software providers and plan professionals. Our policy is to require third-party service providers to enter into confidentiality agreements with us, prohibiting them from using any personal information they obtain for any purposes other than those for which they were retained or as required by law. We may also disclose information about you, when necessary or required, in legal and arbitration proceedings and to government agencies.

We understand that you may be especially concerned about the privacy of your personal health information. We do not sell or rent your personal health information to anyone or disclose it to others for marketing purposes. Except as you have otherwise authorized, we only use and share personal health information for the administration of the Plan and processing claims. The same holds true for any other personal information contained in, or obtained in order to process your claims.

**Reviewing your Personal Information**

If you would like a report on the personal information about you in our possession (other than information collected in connection with or in anticipation of a claim or legal proceeding), you may write us describing the information you would like. If requested, we will also identify in the report any third parties with which we normally share information about you. If you believe that any information we have about you is incorrect or incomplete, you may advise us of any corrections, amendments or deletions which you believe should be made. To obtain a report, please write to William Einhorn, Fund Administrator, 4<sup>th</sup> & Cherry Streets, Philadelphia, PA 19106. We may charge you a reasonable fee to cover the costs of providing this information to you.

**Changes to Our Privacy Policy**

The Trustees may make changes to our privacy policy in the future. The Fund will not make any change affecting you without first sending you a revised privacy policy describing the change.





# Teamsters Health and Welfare Fund

*of Philadelphia and Vicinity*

6981 NORTH PARK DRIVE, SUITE 400 • PENNSAUKEN, NJ 08109 • (856) 382-2400  
TOLL-FREE 1-800-523-2846 • FAX (856) 382-2401 • [www.teamsterfunds.com](http://www.teamsterfunds.com)

## IMPORTANT NOTICE

### *Women's Health and Cancer Rights Act of 1998*

Dear Plan Participant/Beneficiary:

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This Notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act of 1998, a participant or beneficiary enjoying coverage under the Plan of Benefits of the Teamsters Health and Welfare Fund of Philadelphia and Vicinity who elect breast reconstruction in connection with a mastectomy also will be covered for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Of course, the coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Deductibles and coinsurances established for other benefits under your Plan also apply to these reconstructive surgery benefits.

The Women's Health and Cancer Rights Act of 1998 applies to your benefits immediately.

Please keep this information with your other group health plan documents. If you have any questions about the Health and Welfare Fund's coverage of mastectomies and reconstructive surgeries, please call the Fund's Member Services Department at 1-800-523-2846, extension 1910, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Very truly yours,

WILLIAM J. EINHORN  
Administrator  
Teamsters Health and Welfare Fund  
of Philadelphia and Vicinity



## Teamsters Health and Welfare Fund *of Philadelphia and Vicinity*

6981 N. PARK DRIVE, SUITE 400 • PENNSAUKEN, NJ 08109 • (856) 382-2400  
TOLL-FREE 1-800-523-2846 • FAX (856) 382-2401 • [www.teamsterfunds.com](http://www.teamsterfunds.com)

UNION TRUSTEES  
PAUL CARDULLO  
WILLIAM T. HAMILTON  
HOWARD WELLS

ADMINISTRATOR  
WILLIAM J. EINHORN

EMPLOYER TRUSTEES  
KENNETH F. LEEDY  
BOB SCHAEFFER, JR.  
TOM J. VENTURA

### **IMMEDIATE ACTION REQUIRED!**

Dear Member:

Our office is in the process of updating our records so as to avoid any interruption in the processing of your claims.

As you are aware, your Plan of Benefits contains a “Coordination of Benefits” provision. This means that if your spouse is scheduled to work 32 or more hours per week and is offered medical benefits through his/her employer, he/she **MUST** enroll in that company’s plan unless they are required to pay 100% of the premium.

In the event that your spouse must pay 100% of the premium or if he/she is not offered coverage, we will need a letter from his/her employer stating that fact.

We ask that you complete the reverse side of this form and return it to our office as soon as possible.

In the event that we do not receive a properly completed form from you, we will have no alternative but to deny your spouse’s claims until the required information is received by the Fund office.

Sincerely,

WILLIAM J. EINHORN  
Administrator

## DECLARATION OF SPOUSE HEALTH COVERAGE

(To avoid any interruption in the processing of your claims, please complete and return this form to the Fund office)

MEMBER INFORMATION			
SOCIAL SECURITY #	NAME (LAST PLUS SUFFIX, FIRST, MI)	DATE OF BIRTH	PHONE #
SPOUSE'S INFORMATION			
SOCIAL SECURITY #	NAME (LAST PLUS SUFFIX, FIRST, MI)	DATE OF BIRTH	PHONE #
Does your spouse have other insurance coverage?		YES <input type="checkbox"/>	NO <input type="checkbox"/>

**My spouse is (check one):**

- employed full-time (full-time is defined as scheduled to work 32 or more hrs/week, complete the remainder of this form))
- not currently employed (skip to the signature lines at the bottom and return the form to the Fund office)
- employed part-time (number of hours regularly scheduled each week \_\_\_\_\_)  
(if scheduled less than 32 hours per week, please sign on the signature lines and return to the Fund office)
- self employed

**My spouse is employed by:**

Employer's Name: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Employer's Phone #: \_\_\_\_\_  
 Human Resource Contact Name: \_\_\_\_\_  
 Human Resource Phone #: \_\_\_\_\_

SPOUSE'S MEDICAL COVERAGE			
GROUP #	MEMBER ID	CARRIER NAME	
CARRIER ADDRESS		CARRIER PHONE #	COVERAGE EFFECTIVE DATE
What type of coverage is this policy?		SINGLE <input type="checkbox"/>	FAMILY <input type="checkbox"/>
SPOUSE'S DENTAL COVERAGE			
GROUP #	MEMBER ID	CARRIER NAME	
CARRIER ADDRESS		CARRIER PHONE #	COVERAGE EFFECTIVE DATE
What type of coverage is this policy?		SINGLE <input type="checkbox"/>	FAMILY <input type="checkbox"/>
SPOUSE'S PRESCRIPTION COVERAGE			
GROUP #	MEMBER ID	CARRIER NAME	
CARRIER ADDRESS		CARRIER PHONE #	COVERAGE EFFECTIVE DATE
What type of coverage is this policy?		SINGLE <input type="checkbox"/>	FAMILY <input type="checkbox"/>
SPOUSE'S VISION COVERAGE			
GROUP #	MEMBER ID	CARRIER NAME	
CARRIER ADDRESS		CARRIER PHONE #	COVERAGE EFFECTIVE DATE
What type of coverage is this policy?		SINGLE <input type="checkbox"/>	FAMILY <input type="checkbox"/>

We declare that the foregoing information is true and correct to the best of my knowledge, information and belief. We understand that the Fund reserves the right to suspend or terminate our health coverage if it concludes that we have provided false or misleading information in this Declaration. We understand that if the spouse's employer offers group health insurance, the spouse must enroll in his/her employer's plan. I understand that if the spouse does not so enroll, he/she is ineligible to be covered as a dependent in the Fund's Plan. Finally, we understand that the spouse's group health plan from his/her employer is his/her primary insurance plan. The Fund will only consider spouse's claims for payment that have first been submitted to the spouse's employer's plan. If the spouse should change employment, or his/her eligibility for health coverage should change, We are required to notify the Fund and complete an updated Declaration of Spouse Health Coverage.

<b>Member's Signature:</b>		<b>Date:</b>
<b>Spouse's Signature:</b>		<b>Date:</b>

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Abrams	Edward S.	DMD	Endodontics Limited, P.C.	2137 Welsh Road	Suite 3-A	Philadelphia	PA	19115	(215) 969-1222	Endodontics
Abrams	Edward S.	DMD	Endodontics Limited, P.C.	825 Town Center Drive		Langhorne	PA	19047	(215) 750-5200	Endodontics
Alexander	Maria		Family Dental Care	626 Snyder Avenue	Suite 200	Philadelphia	PA	19148	(215) 391-4100	Endodontics
Appelstein	Neal		Precision Dental Specialties, LLC	77 Garland Lane		Willingboro	NJ	08046	(856) 488-1611	Endodontics
Appelstein	Neal		Precision Dental Specialties, LLC	520 Stokes Road, Bldg. B-18		Medford	NJ	08055	(856) 321-0400	Endodontics
Applestein	Craig	DMD	Precision Dental Specialties, LLC	4 Monroe Avenue		Glassboro	NJ	08028	(856) 235-0770	Endodontics
Barkan	Michael J.	DMD	Endodontics Limited, P.C.	825 Town Center Drive		Langhorne	PA	19047	(215) 750-5200	Endodontics
Barkan	Michael J.	DMD	Endodontics Limited, P.C.	2137 Welsh Road	Suite 3-A	Philadelphia	PA	19115	(215) 969-1222	Endodontics
Bedar	Abraham	DMD	Cosmopolitan Dental, LLC	10,000 Lincoln Drive East	Suite 106	Marlton	NJ	08053	(856) 983-2983	Endodontics
Beder	Abraham		Infinite Endodontics, LLC	210 Delaware Street		Woodbury	NJ	08096	(877) 422-6257	Endodontics
Beder	Abraham		Infinite Endodontics, LLC	222 New Road	Suite 203	Linwood	NJ	08221	(877) 422-6257	Endodontics
Bruno	Frank		American Dental Care, PC	1003 W. Baltimore Pike		Media	PA	19063	(610) 891-0940	Endodontics
Clemens	Vaughn	DDS	Signature Smiles	120 S. 6th Street		Vineland	NJ	08360-4605	(856) 692-5533	Endodontics
Clemens	Vaughn	DDS	Signature Smiles	27-29 South New York Avenue		Atlantic City	NJ	08401	(609) 345-6600	Endodontics
Clemens	Vaughn	DDS	Signature Smiles	1103 West Sherman Avenue		Vineland	NJ	08360	(856) 692-9333	Endodontics
Clemens	Vaughn	DDS	Signature Smiles	7 East Shell Bay Ave, #B		Cape May Court House	NJ	08210	(609) 463-1700	Endodontics
Colletti	Serena M.			3541 Ryan Avenue		Philadelphia	PA	19136	(215) 708-3636	Endodontics
Fleischman	Steven B.	DDS	Endodontics Limited, P.C.	2137 Welsh Road	Suite 3-A	Philadelphia	PA	19115	(215) 969-1222	Endodontics
Fleischman	Steven B.	DDS	Endodontics Limited, P.C.	825 Town Center Drive		Langhorne	PA	19047	(215) 750-5200	Endodontics
Fleisher	Robert M.	DMD	Endodontics Limited, P.C.	825 Town Center Drive		Langhorne	PA	19047	(215) 750-5200	Endodontics
Fleisher	Robert M.	DMD	Endodontics Limited, P.C.	2137 Welsh Road	Suite 3-A	Philadelphia	PA	19115	(215) 969-1222	Endodontics
Goldberg	Jay M.	DDS	Endodontics Limited, P.C.	2137 Welsh Road	Suite 3-A	Philadelphia	PA	19115	(215) 969-1222	Endodontics
Goldberg	Jay M.	DDS	Endodontics Limited, P.C.	825 Town Center Drive		Langhorne	PA	19047	(215) 750-5200	Endodontics
Hodges	Eric N.	DMD		3900 City Line Avenue	Presidential City, #D123	Philadelphia	PA	19131	(215) 477-8941	Endodontics
Kalikow	Richard K.	DDS		921 Penllyn Blue Bell Pike		Blue Bell	PA	19422	(215) 628-0610	Endodontics
Kalikow	Richard K.	DDS		269 North Easton Road		Glenside	PA	19038	(215) 887-5522	Endodontics

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Kaye	Melvin	DDS		2237 Garrett Road		Drexel Hill	PA	19026	(610) 284-1200	Endodontics
Kim	Andrew		Infinite Endodontics, LLC	210 Delaware Street		Woodbury	NJ	08096	(877) 422-6257	Endodontics
Kim	Andrew		Infinite Endodontics, LLC	222 New Road	Suite 203	Linwood	NJ	08221	(877) 422-6257	Endodontics
Kobeski	Joseph	DMD	Platinum Dental Specialties	2207 Oregon Pike	Suite 101	Lancaster	PA	17601	(717) 509-7111	Endodontics
Kobeski	Joseph	DMD	Platinum Dental Specialties	1 Commerce Boulevard		West Grove	PA	19390	(610) 869-9200	Endodontics
Ku	Joanna		Infinite Endodontics, LLC	210 Delaware Street		Woodbury	NJ	08096	(877) 422-6257	Endodontics
Ku	Joanna		Infinite Endodontics, LLC	222 New Road	Suite 203	Linwood	NJ	08221	(877) 422-6257	Endodontics
Kurtz	Elena		Infinite Endodontics, LLC	210 Delaware Street		Woodbury	NJ	08096	(877) 422-6257	Endodontics
Kurtz	Elena		Infinite Endodontics, LLC	222 New Road	Suite 203	Linwood	NJ	08221	(877) 422-6257	Endodontics
Parris	Leonard	DMD	Root Canal Specialist	255 South 17th Street	Medical Tower, Suite 1401	Philadelphia	PA	19103	(215) 545-5455	Endodontics
Porras	Omar		Infinite Endodontics, LLC	210 Delaware Street		Woodbury	NJ	08096	(877) 422-6257	Endodontics
Porras	Omar		Infinite Endodontics, LLC	222 New Road	Suite 203	Linwood	NJ	08221	(877) 422-6257	Endodontics
Saint-Cyr	Spencer Carl	DMD	Infinite Endodontics, LLC	210 Delaware Street		Woodbury	NJ	08096	(877) 422-6257	Endodontics
Saint-Cyr	Spencer Carl	DMD	Infinite Endodontics, LLC	222 New Road	Suite 203	Linwood	NJ	08221	(877) 422-6257	Endodontics
Schoengold	Irwin N.	DMD	Schoengold, Zicchinolfi, PC	261 Old York Road		Jenkintown	PA	19046	(215) 887-1040	Endodontics
Schultz	Todd	DMD	Endodontics Limited, P.C.	2137 Welsh Road	Suite 3-A	Philadelphia	PA	19115	(215) 969-1222	Endodontics
Schultz	Todd	DMD	Endodontics Limited, P.C.	825 Town Center Drive		Langhorne	PA	19047	(215) 750-5200	Endodontics
Segal	Edward M.	DDS		6508 Ridge Avenue		Philadelphia	PA	19128	(215) 482-0504	Endodontics
Shpeen	Stephen E.	DMD, LLC		546 A. Lippincott Drive	South Crossing Office Complex	Marlton	NJ	08053	(856) 988-0023	Endodontics
Thurber	John		Family Dental Care	626 Snyder Avenue	Suite 200	Philadelphia	PA	19148	(215) 391-4100	Endodontics
Titlebaum	Richard A.	DMD	The Dennis Center	63 Garrett Lane		Willingboro	NJ	08046	(609) 871-0900	Endodontics
Wibowo	Felicitas I.	DMD		138 Broadway		Hanover	PA	17331	(717) 632-8571	Endodontics
Yesilsoy	Cemil	DMD, MS		333 N Oxford Valley Road	Suite 507	Fairless Hills	PA	19030	(215) 547-4215	Endodontics
Zicchinolfi	Steven J.	DMD		3541 Ryan Avenue		Philadelphia	PA	19136	(215) 708-3636	Endodontics
Zicchinolfi	Steven J.	DMD	Schoengold, Zicchinolfi, PC	261 Old York Road		Jenkintown	PA	19046	(215) 887-1040	Endodontics
			A+ Endodontic Specialty Care, PC	8539 Bustleton Avenue		Philadelphia	PA	19152	(215) 342-5740	Endodontics

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			A+ Endodontic Specialty Care, PC	1950 Street Road	Suite 200	Bensalem	PA	19020	(215) 638-4696	Endodontics
			A+ Endodontic Specialty Care, PC	404 Middletown Boulevard	Suite 300	Langhorne	PA	19047	(215) 757-4400	Endodontics
			A+ Endodontic Specialty Care, PC	8355 Loretto Avenue	Suite 104	Philadelphia	PA	19152	(215) 342-5750	Endodontics
			A+ Endodontic Specialty Care, PC	8001 Roosevelt Boulevard	Suite 200	Philadelphia	PA	19152	(215) 268-9655	Endodontics
			A+ Endodontic Specialty Care, PC	2501 Secane Drive		Philadelphia	PA	19154	(215) 632-1244	Endodontics
			A+ Endodontic Specialty Care, PC	24 South 14th Street		Quakertown	PA	18951	(215) 536-3210	Endodontics
			A+ Endodontic Specialty Care, PC	1500 Horizon Drive	Suite 104	Chalfont	PA	18914	(215) 997-9980	Endodontics
			A+ Endodontic Specialty Care, PC	456 School Lane	Suite 104	Harleysville	PA	19438	(215) 513-7172	Endodontics
			A+ Endodontic Specialty Care, PC	744 Route 113 North		Souderton	PA	18964	(215) 799-0241	Endodontics
			A+ Endodontic Specialty Care, PC	35-B Woodland Avenue		Morton	PA	19070	(610) 544-3630	Endodontics
			A+ Endodontic Specialty Care, PC	600 West Olney Avenue		Philadelphia	PA	19120	(215) 549-6868	Endodontics
			A+ Endodontic Specialty Care, PC	8 Pond's Edge Drive	Suite 2	Chadds Ford	PA	19317	(610) 388-4466	Endodontics
			A+ Endodontic Specialty Care, PC	6100-02 5th St.	Storefront	Philadelphia	PA	19120	(215) 224-4343	Endodontics
			A+ Endodontic Specialty Care, PC	301 City Avenue	Suite G-5	Bala Cynwyd	PA	19004	(610) 660-9510	Endodontics
			A+ Endodontic Specialty Care, PC	1901 Union Boulevard		Allentown	PA	18109	(610) 437-5353	Endodontics
			A+ Endodontic Specialty Care, PC	479 Thomas Jones Way	Suite 600	Exton	PA	19341	(610) 280-7222	Endodontics
			A+ Endodontic Specialty Care, PC	2230 N. 5th St. Highway		Reading	PA	19605	(610) 371-8844	Endodontics
			A+ Endodontic Specialty Care, PC	1555 Highlands Drive	Suite 190	Lititz	PA	17543	(717) 303-3051	Endodontics
			A+ Endodontic Specialty Care, PC	450 Cresson Blvd.	Suite 210	Oaks	PA	19456	(610) 482-4334	Endodontics
			A+ Endodontic Specialty Care, PC	4259 West Swamp Road		Doylestown	PA	18902	(215) 230-4550	Endodontics
			A+ Endodontic Specialty Care, PC	1247 S. Cedar Crest Blvd.	Suite 300	Allentown	PA	18103	(610) 628-1228	Endodontics
			Exton Endodontics, PC	665 Exton Commons		Exton	PA	19341-2	(610) 524-1610	Endodontics
			Infinite Endodontics, LLC	222 New Road	Suite 203	Linwood	NJ	08221	(877) 422-6257	Endodontics
			Infinite Endodontics, LLC	210 Delaware Street		Woodbury	NJ	08096	(877) 422-6257	Endodontics
			Infinite Endodontics, LLC	2800 Route 130 North	Suite 108	Cinnaminson	NJ	08077	(877) 422-6257	Endodontics
			Infinite Endodontics, LLC	1765 Springdale Road	Suite C-1	Cherry Hill	NJ	08003	(877) 422-6257	Endodontics

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Precision Dental Specialties, LLC	4 Monroe Avenue		Glassboro	NJ	08028	(856) 235-0770	Endodontics
			Premier Endodontics, PC	298 Blair Mill Road, Suite 100		Horsham	PA	19044	(215) 672-8588	Endodontics
			Premier Endodontics, PC	1044 Byberry Road		Bensalem	PA	19020	(215) 338-0188	Endodontics
			Premier Endodontics, PC	4101 Tyson Avenue		Philadelphia	PA	19135	(215) 338-0188	Endodontics
			Premier Endodontics, PC	1288 Valley Forge Road	Suite 70	Phoenixville	PA	19460	(484) 714-0630	Endodontics
			Premier Endodontics, PC	6 Heartstone Court	Suite 304	Exeter	PA	19606	(484) 714-0630	Endodontics
			Schoengold, Zicchinolfi, PC	261 Old York Road		Jenkintown	PA	19046	(215) 887-1040	Endodontics
			West Chester Endodontics, PC	606 East Marshall Street	Suite 204	West Chester	PA	19380	(610) 431-7025	Endodontics
			5th Street Dental Center, Inc.	4646 North Fifth Street		Philadelphia	PA	19140	(215) 324-1950	General Dentistry
			A+ Family Dental Care, P.C.	456 School Lane	Suite 104	Harleysville	PA	19438	(215) 513-7172	General Dentistry
			A+ Family Dental Care, P.C.	1500 Horizon Drive	Suite 104	Chalfont	PA	18914	(215) 997-9980	General Dentistry
			A+ Family Dental Care, P.C.	744 Route 113 North		Souderton	PA	18964	(215) 799-0241	General Dentistry
			A-1 Family Dental	8001 Roosevelt Boulevard	Smyle Times Bldg., Suite 503	Philadelphia	PA	19152	(215) 268-9655	General Dentistry
			A-1 Family Dental	8355 Loretto Avenue		Philadelphia	PA	19152	(215) 342-5750	General Dentistry
			Abington Dental Excellence, Inc.	1130 Old York Road		Abington	PA	19001	(215) 881-8551	General Dentistry
			Absolute Smile	1045 Street Road		Southampton	PA	18966	(215) 355-4007	General Dentistry
			Advanced & Comfort Dentistry	3655 Municipal Drive		Whitehall	PA	18052	(610) 432-1200	General Dentistry
			Advanced Dental Group	150 West State Street		Doylestown	PA	18901	(215) 230-4464	General Dentistry
			Advanced Family Dentistry	35 B Woodland Avenue		Morton	PA	19070	(610) 544-3630	General Dentistry
			Advanced Family Dentistry	600 West Olney Avenue		Philadelphia	PA	19120	(215) 549-6868	General Dentistry
			Advanced Family Dentistry	8 Ponds Edge Drive	Suite 2	Chadds Ford	PA	19317	(610) 388-4466	General Dentistry
			Advanta Dental	237 Penn Avenue		Scranton	PA	18503	(570) 347-2920	General Dentistry
			American Dental Care, LLC	4811 Jonestown Road	Suite 129	Harrisburg	PA	17109	(717) 526-2011	General Dentistry
			American Dental Care, LLC	817 North Easton Road		Doylestown	PA	18901	(215) 348-4041	General Dentistry
			American Dental Care, PA	1450 Clements Bridge Road		Woodbury	NJ	08096	(856) 845-6222	General Dentistry
			American Dental Care, PC	6162 Ridge Avenue		Philadelphia	PA	19128	(215) 483-1900	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			American Dental Care, PC	437 Chestnut Street	Suite 500	Philadelphia	PA	19106	(215) 625-4865	General Dentistry
			American Dental Care, PC	722 Market Street		Philadelphia	PA	19106	(215) 922-5100	General Dentistry
			American Dental Care, PC	187 E. City Avenue		Bala Cynwyd	PA	19004	(610) 667-9713	General Dentistry
			American Dental Care, PC	9229 Roosevelt Boulevard		Philadelphia	PA	19114	(215) 969-0900	General Dentistry
			American Dental Care, PC	515 Baltimore Pike		Springfield	PA	19064	(610) 543-4900	General Dentistry
			American Dental Care, PC	1003 W. Baltimore Pike		Media	PA	19063	(610) 891-0940	General Dentistry
			American Dental Care, PC	2385 Cheltenham Avenue	Washington	Philadelphia	PA	19150	(215) 886-7177	General Dentistry
			American Dental Care, PC	6780 Market Street		Upper Darby	PA	19082	(610) 352-7600	General Dentistry
			American Family Dental Care, P.C.	11911 Bustleton Avenue		Philadelphia	PA	19116	(215) 673-9050	General Dentistry
			American Family Dental Care, P.C.	1901 Union Boulevard		Allentown	PA	18109	(610) 437-5353	General Dentistry
			American Family Dental Care, P.C.	301 City Avenue	Suite G-5	Bala Cynwyd	PA	19004	(610) 660-9510	General Dentistry
			Amjad Dental Associates, Inc.	500-B Godfrey Avenue		Philadelphia	PA	19120	(215) 745-9100	General Dentistry
			Amjad Dental Associates, Inc.	2616 North Broad Street		Colmar	PA	18915	(215) 822-7667	General Dentistry
			A-One Dental Care	11 West Lafayette Street		Norristown	PA	19401	(610) 277-7660	General Dentistry
			Apex Dental Care, LLC	1600 Horizon Drive, Ste. 119		Chalfont	PA	18914	(215) 996-9968	General Dentistry
			Berlin Plaza Dental Associates	116 Walker Avenue	Berlin Circle Plaza	West Berlin	NJ	08091	(856) 768-5151	General Dentistry
			Blue Bell Dental Assoc., PC	1115 DeKalb Pike		Center Square	PA	19422	(610) 278-0420	General Dentistry
			Braden Dental of South Jersey, PC	530 Crown Point Road	Suite 5	West Deptford	NJ	08086	(856) 845-4225	General Dentistry
			Celebrity Smiles	1811 Bethlehem Pike	Suite A102	Flourtown	PA	19031	(215) 233-5811	General Dentistry
			Center for Family & Cosmetic Dentistry & Norwood	7 West Winona Avenue		Norwood	PA	19074	(610) 532-0221	General Dentistry
			Chadds Ford Dental Associates	6 Dickinson Drive	Suite 102	Chadds Ford	PA	19317	(610) 558-5699	General Dentistry
			Coatesville Denter Center	6 North Third Avenue		Coatesville Washington	PA	19320	(610) 384-4555	General Dentistry
			Colonial Dental Associates	1091 General Knox Road		Crossing	PA	18977	(215) 493-9525	General Dentistry
			Community Medical and Dental Center	309 Gravel Pike		Collegeville	PA	19426	(610) 489-1313	General Dentistry
			Cross Keys Dental, LLC	175 Cross Keys Road	Suite 103	Berlin	NJ	08009	(856) 753-3368	General Dentistry
			Dental Choice-Burlington, PC	1112B Sunset Road	Sunset Strip Shopping	Burlington	NJ	08016	(609) 387-8863	General Dentistry



Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Dentex Dental Group, Ltd.	1701 East Montgomery Avenue		Philadelphia	PA	19148	(215) 462-4047	General Dentistry
			Drexel Hill Family Dentistry	4244 Ferne Boulevard		Drexel Hill	PA	19026	(610) 259-3557	General Dentistry
			East Side Family Dentistry	1640 Union Boulevard		Allentown	PA	18109	(610) 776-7578	General Dentistry
			Fairless Hills Dental Center	532 South Oxford Valley Road		Fairless Hills	PA	19030	(215) 946-3655	General Dentistry
			Family Dental	626 Snyder Avenue		Philadelphia	PA	19148	(215) 334-4900	General Dentistry
			Family Dentistry	6525 C Frontier Drive		Springfield	VA	22150	(703) 313-7000	General Dentistry
			Frank T. Trifiletti, DDS, PA	521 Sicklerville Road		Sicklerville	NJ	08081	(856)728-1717	General Dentistry
			Frankford Avenue Dental	4510 Frankford Avenue		Philadelphia	PA	19124	(215) 535-1990	General Dentistry
			Fridman Dental Care	1707 West Passyunk Avenue		Philadelphia	PA	19145	(215) 271-7259	General Dentistry
			Fries Mill Dental Associates, PA	188 Fries Mill Road	Suite L-3	Turnersville	NJ	08012	(856) 629-0088	General Dentistry
			Gentle Dental	4736 Neshaminy Boulevard		Bensalem	PA	19020	(215) 702-8850	General Dentistry
			Gentle Dental 52nd	5139 Chestnut Street		Philadelphia	PA	19139	(215) 471-1600	General Dentistry
			Gentle Dental of Allentown	2015 Hamilton Street		Allentown	PA	18104	(610) 434-8975	General Dentistry
			Gentle Dental of Tabor Road	1335 West Tabor Road		Philadelphia	PA	19141	(215) 548-8080	General Dentistry
			Georgetown Smile, P.C.	4400 MacArthur Blvd., N.W., Ste. 200		Washington	DC	20007	(202) 333-0003	General Dentistry
			Gor Family Dentistry	8 Ritz Center		Voorhees	NJ	08043	(856) 782-7448	General Dentistry
			Haddonfield Family Dentistry	5 North Haddon Avenue		Haddonfield	NJ	08033	(856) 429-5612	General Dentistry
			Havertown Dental Assocs, PC	1220 West Chester Pike		Havertown	PA	19083	(610) 789-0158	General Dentistry
			Healthy Smiles Family Dentistry, LLC	1233 Haddonfield Berlin Road		Voorhees	NJ	08043	(856) 768-8988	General Dentistry
			Hunting Park Dental	1999 W. Hunting Park Avenue		Philadelphia	PA	19140	(215) 229-1390	General Dentistry
			Jeso Advanced Family Dentistry	233 A McClellan Street		Philadelphia	PA	19148	(215) 755-6626	General Dentistry
			Lansdale Dental, P.C.	233 South Broad Street		Lansdale	PA	19446	(215) 393-9008	General Dentistry
			Lionville Dental Associates, LLC	67 Dowlin Forge Road	Suite C	Exton	PA	19341 1548	(610) 594-2001	General Dentistry
			M. H. Kaye Pavilion, Inc.	2050 Columbia Avenue		Lancaster	PA	17603	(717) 394-7218	General Dentistry
			Maidencreek Family Dentistry	1032 Park Road		Blandon	PA	19510	(610) 926-9300	General Dentistry
			Media Smiles, PC	1215 West Baltimore Pike	Suite 12	Media	PA	19063	(610) 566-0885	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Nice Care Dental Associates of South Phila.	1320 Ritner Street		Philadelphia	PA	19148	(215) 389-3876	General Dentistry
			Ocean Family Dental	524 South Main Street		West Creek	NJ	08092	(609) 597-9290	General Dentistry
			Ocean Family Dental	508 Long Beach Boulevard		Ship Bottom	NJ	08008	(609) 494-4492	General Dentistry
			O'Donnell & Phillips, LLC	230 Harrisburg Avenue		Lancaster	PA	17603	(717) 293-2784	General Dentistry
			Oxford Valley Dental Excellence	240 Middletown Boulevard		Langhorne	PA	19047	(215) 750-2222	General Dentistry
			Parkway Family Dentistry, PC	1732 DeKalb Pike		Blue Bell	PA	19422	(610) 278-1110	General Dentistry
			Perfect Smiles Dentistry	101 South White Horse Pike		Lindenwold	NJ	08021	(856) 566-7466	General Dentistry
			Personalized Dental Care, PC	805 Inman Avenue		Colonia	NJ	07067	(732) 388-7750	General Dentistry
			Pinelands Family Dental Care, PA	332 Stokes Road		Medford	NJ	08055	(609) 953-9999	General Dentistry
			Plymouth Green Dental Associates, PC	1000 Germantown Pike Suite 1-4		Plymouth Meeting	PA	19462	(610) 278-6500	General Dentistry
			Precision Dental Specialties, LLC	77 Garland Lane		Willingboro	NJ	08046	(856) 488-1611	General Dentistry
			Precision Dental Specialties, LLC	520 Stokes Road, Bldg. B-18		Medford	NJ	08055	(856) 321-0400	General Dentistry
			Radiant Smiles @ Floral Vale	117 Floral Vale Boulevard		Yardley	PA	19067	(215) 860-4600	General Dentistry
			Rapoza Family Dentistry, PC	1319 Lincoln Avenue		Prospect Park	PA	19076	(610) 532-5008	General Dentistry
			Rapoza Family Dentistry, PC	880 Township Line Road		Plymouth Meeting	PA	19462	(610) 279-8001	General Dentistry
			Signature Smiles	7 E Shellbay Avenue		Cape May Court House	NJ	08210	(609) 461-1700	General Dentistry
			Signature Smiles	27-29 South New York Avenue		Atlantic City	NJ	08401	(609) 345-6600	General Dentistry
			Signature Smiles	266 Georgetown Road		Carneys Point	NJ	08069	(856) 299-0030	General Dentistry
			Signature Smiles	1103 West Sherman Avenue		Vineland	NJ	08360	(856) 692-9333	General Dentistry
			Silvania Curiani, David & Associates, PC	2675 East Cumberland Street		Philadelphia	PA	19125	(215) 426-7307	General Dentistry
			Smile by Design	1330 West Chester Pike		Havertown	PA	19083	(610) 789-4040	General Dentistry
			Smile by Design	335 West Lancaster Avenue		Wayne	PA	19087	(610) 964-0111	General Dentistry
			Soco Mgmt. of Springfield	891 Baltimore Pike		Springfield	PA	19064	(610) 544-8881	General Dentistry
			Soma Enterprises, PA	68 South Whitehorse Pike		Berlin	NJ	08009	(856) 767-4445	General Dentistry
			Special Touch Dentistry, LLC	240 Geiger Road		Philadelphia	PA	19115	(215) 508-4200	General Dentistry
			Springdale Family Dental	1765 Springdale Road		Cherry Hill	NJ	08003	(856) 424-0170	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Star Dental, Inc.	627 E. Allegheny Ave.		Philadelphia	PA	19134	(215) 423-1900	General Dentistry
			Star Dental, Inc.	101 Long Lane		Upper Darby	PA	19082	(610) 352-2263	General Dentistry
			Sunset Family Dental, LLC	77 Garland Lane		Willingboro	NJ	08046	(609) 880-0090	General Dentistry
			Torresdale Dental Associates	7108 Torresdale Avenue		Philadelphia	PA	19135	(215) 338-4345	General Dentistry
			University City Dental Associates	5338 Baltimore Avenue		Philadelphia	PA	19143	(215) 476-2122	General Dentistry
			West Deptford Dental Associates	530 Crown Point Road	Crown Point Plaza	Thorofare	NJ	08086	(856) 848-6604	General Dentistry
			Wilson Park Dental	2520 Snyder Avenue		Philadelphia	PA	19145	(215) 755-6866	General Dentistry
Abbasian	Vargha	DDS, PC		1653 Elkton Road		Elkton	MD	21921	(410) 620-7055	General Dentistry
Abdollahi	Mitra	DMD	White Horse Pike Family Dentistry	3 North Whitehorse Pike		Somerdale	NJ	08083	(856) 782-0800	General Dentistry
Abolarin	Andrew	DDS	Alpha Dental Care	7439 Frankford Avenue	Second Floor	Philadelphia	PA	19136	(215) 613-5808	General Dentistry
Abolarin	Olusegun	DDS	Alpha Dental Care	7439 Frankford Avenue	Second Floor	Philadelphia	PA	19136	(215) 613-5808	General Dentistry
Abraham	Kurian M.			1825 Spring Garden Street		Philadelphia	PA	19130	(215) 972-0955	General Dentistry
Abrams	Eric	DMD	Levittown Family Dental Associates, LLC	359 Indian Creek Drive		Levittown	PA	19057	(215) 945-5588	General Dentistry
Adly	Essam	DDS	Cosmetic Dentistry and Implant, LLC	1074 Route #18		East Brunswick	NJ	08816	(732) 613-0008	General Dentistry
Alexander	Maria		Family Dental Care	626 Snyder Avenue	Suite 200	Philadelphia	PA	19148	(215) 391-4100	General Dentistry
Alper	Cheryl	DMD, PC		406 Crabtree Drive		Levittown	PA	19055	(215) 946-9469	General Dentistry
Alten	Steven B.	DDS	General and Cosmetic Dentistry	2529 South Fifth Street		Philadelphia	PA	19148	(215) 271-0672	General Dentistry
Amjad	Hajira		Amjad Dental Associates, Inc.	500-B Godfrey Avenue		Philadelphia	PA	19120	(215) 745-9100	General Dentistry
Amjad	Hajira		Amjad Dental Associates, Inc.	2616 North Broad Street		Colmar	PA	18915	(215) 822-7667	General Dentistry
Amjad	Hammad R.		Amjad Dental Associates, Inc.	2616 North Broad Street		Colmar	PA	18915	(215) 822-7667	General Dentistry
Amjad	Hammad R.		Amjad Dental Associates, Inc.	500-B Godfrey Avenue		Philadelphia	PA	19120	(215) 745-9100	General Dentistry
Amjad	Muhammad	DDS	Amjad Dental Associates, Inc.	2616 North Broad Street		Colmar	PA	18915	(215) 822-7667	General Dentistry
Amjad	Muhammad	DDS	Amjad Dental Associates, Inc.	500-B Godfrey Avenue		Philadelphia	PA	19120	(215) 745-9100	General Dentistry
Anagrostakos	Paul		Feasterville Family Dentistry	4 Arbor Lane		Treose	PA	19053	(215) 357-4321	General Dentistry
Anuradha	Ganta	DDS	Advanced Family Dental Care, PC	327 Township Line Road		Elkins Park	PA	19027	(215) 663-1223	General Dentistry
Appel	Steven	DDS, PC		1430 Snyder Avenue, 2nd Floor		Philadelphia	PA	19145	(215) 677-9314	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Applestein	Craig	DMD	Precision Dental Specialties, LLC	77 Garland Lane		Willingboro	NJ	08046	(856) 488-1611	General Dentistry
Arshad	Mohammad	DDS		249 West Duncannon Avenue		Philadelphia	PA	19120	(215) 329-0416	General Dentistry
Asgari	David	DMD		202 Concord Road		Aston	PA	19014	(610) 872-7461	General Dentistry
Asgari	David	DMD		1653 Elkton Road		Elkton	MD	21921	(410) 620-7055	General Dentistry
Asgari	David	DMD	Family Dentistry	6525 C Frontier Drive		Springfield	VA	22150	(703) 313-7000	General Dentistry
Asta	John J.	DDS		359 Indian Creek Drive		Levittown	PA	19057	(215) 945-5588	General Dentistry
Au	Augustine C	DDS		121 North 10th Street		Philadelphia	PA	19107	(215) 923-1304	General Dentistry
Au	Felice Hom	DMD		4837 North Broad Street		Philadelphia	PA	19141	(215) 329-9988	General Dentistry
Au	Felice Hom	DMD		113 Bethlehem Pike		Colmar	PA	18915	(215) 996-1818	General Dentistry
Au	Raymond C.	DDS		113 Bethlehem Pike		Colmar	PA	18915	(215) 996-1818	General Dentistry
Au	Raymond C.	DDS		4837 North Broad Street		Philadelphia	PA	19141	(215) 329-9988	General Dentistry
Au	Raymond C.	DDS		121 North 10th Street		Philadelphia	PA	19107	(215) 923-1304	General Dentistry
Backiel	Deborah	DMD, PC		1500 JFK Boulevard, Suite 300		Philadelphia	PA	19102	(267) 514-8100	General Dentistry
Bagley	Jacob M.	DDS		508 Front Street		Elmer	NJ	08318	(856) 358-2626	General Dentistry
Baker	Joseph	DDS		1024 West Marshall Street		Norristown	PA	19401	(610) 275-8830	General Dentistry
Band	Steven	DDS		9880 Bustleton Avenue	Einstein Center One	Philadelphia	PA	19115	(215) 673-4888	General Dentistry
Barksdale	George A.	DDS		2520 Snyder Avenue		Philadelphia	PA	19145	(215) 755-6866	General Dentistry
Barot	Ashok	DDS		7519 Torresdale Avenue		Philadelphia	PA	19136	(215) 335-2200	General Dentistry
Barot	Ashok	DDS	Wilson Park Dental	2520 Snyder Avenue		Philadelphia	PA	19145	(215) 755-6866	General Dentistry
Beadle	Robert	DDS		5945 Lansdowne Avenue		Philadelphia	PA	19151	(215) 871-0960	General Dentistry
Becker	George J.	DMD		2810 Cottman Avenue		Philadelphia	PA	19149	(215) 338-9406	General Dentistry
Belder	Michael	DDS	Advanced Dental Group	1051 County Line Road		Valley Forge	PA	19006	(215) 322-2262	General Dentistry
Belder	Michael	DDS	Advanced Dental Group	528 Street Road		Southampton	PA	18966	(215) 322-2262	General Dentistry
Berkyan	Sara	DDS	Westtown Dental Care	1558 McDaniel Drive		West Chester	PA	19380	(484) 887-0777	General Dentistry
Berrios	Karen	DMD		3100 Levick Street		Philadelphia	PA	19149	(215) 288-2063	General Dentistry
Best	Naomi	DMD	Contemporary Dental Associates	2 Rose Street	#A	Willingboro	NJ	08046	(609) 877-7687	General Dentistry

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Dental PPO Providers

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Bhatia	Nidhi	DDS	Abington Dental Excellence, Inc.	1130 Old York Road		Abington	PA	19001	(215) 881-8551	General Dentistry
Bhatt	B.G.	DMD	B.G. Bhatt, DMD & Associates, Inc.	6200 Bustleton Avenue		Philadelphia	PA	19149	(215) 289-9090	General Dentistry
Bhavsar	Naresh		The Family Holland Dental, PC	295 Buck Road	Suite 109	Holland	PA	18966	(215) 953-0553	General Dentistry
Bonelli	Melba	DMD	Dental Choice, P.C.	4001 Lincoln Drive West	Suite D	Marlton	NJ	08053	(856) 983-9300	General Dentistry
Bower	David H.	DMD		3000 Joshua Road		Lafayette Hill	PA	19444	(610) 825-6933	General Dentistry
Brahen	Roy	DDS		7538 Frankford Avenue		Philadelphia	PA	19136	(215) 333-4744	General Dentistry
Bresler	David	DDS	Cavity Busters	1650 Limekiln Pike		Dresher	PA	19025	(215) 643-1300	General Dentistry
Bresler	David	DDS	Special Touch Dentistry, LLC	240 Geiger Road		Philadelphia	PA	19115	(215) 508-4200	General Dentistry
Bruggeworth	Scott	DDS	Signature Smiles	1103 West Sherman Avenue		Vineland	NJ	08360	(856) 692-9333	General Dentistry
Bruggeworth	Scott	DDS	Signature Smiles	7 E Shell Bay Avenue		Cape May Court House	NJ	08210	(609) 463-1700	General Dentistry
Bruggeworth	Scott	DDS	Signature Smiles	27-29 South New York Avenue		Atlantic City	NJ	08401	(609) 345-6600	General Dentistry
Bruggeworth	Scott	DDS	Signature Smiles	120 S. 6th Avenue		Vineland	NJ	08360	(856) 692-5533	General Dentistry
Bui	Houng T.		South Side Dental, LLC	4808 Derry Street		Harrisburg	PA	17111	(717) 564-9250	General Dentistry
Buongiovanni	George	DMD	Marlton Dental Center	1 Blanchard Road		Marlton	NJ	08053	(856) 768-0129	General Dentistry
Butler	Paul	DDS		27 South 11th Street		Philadelphia	PA	19107	(215) 922-6516	General Dentistry
Cantwell	Michele	DMD	Cantwell Dental Group	2207 Oregon Pike	Suite 101	Lancaster	PA	17601	(717) 509-7111	General Dentistry
Carp	Brian Jon	DMD	Carp Dental Associates, PC	1325 West Airy Street		Norristown	PA	19401	(610) 275-1565	General Dentistry
Carvajal	Jorge	DMD	University City Dental, LLC	3805 Ventnor Avenue		Atlantic City	NJ	08401	(609) 572-0680	General Dentistry
Cavanaugh	Catherine	DMD	Media Smiles, PC	1215 West Baltimore Pike	Suite 12	Media	PA	19063	(610) 566-0885	General Dentistry
Cerato	Stuart	DDS		11621 Bustleton Avenue		Philadelphia	PA	19116	(215) 673-8887	General Dentistry
Certo, Jr.	Peter C.	DMD		2211 Chichester Avenue	Suite 204 2100 F STREET, SUITE G	Boothwyn	PA	19061	(610) 364-1345	General Dentistry
Chae	Jae M.	DMD	City Dental, LLC	1100 Washington Ave		Philadelphia	PA	19147	(215) 462-4877	General Dentistry
Chao	Rudolph	DMD	Marlton Dental Center	1 Blanchard Road		Marlton	NJ	08053	(856) 768-0129	General Dentistry
Charnitski	Stephen	DMD	Gentle Dental of Haverford	354 Lancaster Avenue		Haverford	PA	19041	(610) 896-2447	General Dentistry
Chaudhry	Junaid	DMD		402 North Easton Road		Glenside	PA	19038	(215) 887-7788	General Dentistry
Chaudhry	Junaid	DMD	Academy Family Dental Care	10431 Academy Road		Philadelphia	PA	19114	(215) 637-7474	General Dentistry

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Chaudhry	Juniad	DMD	Five Points Family Dentistry	7234 Rising Sun Avenue		Philadelphia	PA	19111	(215) 745-4313	General Dentistry
Chaudhry	Juniad	DMD	Smile Designers	7234 Rising Sun Avenue		Philadelphia	PA	19111	(215) 745-4313	General Dentistry
Checchio	Lennie M.	DDS		461 N. Warminster Road		Hatboro	PA	19044	(215) 333-9697	General Dentistry
Chen	Thomas	DMD		913 East Boot Road		West Chester	PA	19380	(610) 701-0102	General Dentistry
Chen Lemper	Jian Ying		Jenny Chen Family Dentistry, LLC	207 North Guernsey Road		West Grove	PA	19390	(610) 869-0991	General Dentistry
Cheng	James	DMD		724 MacDade Boulevard		Collingdale	PA	19023	(610) 586-3311	General Dentistry
Chennat	M.T.	DMD	M.T. Chennat, DMD & Associates	8227 Stenton Avenue		Philadelphia	PA	19150	(215) 242-5950	General Dentistry
Cherian	Mathew K.	DDS	Advanced Family Dental Care, PC	327 Township Line Road		Elkins Park	PA	19027	(215) 663-1223	General Dentistry
Cherian	Matthew P.	DMD	Abington Dental Excellence, Inc.	1130 Old York Road		Abington	PA	19001	(215) 881-8551	General Dentistry
Chew	Dennis W.	DDS	Cosmopolitan Dental, LLC	10,000 Lincoln Drive East	Suite 106	Marlton	NJ	08053	(856) 983-2983	General Dentistry
Cho	Davis S.	DMD	Torresdale Dental Associates	7108 Torresdale Avenue		Philadelphia	PA	19135	(215) 338-4345	General Dentistry
Cohen	Philip	DDS		2520 Snyder Avenue		Philadelphia	PA	19145	(215) 755-6866	General Dentistry
Cohen	Ronald	DMD	Da Vinci Dental Specialists	316 North York Road		Warminster	PA	18974	(215) 383-6700	General Dentistry
Cohen	Ronald David	DMD, PC		668 Woodbourne Road		Langhorne	PA	19047	(215) 750-1880	General Dentistry
Cooper	Joel B.	DMD	Family Dental Care Center	43 South Lansdowne Avenue		Lansdowne	PA	19050	(610) 623-7610	General Dentistry
Corsi, Jr.	Gerald	DMD	Holdbrook Pediatric Dental, LLC	250 Haddonfield -Berlin Road		Gibbsboro	NJ	08026	(856) 783-0444	General Dentistry
Coslet	Laura J.	DMD	Hometown Family Dentistry, PA	402 White Horse Pike South 122 North Philadelphia		Magnolia	NJ	08049	(856) 566-9700	General Dentistry
Crocken	Kerry	DDS	Maryland Family Dental, LLC	Boulevard		Aberdeen	MD	21001	(410) 272-2636	General Dentistry
Crocken	Kerry F.	DDS		1653 Elkton Road		Elkton	MD	21921	(410) 620-7055	General Dentistry
Crocken	Kerry F.	DDS		202 Concord Road		Aston	PA	19014	(610) 872-7461	General Dentistry
Cullin	Marie J.	DMD	Torresdale Dental Associates	7108 Torresdale Avenue		Philadelphia	PA	19135	(215) 338-4345	General Dentistry
Cumba	José	DMD	Dentofacial Associates	435 West Landis Avenue		Vineland	NJ	08360	(856) 691-3220	General Dentistry
Cusses	Anastassius T.		Gentle Dental of Springfield	760 Sproul Road	Suite 100	Springfield	PA	19064	(610) 544-8881	General Dentistry
Dachowski	Damian	DMD		3425 Limekiln Pike	Suite 5	Chalfont	PA	18914	(215) 997-4434	General Dentistry
Dai	David	DMD	Star Dental, Inc.	627 E. Allegheny Ave.		Philadelphia	PA	19134	(215) 423-1900	General Dentistry
Dai	David	DMD	Star Dental, Inc.	101 Long Lane		Upper Darby	PA	19082	(610) 352-2263	General Dentistry

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Dai	Michele	DMD	Star Dental, Inc.	627 E. Allegheny Ave.		Philadelphia	PA	19134	(215) 423-1900	General Dentistry
Dai	Michele	DMD	Star Dental, Inc.	101 Long Lane		Upper Darby	PA	19082	(610) 352-2263	General Dentistry
Dai	Xiaoyan	DDS	Gentle Dental of Thorndale	3307 East Lincoln Highway		Thorndale	PA	19372	(610) 384-9099	General Dentistry
Daly	Gerald A.	DMD		1501 Wadsworth Avenue		Philadelphia	PA	19150	(215) 247-6337	General Dentistry
Daniels	Robert	DMD		321 East Street Road		Treose	PA	19053	(215) 357-2161	General Dentistry
Danzig	Stuart J.	DDS		9303 Baner Street		Philadelphia	PA	19115	(215) 464-5150	General Dentistry
Davis	Robert S.	DMD		1175 Dermond Road		Drexel Hill	PA	19026	(610) 446-3377	General Dentistry
Davis	Robert S.	DMD		1288 Valley Forge Rd # 52	The Commons at Valley Forge,	Phoenixville	PA	19460	(610) 933-4482	General Dentistry
Davis	Steven M.	DMD		2981 Richmond Street		Philadelphia	PA	19134	(215) 739-0404	General Dentistry
Day	Robert E.	DMD		1908 Kings Highway		Swedesboro	NJ	08085	(856) 467-1900	General Dentistry
DeCardona	José	DDS		11410 Bustleton Avenue		Philadelphia	PA	19116	(215) 676-4646	General Dentistry
Dennis	Alfred	DMD		63 Garrett Lane		Willingboro	NJ	08046	(609) 871-0900	General Dentistry
Desai	Ankur J.	DDS	Healthy Smiles of New Egypt	78 Maple Avenue	Suite D	New Egypt	NJ	08533	(609) 758-8200	General Dentistry
Desai	G.	DMD		6032 Lansdowne Avenue		Philadelphia	PA	19151	(215) 473-7444	General Dentistry
Deshmane	Jyoti	DMD	All Family Dental Care, Inc.	Routes 73 & 113		Collegeville	PA	19426	(610) 222-8189	General Dentistry
Lissade	Marcelle		Havertown Dental Assocs, PC	1220 West Chester Pike		Havertown	PA	19083	(610) 789-0158	General Dentistry
Dhillon	Neil	DMD	Complete Care Dental	1300 MacDade Boulevard	Suite 5	Woodlyn	PA	19094	(610) 833-1919	General Dentistry
Dibor	Chichi N.	DMD	Dibor Dental Associates, Inc.	5525 Wayne Avenue		Philadelphia	PA	19144	(215) 843-4900	General Dentistry
DiGuilio	Yolimar	DMD	Hometown Family Dentistry, PA	402 White Horse Pike South		Magnolia	NJ	08049	(856) 566-9700	General Dentistry
Dobraslav	Valid	DMD	V. Centrum	1225 Vine Street		Philadelphia	PA	19107	(215) 564-1679	General Dentistry
Donn	Craig	DDS		1940 Marlton Pike E		Cherry Hill	NJ	2141	(856) 424-7477	General Dentistry
Donskoy	Jennifer	DDS,	Dentallux, LLC	1308 Cottman Avenue		Philadelphia	PA	19111	(215) 745-5100	General Dentistry
Doshi	Prafull M.	PC	Maidencreek Family Dentistry	1032 Park Road		Blandon	PA	19510	(610) 926-9300	General Dentistry
Drain	Dorothy	DMD	Lakeside Dental Cosmetic & Family Dentistry	601 Liberty Place		Sicklerville	NJ	08081	(856) 740-1110	General Dentistry
Dubin	Stanley	PC		2901 Secane Drive		Philadelphia	PA	19154	(215) 632-1244	General Dentistry
Dubin	Stanley	PC		1038 Knorr Street		Philadelphia	PA	19111	(215) 342-0822	General Dentistry

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Duca, Jr.	Peter R.	DMD, PC		520 Stokes Road	Ironstone Bldg, B-18	Medford	NJ	08055	(609) 953-7400	General Dentistry
Dudhat	Dilip N.	DMD	Advanced & Comfort Dentistry	3655 Municipal Drive		Whitehall	PA	18052	(610) 432-1200	General Dentistry
Dudhat	Dilip N.	DMD	Advanced Dental Esthetics, P.C.	2406 North Broad Street		Colmar	PA	18915	(215) 997-2300	General Dentistry
Dudhat	Dilip N.	DMD	Advanced Dental Smiles, P.C.	533 North York Road		Hatboro	PA	19404	(215) 672-9444	General Dentistry
Dudhat	Dilip N.	DMD	Blue Bell Dental Assoc., PC	1115 DeKalb Pike		Center Square	PA	19422	(610) 278-0420	General Dentistry
Dudhat	Dilip N.	DMD	Radiant Smiles @ Floral Vale	117 Floral Vale Boulevard		Yardley	PA	19067	(215) 860-4600	General Dentistry
Dunnous	Robert	DDS		5542 Ridge Avenue		Philadelphia	PA	19128	(215) 482-4250	General Dentistry
Dunnous	Robert	DDS		1601 Walnut Street	Suite 918	Philadelphia	PA	19102	(215) 569-8989	General Dentistry
Dunoff	Keith L.	DMD	Berlin Plaza Dental Associates	116 Walker Avenue	Berlin Circle Plaza	West Berlin	NJ	08091	(856) 768-5151	General Dentistry
Duong	Linh Hong	DMD		310 North West End Avenue		Lancaster	PA	17603	(717) 390-1881	General Dentistry
Dyer	Dottie	DDS	West Deptford Dental Associates	530 Crown Point Road	Crown Point Plaza	Thorofare	NJ	08086	(856) 848-6604	General Dentistry
Dzilala	Suleiman M.		University City Dental	5338 Baltimore Avenue		Philadelphia	PA	19143	(215) 476-2122	General Dentistry
Edelson	Linda	DDS		5 Cherry Blossom Way		Churchville	PA	18966	(215) 322-5361	General Dentistry
Elessawi	Julie	DDS	Perfect Smile Dental Services	326 Broad Street		Red Bank	NJ	07701	(732) 224-9339	General Dentistry
Elliott	Donald	DDS		609 Germantown Pike		Lafayette Hill	PA	19444	(610) 828-6475	General Dentistry
Emma	Christopher	DMD	Encore Dental	185 Drum Point Road		Brick	NJ	08723	(732) 202-7008	General Dentistry
Eslami	Ali	DDS	Turnersville Family Dentistry	123 Egg Harbor Road	Suite 200	Sewell	NJ	08080	(856) 227-1142	General Dentistry
Eslami	Ali	DDS	Turnersville Family Dentistry	415 Chris Gaupp Dr.	Unit A	Galloway	NJ	08205	(609) 748-0702	General Dentistry
Espinoza	Juan I.	DMD		324 West Roosevelt Boulevard		Philadelphia	PA	19120	(215) 455-5385	General Dentistry
Falcone	Dominick	DMD		1546 Blackwood-Clementon Rd.		Blackwood	NJ	08012	(856) 232-7772	General Dentistry
Feldman	Stanley M.	DDS		8001 Roosevelt Boulevard	Suite 503	Philadelphia	PA	19152	(215) 338-1707	General Dentistry
Feldman	Theodore	DDS		626 Snyder Avenue		Philadelphia	PA	19148	(215) 334-4900	General Dentistry
Feshuk	John	DDS		5956 North 5th Street		Philadelphia	PA	19120	(215) 924-6443	General Dentistry
Feshuk	John	DDS		3920 Atlantic Avenue		Atlantic City	NJ	08401	(609) 345-5510	General Dentistry
Feshuk	John	DDS	Pleasantville Dental Group	216 South Main Street		Pleasantville	NJ	08232	(609) 641-5900	General Dentistry
Fishman	Barry	DDS		817 North Easton Road		Doylestown	PA	18901	(215) 348-4041	General Dentistry



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Fleisher	Neil R.	DDS		8031 Castor Avenue		Philadelphia	PA	19152	(215) 745-9706	General Dentistry
Fleisher	Neil R.	DDS		2417 South 9th Street		Philadelphia	PA	19148	(215) 462-7228	General Dentistry
Friedenberg	Charles	DDS		4609 Frankford Avenue		Philadelphia	PA	19124	(215) 744-7161	General Dentistry
Friedland	Gary J.	DDS	Fries Mill Dental Associates, PA	188 Fries Mill Road	Suite L-3	Turnersville	NJ	08012	(856) 629-0088	General Dentistry
Friedman	Eric	DMD	Absolute Smile	1045 Street Road		Southampton	PA	18966	(215) 355-4007	General Dentistry
Friedman	Eric	DMD	Advanta Dental	237 Penn Avenue		Scranton	PA	18503	(570) 347-2920	General Dentistry
Fruehan	James R.	DMD		326 North Main Street		Moscow	PA	18444	(570) 842-9664	General Dentistry
Fruehan	James R.	DMD		Route 590	Shopping Plaza	Hamlin	PA	18427	(570) 689-7784	General Dentistry
Fuentes	Laura	DDS	DaVinci Dental Arts, PA	102 James Street	Suite 304	Edison	NJ	08820	(732) 744-1188	General Dentistry
Ganesh	Praveena	DMD	Abington Dental Excellence, Inc.	1130 Old York Road		Abington	PA	19001	(215) 881-8551	General Dentistry
Ganesh	Praveena	DMD	Blue Bell Dental Assoc., PC	1115 DeKalb Pike		Center Square	PA	19422	(610) 278-0420	General Dentistry
Gelbert	Robert S.	DDS		59 North Lakeview Drive	Suite 2	Gibbsboro	NJ	08026	(856) 783-0220	General Dentistry
Gelman	Irving	DDS	Gelman Dental Associates	639 Market Street		Camden	NJ	08102	(856) 964-0979	General Dentistry
Gelman	Robert	DDS	Gelman Dental Associates	639 Market Street		Camden	NJ	08102	(856) 964-0979	General Dentistry
Ghani	Mohammad A.	DMD	Advance Dental Care Consultants, P	1225 Vine Street	Suite 401	Philadelphia	PA	19107	(215) 564-1679	General Dentistry
Ginn	Michael	DDS		3691 Morrell Avenue		Philadelphia	PA	19114	(215) 637-3354	General Dentistry
Ginn	Michael	DDS		40 Blancoyd Avenue		Merion Station	PA	19066	(610) 664-0933	General Dentistry
Giordano	Robert	DMD		2530 South Broad Street		Philadelphia	PA	19145	(215) 336-8400	General Dentistry
Gohel	Jiten P.	DMD, PC		913 East Boot Road		West Chester	PA	19380	(610) 701-0102	General Dentistry
Goldin	Sofia	DMD		227 Bustleton Pike		Treose	PA	19053	(215) 942-0909	General Dentistry
Goldstein	Ronald	DMD		600 Park Boulevard	Building 6, Ste. 3	West Cape May	NJ	08204	(609) 884-6080	General Dentistry
Goldstein	Ronald	DMD	American Family Dental Care, P.C.	301 City Avenue	Suite G-5	Bala Cynwyd	PA	19004	(610) 660-9510	General Dentistry
Gorin	Jack	DDS		7147 Castor Avenue		Philadelphia	PA	19149	(215) 342-1216	General Dentistry
Groder	Barry D.	DDS		9819 Haldeman Avenue		Philadelphia	PA	19115	(215) 677-6951	General Dentistry
Gross	Andrew	DMD		63 Chestnut Road		Paoli	PA	19301	(610) 647-4363	General Dentistry
Gugger	Robert	DDS	Dentex Dental Group, Ltd.	6227 Rising Sun Avenue		Philadelphia	PA	19119	(215) 742-4999	General Dentistry

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Gut	Victor	DDS	Heritage Dental, LLC Essex Dental Community First Care	931 North Main Street		Pleasantville	NJ	08232	(609) 646-3890	General Dentistry
Habboush	Sarman	DMD	Co.	106 North Essex Avenue		Narberth	PA	19072	(610) 668-7750	General Dentistry
Haider	Fatema	DMD	Witman Dental Center	2326 South 3rd Street		Philadelphia	PA	19148	(215) 551-9151	General Dentistry
Rapoza	Judee	DMD	Rapoza Family Dentistry, PC	1319 Lincoln Avenue		Prospect Park Plymouth	PA	19076	(610) 532-5008	General Dentistry
Rapoza	Judee	DMD	Rapoza Family Dentistry, PC	880 Township Line Road		Meeting	PA	19462	(610) 279-8001	General Dentistry
Hinrichsen	William B.	DMD	Gentle Dental of Collingdale	1420 MacDade Boulevard, #A		Collingdale	PA	19023	(610) 534-0300	General Dentistry
Ho	Ly T.	DDS	Absolute Smile	2701 W. 10th Street	Suite B	Chester	PA	19013	(610) 364-0404	General Dentistry
Hoang	Mark	DDS	Avenue of the Arts Nice Care Dental Associates of	624 S. Broad St.		Philadelphia	PA	19146	(215) 545-0660	General Dentistry
Horn	Juana	DDS	South Phila.	1320 Ritner Street		Philadelphia	PA	19148	(215) 389-3876	General Dentistry
Horowitz	Dvaid	DMD	Advanta Dental	237 Penn Avenue		Scranton	PA	18503	(570) 347-2920	General Dentistry
Horwitz	Harris	DDS, PC		1628 Wadsworth Avenue		Philadelphia	PA	19150	(215) 248-5700	General Dentistry
Huynh	Thomas	DMD	Stoneybrook Dental Associates	35 Stonybrook Drive		Levittown	PA	19055	(215) 946-7170	General Dentistry
Ireland, III	Charles S.	DMD		2400 Pershing Avenue		Roslyn	PA	19001	(215) 706-0607	General Dentistry
Isayev	Irina	DDS		13060 Bustleton Avenue		Philadelphia	PA	19116	(215) 671-1783	General Dentistry
Jacob	Joly	DMD		6921 Frankford Avenue	Suite F	Philadelphia	PA	19135	(215) 335-1060	General Dentistry
Jacob	Joly	DMD		443 West Girard Avenue		Philadelphia	PA	19123	(215) 763-7985	General Dentistry
Jagirdar	Brian	DMD		1175 Karin Street		Vineland	NJ	08360	(856) 205-9500	General Dentistry
Jain	Arvind	DMD	Delaware Maryland Dental of Salisbury	123 West College Avenue		Salisbury	MD	21804	(410) 546-5900	General Dentistry
Jones	Richard S.	DMD	Pinelands Family Dental Care, PA	332 Stokes Road		Medford	NJ	08055	(609) 953-9999	General Dentistry
Julka	Maneesh	DDS	Perfect Smiles Dentistry	101 South White Horse Pike		Lindenwold	NJ	08021	(856) 566-7466	General Dentistry
Kabouridou	Olga Maria	DMD		1901 South Broad Street		Philadelphia	PA	19148	(215) 551-7300	General Dentistry
Kachur	Elena	DMD	Plymouth Green Dental Associates, PC	1000 Germantown Pike Suite F- 4		Plymouth Meeting	PA	19462	(610) 278-6500	General Dentistry
Kaczaj	Marta A.	DMD	West Avenue Family Dentistry	609 West Avenue		Jenkintown	PA	19046	(215) 885-7337	General Dentistry
Kahn	Aurangzaib	DDS	AZ Dental	5517 Westfield Avenue		Pennsauken	NJ	08110	(856) 661-9191	General Dentistry
Kahn	Aurangzaib	DDS	AZ Dental	10 North Blackhorse Pike		Blackwood	NJ	08012	(856) 661-9191	General Dentistry
Kalanuria	Vinita	DDS	Advanced Dental Smiles, P.C.	533 North York Road		Hatboro	PA	19404	(215) 672-9444	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Karagodsky	Dmitry	DDS		11880 Bustleton Avenue		Philadelphia	PA	19116	(215) 969-2015	General Dentistry
Kavitha	Chadhalavada	DDS	Eastern Dental Associates	1936 Cottman Avenue		Philadelphia	PA	19111	(215) 728-0777	General Dentistry
Kavitha	Chadhalavada		Eastern Dental Associates of Overbrook	2121 North 63rd St.		Philadelphia	PA	19151	(215) 878-0058	General Dentistry
Kazmierczak	Francis J.	DMD	Stonybrook Dental Associates	35 Stonybrook Drive		Levittown	PA	19055	(215) 946-7170	General Dentistry
Kim	Alden	DMD, PC		27 North Broadway		Gloucester City	NJ	08030	(856) 456-0164	General Dentistry
Kim	Soon Ju	DMD	Parkway Family Dentistry, PC	1732 DeKalb Pike		Blue Bell	PA	19422	(610) 278-1110	General Dentistry
Klinges	Joseph	DMD	Kurt Lansing & Associates, Inc.	35 Stonybrook Dr		Levittown	PA	19055	(215) 946-7170	General Dentistry
Klinges	Joseph	DMD	Peach Dental Centers	3200 Frankford Avenue		Philadelphia	PA	19134	(215) 739-5600	General Dentistry
Klinges	Joseph	DMD	Peach Dental Centers	640 Snyder Avenue		Philadelphia	PA	19148	(215) 334-4845	General Dentistry
Klinges	Joseph	DMD	Peach Dental Centers	4000 North Ninth Street		Philadelphia	PA	19140	(215) 223-7550	General Dentistry
Klinges	Joseph	DMD	Penns Landing Dental	765 Front Street		Philadelphia	PA	19147	(215) 389-1685	General Dentistry
Ko	Yuiman	DDS		207 West Germantown Pike		East Norriton	PA	19401	(610) 278-1701	General Dentistry
Ko	Yui-Man	DDS		11601 Bustleton Avenue		Philadelphia	PA	19116	(215) 677-0910	General Dentistry
Ko	Yui-Man	DDS		933 Arch Street	Second Floor	Philadelphia	PA	19107	(215) 629-2288	General Dentistry
Koumaras	Michael		Lennie M. Checchio, DDS, Ltd.	9525 Frankford Avenue		Philadelphia	PA	19114	(215) 333-9697	General Dentistry
Kovac	Deron T.	DMD		208 West State Street		Kennett Square	PA	19348	(610) 444-3433	General Dentistry
Lansing	Kurt	DDS	Kurt Lansing & Associates, Inc.	35 Stonybrook Dr		Levittown	PA	19055	(215) 946-7170	General Dentistry
Lavalla	James	DDS	Family Dental Care	626 Snyder Avenue	Suite 200	Philadelphia	PA	19148	(215) 391-4100	General Dentistry
Lazarus	Henry	DMD		4603 Springfield Avenue		Philadelphia	PA	19143	(215) 382-5126	General Dentistry
Leben	Murry J. Edward	DMD		147 South Washington Avenue		Bergenfield	NJ	07621	(201) 385-5454	General Dentistry
Lee	Jungmin	DMD	Torresdale Dental Associates	7108 Torresdale Avenue		Philadelphia	PA	19135	(215) 338-4345	General Dentistry
Lehehaupt	Solomon	DDS		229 Plaza Building		Morrisville	PA	19067	(215) 295-1348	General Dentistry
Levin	Robert	DDS		4003 West Lincoln Drive	E Greenlee Exec. Campus	Marlton	NJ	08053	(856) 983-2983	General Dentistry
Levine	Eric	DMD		712 Haddonfield Road		Cherry Hill	NJ	08002	(856) 662-1155	General Dentistry
Levine	Eric	DMD	Berlin Plaza Dental Associates	116 Walker Avenue		West Berlin	NJ	08091	(856) 768-5151	General Dentistry
Levine	Steven S.	DMD		102 West White Horse Rd., Ste. 101	Voorhees Professional	Voorhees	NJ	08043	(856) 784-5061	General Dentistry

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Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Levito, Jr.	Vincent J.	DMD		1731 Markley Street		Norristown	PA	19401	(610) 277-0755	General Dentistry
Lieberman	Andrew	DMD		1015 Chestnut Street	Suite 417	Philadelphia	PA	19107	(215) 574-0462	General Dentistry
Lin	Vincent	DDS		3533 Brookview Road		Philadelphia	PA	19154	(215) 637-9066	General Dentistry
Lin	Vincent	DDS		2142 South Broad Street		Philadelphia	PA	19145	(215) 468-5334	General Dentistry
Lipskaya	Olga	DDS	Yes Dental, PC	2327 Cottman Avenue		Philadelphia	PA	19149	(215) 332-8700	General Dentistry
Liss	Ira	DMD	Longshore Family Dentistry	2001 Longshore Street		Philadelphia	PA	19149	(215) 331-6399	General Dentistry
Litvinov	Alexander S.	DDS		712 Haddonfield Road		Cherry Hill	NJ	08002	(856) 662-1155	General Dentistry
Liu	Ji-Guang	DDS	Gentlel Dental of Center City	201 South 13th Street		Philadelphia	PA	19107	(215) 732-5000	General Dentistry
Liu	John	DDS		9003 Bergenline Avenue		North Bergen	NJ	07047	(201) 869-8400	General Dentistry
Liu	Shaochen	DMD	Prime Dental, LLC	101 Old York Road	Suite 401	Jenkintown	PA	19046	(215) 884-2707	General Dentistry
Lopez	William	DMD	Harrisburg Dental Health Associates	2111 North Second Street		Harrisburg	PA	17110	(717) 232-5212	General Dentistry
Loroh	Lance	DDS, PC		1904 Old York Road		Abington	PA	19001	(215) 659-6313	General Dentistry
Louick	Jonathan M.	DMD	Colmar Dental Associates, LLC	2200 North Broad Street		Colmar	PA	18915-9	(215) 362-2333	General Dentistry
Louick	Jonathan M.	DMD	Lionville Dental Associates, LLC	67 Dowlin Forge Road	Suite C	Exton	PA	1548	(610) 594-2001	General Dentistry
Loverde	Patrick J.	DMD		274 Broad Street		Bloomfield	NJ	07003	(973) 748-1118	General Dentistry
Lysenko	Tatyana	DDS	Smile America Family Dentistry	3201 Route 38	Suite 102	Mount Laurel	NJ	08054	(856) 722-0333	General Dentistry
Maher	Mena	DDS		1221 South 11th Street		Philadelphia	PA	19147	(215) 334-1200	General Dentistry
Kruszynski	Danuta K.	DDS	Harold H. Marcus Associates	7215 Passyunk Avenue	Eastwick Professional	Philadelphia	PA	19142	(215) 727-1800	General Dentistry
Malik	Arif S.	DDS		6412 Woodland Avenue		Philadelphia	PA	19142	(215) 726-1480	General Dentistry
Malik	Mubarik	DDS		2919 North 22nd Street		Philadelphia	PA	19132	(215) 227-0107	General Dentistry
Mallya	Rachel J.	DMD		27 Garrett Road		Upper Darby	PA	19082	(610) 352-7766	General Dentistry
Mamoun	John	DMD	Sunbeam Dental, LLC	100 Craig Road	Suite 106	Manalapan	NJ	07726	(732) 431-2888	General Dentistry
Mann	Farrell	DDS		2216 MacDade Boulevard		Holmes	PA	19043	(610) 532-7752	General Dentistry
Mann	Harris I.	DMD		11621 Bustleton Avenue		Philadelphia	PA	19116	(215) 673-8887	General Dentistry
Marcantonis	George	DMD	Frank T. Trifiletti, DDS, PA	521 Sicklerville Road		Sicklerville	NJ	08081	(856)728-1717	General Dentistry
Marcus	Harold	DDS	Harold H. Marcus Associates	7215 Passyunk Avenue	Eastwick Professional	Philadelphia	PA	1525	(215) 727-1800	General Dentistry

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Marcus	Joni R.	DMD	Harold H. Marcus Associates	7215 Passyunk Avenue	Eastwick Professional	Philadelphia	PA	1525	(215) 727-1800	General Dentistry
Marcus	Raef	DMD		330 Middletown Boulevard	Suite 400	Langhorne	PA	19047	(215) 752-5444	General Dentistry
Maret	Jameela	DDS	Cross Keys Dental, LLC	175 Cross Keys Road	Suite 103	Berlin	NJ	08009	(856) 753-3368	General Dentistry
Markiewicz	Stanley	DMD		5956 North 5th Street		Philadelphia	PA	19120	(215) 924-6443	General Dentistry
Markiewicz	Stanley	DMD	Pleasantville Dental Group	216 South Main Street		Pleasantville	NJ	08232	(609) 641-5900	General Dentistry
Maron	Andrew	DDS	Perfect Smile Dental Services	326 Broad Street		Red Bank	NJ	07701	(732) 224-9339	General Dentistry
Martin	Jeffrey U.	DMD		6 North Lexington Avenue		Havertown	PA	19083	(610) 446-3883	General Dentistry
Martin	Jeffrey U.	DMD		358 Ray Mar Road		Oxford	PA	19363	(717) 529-6533	General Dentistry
Martin	Kenneth	DMD		358 Ray Mar Road		Oxford	PA	19363	(717) 529-6533	General Dentistry
Martin	Kenneth	DMD		6 North Lexington Avenue		Havertown	PA	19083	(610) 446-3883	General Dentistry
Mashru	Poonam	DMD	Family Dental Care of South Jersey	707 Haddonfield Berlin Road	Unit B	Voorhees	NJ	08043	(856) 309-2244	General Dentistry
Mathis	Veronica	DMD, PA		9001 Lincoln Drive West	Suite J Bridal House, C-200	Marlton	NJ	08053	(856) 810-8300	General Dentistry
Matz	Michael	DMD	Elkins Park Dental Group	8302 Old York Road		Elkins Park	PA	19027	(215) 576-1770	General Dentistry
McBride	Dennis	DDS		1024 West Marshall Street		Norristown	PA	19401	(610) 275-8830	General Dentistry
McFadden	Judith	DMD	Dental Health Center	3386 Memphis Street		Philadelphia	PA	19134	(215) 739-3100	General Dentistry
McMaugh	William T.	DDS		1128 Old York Road		Abington	PA	19001	(215) 572-0444	General Dentistry
Mehta	Taral T.	DMD	Celebrity Smiles	1811 Bethlehem Pike	Suite A102	Flourtown	PA	19031	(215) 233-5811	General Dentistry
Mensah	Prince Ofori	DMD, PC		1619 Grant Avenue, Suite 23		Philadelphia	PA	19115	(215) 673-4940	General Dentistry
Mensah	Beth M.	DDS	Bresler-Richmond Dental Center	6801 Ridge Avenue	P.O. Box 6300-50395	Philadelphia	PA	19128	(215) 483-6633	General Dentistry
Merdad	Memar	DDS	Oxford Crossing Family & Cosmetic Dentistry	333 N Oxford Valley Rd	Suite 505	Fairless Hills	PA	19030	(215) 269-1430	General Dentistry
Mereminsky	Edward	DMD	Stonybrook Dental Associates	35 Stonybrook Drive		Levittown	PA	19055	(215) 946-7170	General Dentistry
Metz	August	DMD	Apex Smiles, LLC	771 2nd Street Pike		Southampton	PA	18966	(215) 357-2739	General Dentistry
Metz	August	DMD	Castor Dental Care, LLC	7258 Castor Avenue		Philadelphia	PA	19149	(215) 728-1144	General Dentistry
Miller	Seth			403 Benson Street		Philadelphia	PA	19111	(215) 728-6262	General Dentistry
Morazan	Christian	DDS	DaVinci Dental Arts, PA	102 James Street	Suite 304	Edison	NJ	08820	(732) 744-1188	General Dentistry
Moses	Larry	DDS	Carp Dental Associates	1325 West Airy Street		Norristown	PA	19401	(610) 275-1565	General Dentistry

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Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Moses, II	Richard James	DMD		1421 East Chocolate Avenue		Hershey	PA	17033-1165	(717) 534-2222	General Dentistry
Mosmen	Kevin J.	DMD	Blue Bell Dental Assoc., PC	1115 DeKalb Pike		Center Square	PA	19422	(610) 278-0420	General Dentistry
Mostatab	Rebecca	DMD	Smile by Design	335 West Lancaster Avenue		Wayne	PA	19087	(610) 964-0111	General Dentistry
Mostatab	Rebecca	DMD	Smile by Design	1330 West Chester Pike		Havertown	PA	19083	(610) 789-4040	General Dentistry
Motamedi	Tamaz	DMD		200 West Third Street	Suite C	Moorestown	NJ	08057	(856) 234-5040	General Dentistry
Motamedi	Taraz	DMD	Garden State Dental Arts	515 Burlington Avenue		Delanco	NJ	08075	(856) 764-9100	General Dentistry
Motwani	Amit	DMD	Warrington Dental, PC	1380 Easton Road		Warrington	PA	18976	(215) 491-4711	General Dentistry
Mulligan	Brendan F.	DMD		208 West State Street		Kennett Square	PA	19348	(610) 444-3433	General Dentistry
Mullins	Newton C.	DDS		4 West Brookhaven Road		Brookhaven	PA	19015	(610) 872-7200	General Dentistry
Mulnick	Harris	DDS		7520 Castor Avenue		Philadelphia	PA	19152	(215) 745-5757	General Dentistry
Nadimpalli	Sujatha	DMD	New Britain Dental Center	108A West Butler Avenue		Doylestown	PA	18901	(267) 247-5449	General Dentistry
Naik	Atul D.	DDS		446 Wroxham Drive		Reading	PA	19610	(215) 384-4555	General Dentistry
Naik	Atul D.	DDS		6 North 3rd Avenue		Coatesville	PA	19320	(610) 384-4555	General Dentistry
Naik	Atul D.	DDS	Muhlenberg Dental Associates	513 Muhlenberg Street		Reading	PA	19605	(610) 929-7900	General Dentistry
Nash	Joel E.	DDS	Precious Pearls Dental, PC	706 South Street		Philadelphia	PA	19147	(215) 238-8800	General Dentistry
Navathe	Seema	DDS		5945 Lansdowne Avenue		Philadelphia	PA	19151	(215) 871-0960	General Dentistry
Newell	Gary	DDS		2217 Mt. Carmel Avenue		Glenside	PA	19038	(215) 572-7170	General Dentistry
Newsome	Chantel	DDS		109 East Main Street	Suite 104	Elkton	MD	21921	(410) 392-8799	General Dentistry
Ni	Hong	DMD	Nice Care Dental Associates of New Jersey	1400 Chews Landing Road		Laurel Springs	NJ	08021	(856) 227-2221	General Dentistry
Ni	Hong	DMD	Nice Care Dental Associates of South Phila.	1320 Ritner Street		Philadelphia	PA	19148	(215) 389-3876	General Dentistry
Ni	Hong	DMD	Nice Care Dental Associates of South Phila.	1311 South Street		Philadelphia	PA	19147	(215) 385-1717	General Dentistry
Noumeh	Talel		East Side Family Dentistry	1640 Union Boulevard		Allentown	PA	18109	(610) 776-7578	General Dentistry
Ochsenreith	Steven	DMD		4951 Frankford Avenue		Philadelphia	PA	19124	(215) 288-6660	General Dentistry
Okon	Joel	DDS		254 Gibbsboro Road		Lindenwold	NJ	08021	(856) 783-3777	General Dentistry
Pagano	F. Frank	DDS		522 Westside Avenue		Jersey City	NJ	07304	(201) 433-8785	General Dentistry
Pagano	F. Frank	DDS		1225 Morris Avenue		Union	NJ	07083	(908) 687-1663	General Dentistry

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Pandya	Kaushik	DDS	Gentle Dental Oregon	1419 West Oregon Avenue		Philadelphia	PA	19145	(215) 468-0220	General Dentistry
Park	Inkook	DMD	Parkway Family Dentistry, PC	1732 DeKalb Pike		Blue Bell	PA	19422	(610) 278-1110	General Dentistry
Park	Sang		Havertown Dental Assocs, PC	1220 West Chester Pike		Havertown	PA	19083	(610) 789-0158	General Dentistry
Pasalic	Aida	DMD	Blue Bell Dental Assoc., PC	1115 DeKalb Pike		Center Square	PA	19422	(610) 278-0420	General Dentistry
Patel	Amish	DMD	Ameri Dental Group, PC	43 South Lansdowne Avenue		Lansdowne	PA	19050	(610) 623-7610	General Dentistry
Patel	Amish	DMD	Ameri Dental Group, PC	875 Main Street		Darby	PA	19023	(484) 494-3300	General Dentistry
Patel	Bela P.	DMD		5460 Torresdale Avenue		Philadelphia	PA	19124	(215) 288-8424	General Dentistry
Patel	Bhargav	DMD	Hershey Dental Care, PC	555 East Chocologe Avenue	Suite 101	Hershey	PA	17033	(717) 312-7030	General Dentistry
Patel	Jayendra	DMD	Welsh Dental Care	8950 Haven Place		Philadelphia Washington	PA	19152	(215) 698-2098	General Dentistry
Patel	Kamlesh	DMD	Colonial Dental Associates	1091 General Knox Road		Crossing	PA	18977	(215) 493-9525	General Dentistry
Patel	Kamlesh	DMD	University City Dental	5338 Baltimore Avenue		Philadelphia	PA	19143	(215) 476-2122	General Dentistry
Patel	Katan B.	DMD	Aramingo Family Practice	3330 Aramingo Ave	Imperial Plaza	Philadelphia	PA	19134	(215) 423-9060	General Dentistry
Patel	Mukund K.	DDS		2776 Knights Road		Bensalem	PA	19020	(215) 639-5822	General Dentistry
Patel	Nalin	DMD	Oxford Valley Dental Excellence	240 Middletown Boulevard		Langhorne	PA	19047	(215) 750-2222	General Dentistry
Patel	Partha	DDS, PC	Family Dentistry of Warrington	1214 Easton Road	Suite 201	Warrington	PA	18976	(215) 918-2900	General Dentistry
Patel	Rasik G.		Patelka Dental, LLC	8037 Frankford Avenue	Second Floor	Philadelphia	PA	19136	(215) 338-5454	General Dentistry
Patel	Rasik G.		Patelka Dental, LLC	8332 Bustleton Avenue	Unit C	Philadelphia	PA	19152	(215) 342-9000	General Dentistry
Patoliya	Keyur		Advanced Dental Designs, PC	6529 Germantown Avenue		Philadelphia	PA	19119	(215) 848-8214	General Dentistry
Paul	Michael S.	DMD	Irvin Paul, DDS, PC	41 South State Road		Upper Darby	PA	19082	(610) 789-2410	General Dentistry
Pearson	Earl P.	DMD, PC		8227 Stenton Avenue		Philadelphia	PA	19150	(215) 242-1757	General Dentistry
Pelle	Frank	DMD		900 Magee Avenue		Philadelphia	PA	19111	(215) 745-8041	General Dentistry
Pereira	Raul			324 West Roosevelt Boulevard 4400 MacArthur Blvd., N.W.,		Philadelphia	PA	19120	(215) 888-3791	General Dentistry
Peretz	A. J.	DDS	Georgetown Smile, P.C.	Ste. 200		Washington	DC	20007	(202) 333-0003	General Dentistry
Pfleger	Anthony	DMD		2050 Columbia Avenue		Lancaster	PA	17603	(717) 394-7218	General Dentistry
Popky	Howard D.	DDS	Markley Medical Center	1651 Markley Street	Suite 103	Norristown	PA	19401	(610) 279-6777	General Dentistry
Pratt	Andrew	DMD	Chadds Ford Dental Associates	6 Dickinson Drive	Suite 102	Chadds Ford	PA	19317	(610) 558-5699	General Dentistry

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Pudlo	Richard	DDS	M. H. Kaye Pavilion, Inc.	2050 Columbia Avenue		Lancaster	PA	17603	(717) 394-7218	General Dentistry
Quagliariello	Denis A.	DMD		1502 West Chester Pike	Suite 20	West Chester	PA	19382	(610) 692-3312	General Dentistry
Ramer	Elliott	DMD	Family Dentistry	1991 Sproul Road, Suite 650		Broomall	PA	19008	(610) 329-1670	General Dentistry
Rapoza	Anthony J.	DMD	Rapoza Family Dentistry, PC	880 Township Line Road		Plymouth Meeting	PA	19462	(610) 279-8001	General Dentistry
Rapoza	Anthony J.	DMD	Rapoza Family Dentistry, PC	1319 Lincoln Avenue		Prospect Park	PA	19076	(610) 532-5008	General Dentistry
Raven	Louis E.	DDS		63 North Hanover Street		Pottstown	PA	19464	(610) 326-4470	General Dentistry
Reddy	Konreddy J.	DDS		11 West Lafayette Street		Norristown	PA	19401	(610) 277-7660	General Dentistry
Reine-Mutch	Shanni L.	DDS	Hometown Family Dentistry, PA	402 White Horse Pike South	506 A-1	Magnolia	NJ	08049	(856) 566-9700	General Dentistry
Resue, Jr.	Dale C.	DMD		1999 Sproul Road		Broomall	PA	19008	(610) 325-4444	General Dentistry
Rigau	Charles	DMD		2851 Knights Road		Bensalem	PA	19020	(215) 638-7725	General Dentistry
Rigberg	Andrew	DMD		6808 Frankford Avenue		Philadelphia	PA	19135	(215) 624-7418	General Dentistry
Rosen	Jeffrey	DMD	Kurt Lansing & Associates, Inc.	35 Stonybrook Drive		Levittown	PA	19055	(215) 946-7170	General Dentistry
Rosen	Scott	DMD	Peach Dental Centers	640 Snyder Avenue		Philadelphia	PA	19148	(215) 334-4845	General Dentistry
Rosen	Scott	DMD	Peach Dental Centers	4000 North Ninth Street		Philadelphia	PA	19140	(215) 223-7550	General Dentistry
Rosen	Scott	DMD	Peach Dental Centers	3200 Frankford Avenue		Philadelphia	PA	19134	(215) 739-5600	General Dentistry
Rosen	Scott	DMD	Penns Landing Dental	765 Front Street		Philadelphia	PA	19147	(215) 389-1685	General Dentistry
Ruch, Jr.	Donald Robert	DMD		1231 Drexel Avenue		Drexel Hill	PA	19026	(610) 449-5055	General Dentistry
Rundbaken	Roger P.	DMD		2183 MacDade Boulevard		Holmes	PA	19043	(610) 461-6371	General Dentistry
Rust	Toni	DDS		5542 Ridge Avenue		Philadelphia	PA	19128	(215) 482-4250	General Dentistry
Saffar	Ronald J.	DDS		1940 E. Rt. 70		Cherry Hill	NJ	08003	(856) 428-1441	General Dentistry
Saffar	Ronald J.	DDS		1800 Clements Bridge Road		Deptford	NJ	08096	(856) 845-7846	General Dentistry
Saffar	Ronald J.	DDS		770 River Road		West Trenton	NJ	08628	(609) 883-3636	General Dentistry
Saffar	Ronald J.	DDS		431 59th Street		Wst New York	NJ	07093	(201) 223-2700	General Dentistry
Sandhu	Satinder	DDS	649 Dental Associates	649 East Allegheny Avenue		Philadelphia	PA	19134	(215) 634-0649	General Dentistry
Sandhu	Satinder	DDS	Peach Dental Centers	640 Snyder Avenue		Philadelphia	PA	19148	(215) 334-4845	General Dentistry
Sandhu	Satinder	DDS	Peach Dental Centers	3200 Frankford Avenue		Philadelphia	PA	19134	(215) 739-5600	General Dentistry



Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Sandhu	Satinder	DDS	Peach Dental Centers	4000 North Ninth Street		Philadelphia	PA	19140	(215) 223-7550	General Dentistry
Sandhu	Satinder	DDS	Penns Landing Dental Centers	765 South Front Street		Philadelphia	PA	19147	(215) 389-1685	General Dentistry
Sandler	Marc	DDS		7675 Bustleton Avenue		Philadelphia	PA	19152	(215) 338-3336	General Dentistry
Savani	Bhaskar M.	DMD	A+ Family Dental Care, PC	22-24 South 14th Street		Quakertown	PA	18951	(215) 536-3210	General Dentistry
Savani	Bhaskar M.	DMD	A+ Family Dental Care, PC	1950 Street Road	Suite 200	Bensalem	PA	19020	(215) 638-4696	General Dentistry
Savani	Bhaskar M.	DMD	A+ Family Dental Care, PC	8539 Bustleton Avenue		Philadelphia	PA	19152	(215) 342-5740	General Dentistry
Savani	Bhasker	DMD	Advanced Family Dentistry	35 B Woodland Avenue		Morton	PA	19070	(610) 544-3630	General Dentistry
Savani	Bhasker	DMD	Advanced Family Dentistry	8 Ponds Edge Drive	Suite 2	Chadds Ford	PA	19317	(610) 388-4466	General Dentistry
Savani	Bhasker	DMD	American Family Dental Care, P.C.	11911 Bustleton Avenue		Philadelphia	PA	19116	(215) 673-9050	General Dentistry
Savani	Bhasker	DMD	American Family Dental Care, P.C.	301 Line Avenue	Suite G-5	Bala Cynwyd	PA	19004	(610) 660-9510	General Dentistry
Savani	Niranjan	DMD	Advanced Family Dentistry	35 B Woodland Avenue		Morton	PA	19070	(610) 544-3630	General Dentistry
Savani	Niranjan M.	DMD	A+ Family Dental Care, PC	22-24 South 14th Street		Quakertown	PA	18951	(215) 536-3210	General Dentistry
Savani	Niranjan M.	DMD	A+ Family Dental Care, PC	1950 Street Road	Suite 200	Bensalem	PA	19020	(215) 638-4696	General Dentistry
Savani	Niranjan M.	DMD	A+ Family Dental Care, PC	8539 Bustleton Avenue		Philadelphia	PA	19152	(215) 342-5740	General Dentistry
Savani	Niranjan M.	DMD	American Family Dental Care, P.C.	301 City Avenue	Suite G-5	Bala Cynwyd	PA	19004	(610) 660-9510	General Dentistry
Savani	Niranjan M.	DMD	American Family Dental Care, P.C.	11911 Bustleton Avenue		Philadelphia	PA	19116	(215) 673-9050	General Dentistry
Schupper	Jeffrey		Family Dental Care of South Jersey	707 Haddonfield Berlin Road	Unit B	Voorhees	NJ	08043	(856) 309-2244	General Dentistry
Schwartz	David		Cottman Dental Group, PC	2901 Secane Drive		Philadelphia	PA	19154	(215) 632-1244	General Dentistry
Segel	George D.	DMD, LLC		391 Eagle Road		Newtown	PA	18940	(215) 579-1600	General Dentistry
Seidman	Larry J.	DDS		12400 Academy Road		Philadelphia	PA	19154	(215) 637-6111	General Dentistry
Seth	Runjan		AC Dental of Hamilton, NJ, PC	3100 Quakerbridge Road		Hamilton	NJ	08619	(609) 689-2660	General Dentistry
Shafagh	Iraj	DDS		109 North Eagle Road		Havertown	PA	19083	(610) 446-6688	General Dentistry
Shafieyan	Mojgan	DDS	Oxford Crossing Family & Cosmetic Dentistry	333 N Oxford Valley Rd	Suite 505	Fairless Hills	PA	19030	(215) 269-1430	General Dentistry
Shah	Arati	DDS	Healthy Smiles of New Egypt	78 Maple Avenue	Suite D	New Egypt	NJ	08533	(609) 758-8200	General Dentistry
Shah	Mooni	DDS	Healthy Smiles of New Egypt	78 Maple Avenue	Suite D	New Egypt	NJ	08533	(609) 758-8200	General Dentistry
Shah	Rajni	DDS		10431 Academy Road	Suite A	Philadelphia	PA	19114	(215) 637-7474	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Shechtman	Matthew W.	DDS	Harold H. Marcus Associates	7215 Passyunk Avenue	Eastwick Professional	Philadelphia	PA	1525	(215) 727-1800	General Dentistry
Shepard	Keith		Signature Smiles	120 S. 6th Street		Vineland	NJ	08360	(856) 692-5533	General Dentistry
Shepard	Keith		Signature Smiles	27-29 South New York Avenue		Atlantic City	NJ	08401	(609) 345-6600	General Dentistry
Shepard	Keith		Signature Smiles	1103 West Sherman Avenue		Vineland	NJ	08360	(856) 692-9333	General Dentistry
Shepard	Keith		Signature Smiles	7 East Shell Bay Ave, #B		Cape May Ct. House	NJ	08210	(609) 463-1700	General Dentistry
Sherly	Douglas B.	DMD	Braden Dental of South Jersey, PC	530 Crown Point Road	Suite 5	West Deptford	NJ	08086	(856) 845-4225	General Dentistry
Shiao	George	DMD	Kurt Lansing & Associates, Inc.	35 Stonybrook Dr		Levittown	PA	19055	(215) 946-7170	General Dentistry
Shipon	Steven	DDS	Family and Cosmetic Dentistry	2226 South Broad Street		Philadelphia	PA	19145	(215) 334-5967	General Dentistry
Shmurak	Gary	DMD	Apex Dental Care, LLC	1600 Horizon Drive, Ste. 119		Chalfont	PA	18914	(215) 996-9968	General Dentistry
Shneidman	Jon	DDS	649 Dental Associates	649 East Allegheny Avenue		Philadelphia	PA	19134	(215) 634-0649	General Dentistry
Shneidman	Jon	DDS	Peach Dental Centers	640 Snyder Avenue		Philadelphia	PA	19148	(215) 334-4845	General Dentistry
Shneidman	Jon	DDS	Peach Dental Centers	4000 North Ninth Street		Philadelphia	PA	19140	(215) 223-7550	General Dentistry
Shneidman	Jon	DDS	Peach Dental Centers	3200 Frankford Avenue		Philadelphia	PA	19134	(215) 739-5600	General Dentistry
Shneidman	Jon	DDS	Penns Landing Dental Centers	765 South Front Street		Philadelphia	PA	19147	(215) 389-1685	General Dentistry
Shore	Jeffrey	DDS	Shore Dental Center	519 Chester Avenue		Norwood	PA	19074	(610) 532-3700	General Dentistry
Shore	Joseph	DDS	Shore Dental Center	519 Chester Avenue		Norwood	PA	19074	(610) 532-3700	General Dentistry
Silber	Stanley	DMD	5th Street Dental Center, Inc.	4646 North Fifth Street		Philadelphia	PA	19140	(215) 324-1950	General Dentistry
Silverman	Donald	DMD	649 Dental Associates	649 East Allegheny Avenue		Philadelphia	PA	19134	(215) 634-0649	General Dentistry
Silverman	Donald	DMD	Peach Dental Centers	3200 Frankford Avenue		Philadelphia	PA	19134	(215) 739-5600	General Dentistry
Silverman	Donald	DMD	Peach Dental Centers	4000 North Ninth Street		Philadelphia	PA	19140	(215) 223-7550	General Dentistry
Silverman	Donald	DMD	Peach Dental Centers	640 Snyder Avenue		Philadelphia	PA	19148	(215) 334-4845	General Dentistry
Silverman	Donald	DMD	Penns Landing Dental	765 Front Street		Philadelphia	PA	19147	(215) 389-1685	General Dentistry
Singh	Monica K.	DMD, LLC		521 Sicklerville Road		Sicklerville	NJ	08081	(856) 728-1717	General Dentistry
Sioutis	Katerina	DMD	Rapoza Family Dentistry, PC	1319 Lincoln Avenue		Prospect Park	PA	19076	(610) 532-5008	General Dentistry
Sisk	Michael A.	DDS	Capitol Dental Care	4700 Union Deposit Road	Suite 210	Harrisburg	PA	17111	(717) 545-2003	General Dentistry
Sisson	June A.	DDS		324 West Roosevelt Boulevard		Philadelphia	PA	19120	(215) 455-5385	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Smith	Jeffrey	DMD		130 East Brookhaven Road		Brookhaven	PA	19015	(610) 876-3300	General Dentistry
Snyder	Mark	DDS	Shore-Snyder Dental Center	519 Chester Avenue		Norwood	PA	19074	(610) 532-3700	General Dentistry
Kim	Jessica	DDS	Harold H. Marcus Associates	7215 Passyunk Avenue	Eastwick Professional	Philadelphia	PA	19142	(215) 727-1800	General Dentistry
Soyka	Robert	DMD	Perfect Smile Dental Services	326 Broad Street		Red Bank	NJ	07701	(732) 224-9339	General Dentistry
Spieler	Eric	DMD	Oasis Dental	1 Belmont Avenue	Suite 516	Bala Cynwyd	PA	19004	(484) 278-4134	General Dentistry
Stein	Barry	DMD		27 South 11th Street		Philadelphia	PA	19107	(215) 922-6516	General Dentistry
Stein	Philip C.	DDS		2132 Cumberland Street		Philadelphia	PA	19125	(215) 739-5206	General Dentistry
Stepansky	Irina	DMD	IF Services, Inc.	11911 Bustleton Avenue		Philadelphia	PA	19116	(215) 673-9050	General Dentistry
Stolber	Robert Lincoln	DDS		6101 Torresdale Avenue		Philadelphia	PA	19135	(215) 333-8667	General Dentistry
Storace	Gaetano A.	DMD		2420 Bristol Road, Suite 6	Westhampton Valley	Bensalem	PA	19020	(215) 750-0769	General Dentistry
Strasseberg	Michael	DMD	Perfect Smile Dental Services	326 Broad Street		Red Bank	NJ	07701	(732) 224-9339	General Dentistry
Suchak	Vaishali		V Smile Dental, LLC	217 Clarksville Road	Suite 7	Junction	NJ	08550	(609) 269-5705	General Dentistry
Sulpovar	Alex		Precision Dentistry, Inc.	179 York Road	Suite 2	Warminster	PA	18974	(215) 394-5558	General Dentistry
Svenson	Jorgen	DDS	Havertown Dental Assocs, PC	1220 West Chester Pike		Havertown	PA	19083	(610) 789-0158	General Dentistry
Szierer	Mark	DMD	Sophisticanted Smiles, PC	85 Reaville Avenue		Flemington	NJ	08822	(908) 806-4333	General Dentistry
Taneja	Deeksha	DMD	Advanced Family Dentistry	35 B Woodland Avenue		Morton	PA	19070	(610) 544-3630	General Dentistry
Taylor	Michael A.	DMD	Perfect Smile Dental Services	326 Broad Street		Red Bank	NJ	07701	(732) 224-9339	General Dentistry
Tecosky	David A.	DMD		2438 Brown Street		Philadelphia	PA	19130	(215) 236-6200	General Dentistry
Tewari	Dinesh	DMD	Brookhaven Center for Family & Cosmetic Dentistry	4 West Brookhaven Road		Brookhaven	PA	19015	(610) 872-7200	General Dentistry
Tewari	Dinesh S.	DMD	Center for Family & Cosmetic Dentistry & Norwood	7 West Winona Avenue		Norwood	PA	19074	(610) 532-0221	General Dentistry
Tewari	Dinesh S.	DMD	Drexel Hill Family Dentistry	4244 Ferne Boulevard		Drexel Hill	PA	19026	(610) 259-3557	General Dentistry
Timian	Peter A.	DMD		636 Lincoln Avenue		Fairless Hills	PA	19030	(215) 295-8783	General Dentistry
Tran	An Xuan	DMD		540 Fresno Drive		Magnolia	NJ	08049	(856) 784-2858	General Dentistry
Trieu	Thi Ba	DMD	Trieu, Trieu & Trieu, P.C.	4527 North Fifth Street		Philadelphia	PA	19140	(215) 329-5962	General Dentistry
Trieu	Thi Ba	DMD	Trieu, Trieu & Trieu, P.C.	1235 Snyder Avenue		Philadelphia	PA	19148	(215) 334-7036	General Dentistry
Trieu	Thi Ba	DMD	Trieu, Trieu & Trieu, P.C.	437 West Chew Avenue		Philadelphia	PA	19120	(215) 549-4888	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Trieu	Thu Ba	DMD	Trieu, Trieu & Trieu, P.C.	437 West Chew Avenue		Philadelphia	PA	19120	(215) 549-4888	General Dentistry
Trieu	Thu Ba	DMD	Trieu, Trieu & Trieu, P.C.	4527 North Fifth Street		Philadelphia	PA	19140	(215) 329-5962	General Dentistry
Trieu	Thu Ba	DMD	Trieu, Trieu & Trieu, P.C.	1235 Snyder Avenue		Philadelphia	PA	19148	(215) 334-7036	General Dentistry
Trieu	Tuyet Ba	DMD	M.T. Chennat, DMD & Associates	8227 Stenton Avenue		Philadelphia	PA	19150	(215) 242-5950	General Dentistry
Trieu	Tuyet Ba	DMD	Trieu, Trieu & Trieu, P.C.	1235 Snyder Avenue		Philadelphia	PA	19148	(215) 334-7036	General Dentistry
Trieu	Tuyet Ba	DMD	Trieu, Trieu & Trieu, P.C.	4527 North Fifth Street		Philadelphia	PA	19140	(215) 329-5962	General Dentistry
Trieu	Tuyet Ba	DMD	Trieu, Trieu & Trieu, P.C.	437 West Chew Avenue		Philadelphia	PA	19120	(215) 549-4888	General Dentistry
Trifiletti	Frank T.	DDS		521 Sicklerville Road		Sicklerville	NJ	08081	(856) 728-1717	General Dentistry
Tummillo	Jerome	DMD		531 US Highway 22		Station	NJ	08889	(908) 534-4001	General Dentistry
Valdes	Veronica	DDS		542 East Girard Avenue		Philadelphia	PA	19125	(215) 423-6090	General Dentistry
VanHorn	James	DMD		402 White Horse Pike South		Magnolia	NJ	08049	(856) 566-9700	General Dentistry
vanvoorenburg	Daniel	DDS, PC		4004 Ashburner Street		Philadelphia	PA	19136	(215) 624-2508	General Dentistry
Varma	G. N.	DMD	Lansdale Dental, P.C.	233 South Broad Street		Lansdale	PA	19446	(215) 393-9008	General Dentistry
Verma	Rajan	DMD	Welsh Dental Care	8950 Haven Place		Philadelphia	PA	19152	(215) 698-2098	General Dentistry
Verrico	Enrico	DMD		2440 South Broad Street		Philadelphia	PA	19145	(215) 336-6282	General Dentistry
Vikas	Arora		PA Smile Center, PC	1212 Vetrans Highway	Suite A-1	Bristol	PA	19007	(215) 874-0407	General Dentistry
Vikas	Arora		Penn Dental Center	2628 North Broad Street		Philadelphia	PA	19132	(215) 227-6700	General Dentistry
Virgilio	John	DDS		5905 Browning Road		Pennsauken	NJ	08109	(856) 662-3379	General Dentistry
Volchonok	Alexandr	DDS	Acument Dental, PC	1133 Cottman Avenue		Philadelphia	PA	19111	(215) 742-7139	General Dentistry
Wadsworth	Wesley	DDS		7258 Castor Avenue		Philadelphia	PA	19149	(215) 728-1144	General Dentistry
Warsowsky	Dennis	DMD		1638 South 20th Street		Philadelphia	PA	19145	(215) 755-7887	General Dentistry
Wasko	Karen	DMD	Stanley J.Wasko, DDS & Associates	3428 Rahn Street		Philadelphia	PA	19136	(215) 331-1330	General Dentistry
Wasko	Stanley J.	DDS	Stanley J.Wasko, DDS & Associates	3428 Rahn Street		Philadelphia	PA	19136	(215) 331-1330	General Dentistry
Weiner	James	DMD	Marlton Dental Center	1 Blanchard Road		Marlton	NJ	08053	(856) 768-0129	General Dentistry
Wentz	William J.	DMD	Family Dental Care Center	43 South Lansdowne Avenue		Lansdowne	PA	19050	(610) 623-7610	General Dentistry
Westfall	Christopher	DMD	Hometown Family Dentistry, PA	402 White Horse Pike South		Magnolia	NJ	08049	(856) 566-9700	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Williams	Craig	DDS		114 Cross Keys Road 122 North Philadelphia	Center, Suite	Berlin	NJ	08009	(856) 768-3550	General Dentistry
Woland	Michael M.	DDS	Maryland Family Dental, LLC	Boulevard		Aberdeen	MD	21001	(410) 272-2636	General Dentistry
Woods	Robert	DMD		5521 Greene Street		Philadelphia	PA	19144	(215) 438-4240	General Dentistry
Xu	Lei	DMD	New Falls Family Dentistry	4512 New Falls Road		Levittown	PA	19056	(215) 943-8820	General Dentistry
Yao	Zheng	DMD	Comfort Family Dental Care, PC	845 West Chester Pike		West Chester	PA	19382	(610) 738-8866	General Dentistry
Ybanez	Danilo	DMD, LLC		15 Dogwood Drive		Cape May Court House	NJ	08210	(609) 465-3930	General Dentistry
Yeh	William	DDS		1008 Passyunk Avenue		Philadelphia	PA	19147	(215) 629-9317	General Dentistry
Yeh	William	DDS		101 Walt Whitman Boulevard		Cherry Hill	NJ	08003	(856) 216-9565	General Dentistry
Yilanjian	Michele		Blooming Smiles Dental	534 North Broad Street		Lansdale	PA	19446	(215) 412-3336	General Dentistry
Yurovsky	Renee	DDS		1831 Chestnut Street	Suite 100	Philadelphia	PA	19103	(215) 545-1202	General Dentistry
Zaccaria	Thomas M.	DDS	Colmar Dental Associates, LLC	2200 North Broad Street		Colmar	PA	18915-9	(215) 362-2333	General Dentistry
Zaccaria	Thomas M.	DDS	Lionville Dental Associates, LLC	67 Dowlin Forge Road	Suite C	Exton	PA	1548	(610) 594-2001	General Dentistry
Zaim	Mazhar H.	DDS		1915 Washington Lane		Philadelphia	PA	19138	(215) 276-4410	General Dentistry
Zhang	Ning	DMD	All Smile Dental Center	393 N Lewis Road		Royersford	PA	19468	(610) 792-0060	General Dentistry
Zheng	Jing		Coatesville Denter Center	6 North Third Avenue		Coatesville	PA	19320	(610) 384-4555	General Dentistry
Zin	Wolodymyr	DDS	Everest Dental, LLC	9892 Bustleton Avenue	Suite 302	Philadelphia	PA	19115	(215) 671-0188	General Dentistry
Zucker	Bruce A.	DDS		101 Dorset Avenue		Croydon	PA	19021	(215) 788-6656	General Dentistry
			5th Street Dental	2822 North 5th Street		Philadelphia	PA	19133	(215) 229-3040	General Dentistry
			A-1 Family Dental Care, PC	12401 Academy Road	Suite 201-202	Philadelphia	PA	19154	(215) 632-1244	General Dentistry
			A-1 Family Dental Care, PC	404 Middletown Boulevard	Suite 300	Langhorne	PA	19047	(215)-757-4400	General Dentistry
			AAA Signature Smile, PC	260 New York Drive		Fort Washington	PA	19034	(215) 646-7000	General Dentistry
			AB Dental	320 N. Oxford Valley Road		Fairless Hills	PA	19030	(215) 946-9400	General Dentistry
			AB Dental	649 E. Allegheny Avenue		Philadelphia	PA	19134	(215) 291-4200	General Dentistry
			AB Dental	1040 Pond Street		Bristol	PA	19007	(215) 744-1044	General Dentistry
			Abdelkader Family Dentistry, PC	358 East Wyoming Avenue		Philadelphia	PA	19120	(215) 324-1746	General Dentistry
			About Smiles, LLC	380 Middletown Boulevard	Suite 708	Langhorne	PA	19047	(215) 757-3040	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Absolute Smile, Inc.	6737 Harbison Avenue		Philadelphia	PA	19149	(215) 331-7585	General Dentistry
			AC Dental of Hadley, PC	4917 Stelton Road		South Plainfield	NJ	07080	(908) 753-9901	General Dentistry
			AC Dental of Hamilton, NJ, PC	3100 Quakerbridge Road		Hamilton	NJ	08619	(609) 689-2660	General Dentistry
			AC Dental of Langhorne	110 Lincoln Highway		Fairless Hills	PA	19030	(215) 269-6525	General Dentistry
			AC Dental of Linden, PC	615 West Edgar Road		Linden	NJ	07036	(908) 862-7171	General Dentistry
			AC Dental of NJ, PC	300 State Route 18	Unit 28	East Brunswick	NJ	08816	(732) 254-9000	General Dentistry
			AC Dental of Princeton, PC	3495 US Route 1		Princeton	NJ	08540	(609) 936-0040	General Dentistry
			AC Dental of Toms River, NJ, Inc.	941 Route 37 West		Toms River	NJ	08755	(732) 244-1163	General Dentistry
			Acument Dental, PC	1133 Cottman Avenue		Philadelphia	PA	19111	(215) 742-7139	General Dentistry
			Advanced Dental Esthetics, P.C.	2406 North Broad Street		Colmar	PA	18915	(215) 997-2300	General Dentistry
			Advanced Dental Smiles, P.C.	533 North York Road		Hatboro	PA	19404	(215) 672-9444	General Dentistry
			Advanced Family Dental Care, PC	327 Township Line Road		Elkins Park	PA	19027	(215) 663-1223	General Dentistry
			Advanced Family Dentistry	2630 West Cheltenham Avenue		Philadelphia	PA	19150	(215) 924-3747	General Dentistry
			Advanced Family Dentistry	2230 North Fifth Street Highway		Reading	PA	19605	(610) 371-8844	General Dentistry
			Afton Family Dental, PC	1815 South Broad Street		Philadelphia	PA	19148	(215) 462-6229	General Dentistry
			All About Dental Care, PC	450 Cresson Boulevard	Suite 210	Oaks	PA	19456	(610) 482-4334	General Dentistry
			All About Dental Care, PC	6181 Ridge Avenue	1st Floor	Philadelphia	PA	19128	(215) 482-0303	General Dentistry
			All Family Dental Care, Inc.	2012 Bridge Road		Skippack	PA	19474	(610) 222-8189	General Dentistry
			All Smile Dental Center	393 N Lewis Road		Royersford	PA	19468	(610) 792-0060	General Dentistry
			Alpha Dental Care	7439 Frankford Avenue	Second Floor	Philadelphia	PA	19136	(215) 613-5808	General Dentistry
			American Dental Care, LLC	1135 East Chocolate Avenue	Suite 101	Hershey	PA	17033	(717) 534-1135	General Dentistry
			American Dental Care, PA	61 South Black Horse Pike		Blackwood	NJ	08012	(856) 227-2740	General Dentistry
			American Dental Care, PA	2 Sheppard Drive		Voorhees	NJ	08043	(856) 751-6546	General Dentistry
			American Dental Care, PC	1501 Wadsworth Avenue		Philadelphia	PA	19063	(215) 247-1040	General Dentistry
			American Family Dental Care, P.C.	1555 Highlands Drive		Lititz	PA	17543	(717) 303-3051	General Dentistry
			American Family Dental Care, P.C.	2230 N. 5th St. Hwy.		Reading	PA	19605	(610) 371-8844	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			American Family Dental Care, P.C.	479 Thomas Jones Way	Suite 600	Exton	PA	19341	(610) 280-7222	General Dentistry
			American Family Dental Care, P.C.	450 Cresson Blvd.	Suite 210	Oakes	PA	19456	(610) 482-4334	General Dentistry
			Apex Smiles, LLC	771 2nd Street Pike		Southampton	PA	18966	(215) 357-2739	General Dentistry
			Apple Family Dentistry	275 DeKalb Pike, Unit 101		North Wales	PA	19454	(215) 699-3700	General Dentistry
			Ardent Smile, PC	4259 West Swamp Road	Suite 104	Doylestown	PA	18902	(215) 230-4550	General Dentistry
			Audubon Family Dentistry	290 South White Horse Pike		Audubon	NJ	08106	(856) 547-3351	General Dentistry
			Brilliant Smiles	610 Blackwood-Clementon Road	Suite E	Pine Hill	NJ	08021	(856) 346-0700	General Dentistry
			Brilliant Smiles	402 White Horse Pike S		Magnolia	NJ	08049	(856) 566-9700	General Dentistry
			Capitol Dental Care	4700 Union Deposit Road	Suite 210	Harrisburg	PA	17111	(717) 545-2003	General Dentistry
			Centre for Cosmetic Dentistry	275 Wilmington West Chester Pike	Suite 111	Chadds Ford	PA	19317	(610) 459-5002	General Dentistry
			Civillico Family Dentistry	1412 Bywood Avenue		Upper Darby	PA	19082	(610) 352-6560	General Dentistry
			Colmar Dental Associates, LLC	2200 North Broad Street		Colmar	PA	18915-9	(215) 362-2333	General Dentistry
			Comfort Family Dental Care, PC	845 West Chester Pike		West Chester	PA	19382	(610) 738-8866	General Dentistry
			Complete Care Dental	1300 MacDade Boulevard	Suite 5	Woodlyn	PA	19094	(610) 833-1919	General Dentistry
			Cosmetic & Family Dentistry, LLC	5810 Greene Street	Suite 6	Philadelphia	PA	19144	(215) 438-1100	General Dentistry
			Cosmetic Dentistry and Implant, LLC	1074 Route #18		East Brunswick	NJ	08816	(732) 613-0008	General Dentistry
			Cosmopolitan Dental, LLC	10,000 Lincoln Drive East	Suite 106	Marlton	NJ	08053	(856) 983-2983	General Dentistry
			Cottman Dental Group, PC	2901 Secane Drive		Philadelphia	PA	19154	(215) 632-1244	General Dentistry
			Creative Smiles, Inc.	9001 J Lincoln Drive West		Marlton	NJ	08053	(856) 810-8300	General Dentistry
			D-3 Dental, P.C.	1126 Horsham Road, Suite B		Ambler	PA	19002	(215) 619-6756	General Dentistry
			DaVinci Dental Arts, PA	102 James Street	Suite 304	Edison	NJ	08820	(732) 744-1188	General Dentistry
			Dental Care of Berlin, LLC	116 Walker Avenue		West Berlin	NJ	08091	(856) 768-511	General Dentistry
			Dental Choice, P.C.	4001 Lincoln Drive West	Suite D	Marlton	NJ	08053	(856) 983-9300	General Dentistry
			Dentex Dental Group, Ltd.	826 West Porter Street		Philadelphia	PA	19148	(215) 336-8391	General Dentistry
			Dentex Dental Group, Ltd.	2734 East Allegheny Avenue		Philadelphia	PA	19134	(215) 427-2787	General Dentistry
			Dentex Dental Group, Ltd.	1625 Chestnut Street	Suite 228	Philadelphia	PA	19103	(215) 336-8399	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Dentex Dental Group, Ltd.	10108 Bustleton Avenue		Philadelphia	PA	19116	(215) 677-3904	General Dentistry
			Dentex Dental Group, Ltd.	6227 Rising Sun Avenue		Philadelphia	PA	19119	(215) 742-4999	General Dentistry
			East Falls Family Dentistry, LLC	3500 Sunnyside Avenue		Philadelphia	PA	19129	(215) 849-1826	General Dentistry
			Essex Dental Community First Care Co.	106 North Essex Avenue		Narberth	PA	19072	(610) 668-7750	General Dentistry
			Everest Dental, LLC	9892 Bustleton Avenue	Suite 302	Philadelphia	PA	19115	(215) 671-0188	General Dentistry
			Family Dental Care	626 Snyder Avenue	Suite 200	Philadelphia	PA	19148	(215) 391-4100	General Dentistry
			Family Dental Care of South Jersey	707 Haddonfield Berlin Road	Unit B	Voorhees	NJ	08043	(856) 309-2244	General Dentistry
			Franklin Mills Mall Dental, LLP	1120 Franklin Mills Circle		Philadelphia	PA	19154	(215) 632-7700	General Dentistry
			Gallery Mall Dental, PC	Ninth & Market Streets	Gallery Mall One	Philadelphia	PA	19107	(215) 627-4290	General Dentistry
			Gentle Dental of Blue Bell, LLC	790 Penllyn Pike	Suite 103	Blue Bell	PA	19422	(215) 646-3900	General Dentistry
			Gentle Dental of Germantown	2627 Germantown Avenue		Philadelphia	PA	19133	(215) 288-8723	General Dentistry
			Gentle Dental of Haverford	354 Lancaster Avenue		Haverford	PA	1300	(610) 896-2447	General Dentistry
			Gentle Dental of Reading	4 South 4th Street	First Floor	Reading	PA	19602	(610) 375-9501	General Dentistry
			Gentle Dental of West Chester	125 Turner Lane		West Chester	PA	19380	(610) 738-9440	General Dentistry
			Gentle Dental Oregon	1419 West Oregon Avenue		Philadelphia	PA	19145	(215) 468-0220	General Dentistry
			Healthy Smiles of New Egypt	78 Maple Avenue	Suite D	New Egypt	NJ	08533	(609) 758-8200	General Dentistry
			Hershey Dental Care, PC	555 East Chocolate Avenue	Suite 101	Hershey	PA	17033	(717) 312-7030	General Dentistry
			High Street Dental, PC	348 High Street		Pottstown	PA	19464	(610) 327-2000	General Dentistry
			Lancaster Dental Arts, PC	60 West Walnut Street		Lancaster	PA	17602	(717) 394-4466	General Dentistry
			Lancaster Dental Arts, PC	155 Highlands Drive	Suite 190	Lititz	PA	17543	(717) 303-3051	General Dentistry
			Lansdowne Family Dental	321 N. Lansdowne Avenue		Lansdowne	PA	19050	(610) 626-5080	General Dentistry
			Levittown Family Dentistry, LLC	359 Indian Creek Drive		Levittown	PA	19058	(215) 945-5588	General Dentistry
			Magic Dental System	8253 Bustleton Avenue		Philadelphia	PA	19152	(215) 745-5734	General Dentistry
			Magic Dental System	2601 East Allegheny Avenue		Philadelphia	PA	19134	(215) 745-5734	General Dentistry
			Marlton Dental Center	1 Blanchard Road		Marlton	NJ	08053	(856) 768-0129	General Dentistry
			Maryland Family Dental, LLC	122 North Philadelphia Boulevard		Aberdeen	MD	21001	(410) 272-2636	General Dentistry



Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Milunsky Family Dentistry, PC	214 State Road		Media	PA	19063	(610) 566-5322	General Dentistry
			New Albany Family Dentistry	2800 Route 130 North	Suite 108	Cinnaminson	NJ	08077	(856) 786-1881	General Dentistry
			NICE Care Dental Associates of New Jersey	1400 Chews Landing Road		Laurel Springs	NJ	08021	(856) 227-2221	General Dentistry
			NICE Care Dental Associates of South Phila.	1311 South Street		Philadelphia	PA	19147	(215) 385-1717	General Dentistry
			Oasis Dental	1 Belmont Avenue	Suite 516	Bala Cynwyd	PA	19004	(484) 278-4134	General Dentistry
			PA Smile Center, PC	1212 Vetrans Highway	Suite A-1	Bristol	PA	19007	(215) 874-0407	General Dentistry
			Patelka Dental, LLC	8037 Frankford Avenue	Second Floor	Philadelphia	PA	19136	(215) 338-5454	General Dentistry
			Patelka Dental, LLC	8332 Bustleton Avenue	Unit C	Philadelphia	PA	19152	(215) 342-9000	General Dentistry
			Penn Dental Center	2628 North Broad Street		Philadelphia	PA	19132	(215) 227-6700	General Dentistry
			Penn Dental Center	3015 North Broad Street		Philadelphia	PA	19132	(215) 225-2511	General Dentistry
			Perfect Smile Dental Services	326 Broad Street		Red Bank	NJ	07701	(732) 224-9339	General Dentistry
			Picasso Dental Arts, LLC	1550 Old York Road	Suite 4	Abington	PA	19001	(215) 657-4440	General Dentistry
			Pottstown Family Dental Spa	728 E High Street		Pottstown	PA	19464	(610) 323-1633	General Dentistry
			Precious Pearls Dental, PC	706 South Street		Philadelphia	PA	19147	(215) 238-8800	General Dentistry
			Precision Dentistry, Inc.	179 York Road	Suite 2	Warminster	PA	18974	(215) 394-5558	General Dentistry
			Prime Dental, LLC	101 Old York Road	Suite 401	Jenkintown	PA	19046	(215) 884-2707	General Dentistry
			Red Lion Cosmetic Dental Center	3201 Red Lion Road		Philadelphia	PA	19114	(215) 637-8070	General Dentistry
			Revere Dental	7265 Revere Street		Philadelphia	PA	19149	(215) 333-0707	General Dentistry
			Rittenhouse Dental Group	255 S. 17th Street	Suite 2807	Philadelphia	PA	19103	(215) 546-2311	General Dentistry
			Scott and Clements Dentistry, Inc.	30 Foster Street		Dallas	PA	18612	(570) 675-4312	General Dentistry
			Silvana Cumani, DMD & Associates,	2200 Montrose Street		Philadelphia	PA	19146	(215) 426-7307	General Dentistry
			Smile America Family Dentistry	3201 Route 38	Suite 102	Mount Laurel	NJ	08054	(856) 722-0333	General Dentistry
			Smile Krafters, PC	1247 S. Cedar Crest Blvd.	Suite 300	Allentown	PA	18103	(610) 628-1228	General Dentistry
			Smile Solutions	1381 E. Boot Road		West Chester	PA	19380	(610) 918-4995	General Dentistry
			Sophisticated Smiles, PC	85 Reaville Avenue		Flemington	NJ	08822	(908) 806-4333	General Dentistry
			Stanley J.Wasko, DDS & Associates	3428 Rahn Street		Philadelphia	PA	19136	(215) 331-1330	General Dentistry

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Star Care Dental	1102 Baltimore Pike	Suite 203	Glen Mills	PA	19342	((610) 358-5151	General Dentistry
			Sunbeam Dental, LLC	100 Craig Road	Suite 106	Manalapan	NJ	07726	(732) 431-2888	General Dentistry
			The Family Holland Dental, PC	295 Buck Road	Suite 109	Holland	PA	18966	(215) 953-0553	General Dentistry
			Warrington Dental Arts	865 Easton Road	Suite 110	Warrington	PA	18976	(267) 483-8351	General Dentistry
			West Avenue Family Dentistry	609 West Avenue		Jenkintown	PA	19046	(215) 885-7337	General Dentistry
			Yes Dental, PC	2327 Cottman Avenue		Philadelphia	PA	19149	(215) 332-8700	General Dentistry
			Central PA Oral & Maxillofacial Surgeons	220 Cumberland Parkway	Suite 5	Mechanicsburg	PA	17055	(717) 697-7000	Oral Surgery
			Miller Oral Surgery, Inc.	395 St. Johns Church Road		Camp Hill	PA	17011	(717) 763-4000	Oral Surgery
			Miller Oral Surgery, Inc.	400 Nationwide Drive		Harrisburg	PA	17110	(717) 657-4400	Oral Surgery
			Oral & Maxillofacial Surgery Institute	4700 Union Deposit Road	Suite 260	Harrisburg	PA	17111	(717) 909-3239	Oral Surgery
			S. Phila. Oral & Max Surg.	1613 South Broad Street		Philadelphia	PA	19148	(215) 389-2511	Oral Surgery
			S. Phila. Oral & Max Surg.	401 East Township Line Rd, #C		Elkins Park	PA	19027	(215) 742-4422	Oral Surgery
			Schwartz & Schelkun Associates	467 Pennsylvania Avenue	Suite 106	Fort Washington	PA	19034	(215) 591-3590	Oral Surgery
			Schwartz & Schelkun Associates	853 Second St. Pk., Suite A-106	Office Complex	Richboro	PA	18954	(215) 355-4500	Oral Surgery
			Signature Smiles	266 Georgetown Road		Carneys Point	NJ	08069	(856) 299-0030	Oral Surgery
			Southeastern PA Oral Surgery	100 East Lehigh Avenue	Episcopal Hospital	Philadelphia	PA	19125	(215) 427-7000	Oral Surgery
			Tap Dentistry, LLC	2001 Liberty Place		Sicklerville	NJ	08081	(856) 875-9595	Oral Surgery
Allen	Paul S.	DMD	Oral & Maxillofacial Surgery Institute	4700 Union Deposit Road	Suite 260	Harrisburg	PA	17111	(717) 909-3239	Oral Surgery
Allora	Louis P.	DMD	Signature Smiles	1103 West Sherman Avenue		Vineland	NJ	08360	(856) 692-9333	Oral Surgery
Allora	Louis P.	DMD	Signature Smiles	7 E Shell Bay Avenue		Cape May Court House	NJ	08210	(609) 463-1700	Oral Surgery
Allora	Louis P.	DMD	Signature Smiles	27-29 South New York Avenue		Atlantic City	NJ	08401	(609) 345-6600	Oral Surgery
Allora	Louis P.	DMD	Signature Smiles	120 S. 6th Street		Vineland	NJ	08360	(856) 692-5533	Oral Surgery
Bahram	Raimie	DMD	Southeastern PA Oral Surgery	100 East Lehigh Avenue	Episcopal Hospital	Philadelphia	PA	19125	(215) 427-7000	Oral Surgery
Bahram	Ramin	DMD	Pennsylvania Oral Surgery Consultants of	720 MacDade Boulevard		Folsom	PA	19033	(610) 461-4600	Oral Surgery
Bahram	Ramin	DMD	Pennsylvania Oral Surgery Consultants of	2546 South Broad Street		Philadelphia	PA	19145	(215) 463-4141	Oral Surgery
Bahram	Ramin	DMD	Pennsylvania Oral Surgery Consultants of	151 South Springfield Road		Clifton Heights	PA	19018	(610) 622-5454	Oral Surgery

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Bahram	Ramin	DMD	Oral Surgery Consultants of Pennsylvania	1601 Walnut Street		Philadelphia	PA	19102	(215) 558-2400	Oral Surgery
Bandola	K.	DMD		1500 N Kings Highway	Suite 100	Cherry Hill	NJ	08034	(856) 428-4445	Oral Surgery
Bandola	K.	DMD		83 South State Street		Vineland	NJ	08360	(856) 205-9922	Oral Surgery
Barber	H. Dexter	DDS	Southeastern PA Oral Surgery	100 East Lehigh Avenue	Episcopal Hospital	Philadelphia	PA	19125	(215) 427-7000	Oral Surgery
Blake	Melvyn A.	DDS		600 State Hwy 73 North	Suite 9A	Marlton	NJ	08053	(856) 596-1460	Oral Surgery
Bortel	Shaun	DMD	Miller Oral Surgery, Inc.	400 Nationwide Drive		Harrisburg	PA	17110	(717) 657-4400	Oral Surgery
Bortel	Shaun	DMD	Miller Oral Surgery, Inc.	395 St. Johns Church Road		Camp Hill	PA	17011	(717) 763-4000	Oral Surgery
Bowser	Daniel	DMD	Oral Surgery Consultants of Pennsylvania	1601 Walnut Street		Philadelphia	PA	19102	(215) 558-2400	Oral Surgery
Bowser	Daniel	DMD	Oral Surgery Consultants of Pennsylvania	720 MacDade Boulevard		Folsom	PA	19033	(610) 461-4600	Oral Surgery
Bowser	Daniel	DMD	Oral Surgery Consultants of Pennsylvania	151 South Springfield Road		Clifton Heights	PA	19018	(610) 622-5454	Oral Surgery
Bowser	Daniel	DMD	Oral Surgery Consultants of Pennsylvania	2546 South Broad Street		Philadelphia	PA	19145	(215) 463-4141	Oral Surgery
Bozentka	Neal E.	DMD		700 South Chester Road		Swarthmore	PA	19081	(610) 328-0773	Oral Surgery
Braid	Stanton M.	DDS	Leonard Reichman Associates	1521 Locust Street	Suite 600	Philadelphia	PA	19102	(215) 735-6241	Oral Surgery
Cunning	David	DMD	Oral & Maxillofacial Surgeons, P.C.	66 North Main Street		Sellersville	PA	18960	(215) 257-3232	Oral Surgery
Cunning	David	DMD	Oral & Maxillofacial Surgeons, P.C.	249 South West End Boulevard		Quakertown	PA	18951	(215) 538-2132	Oral Surgery
Cunning	David	DMD	Oral & Maxillofacial Surgeons, P.C.	101 Progress Drive	Suite 101	Doylestown	PA	18901	(215) 345-7373	Oral Surgery
Cunning	David	DMD	Oral & Maxillofacial Surgeons, P.C.	755 York Road	Suite 206	Warminster	PA	18974	(215) 675-1080	Oral Surgery
Cunning	David	DMD	Oral & Maxillofacial Surgeons, P.C.	1500 Horizon Drive	Suite 108	Chalfont	PA	18914	(215) 996-1990	Oral Surgery
Dachowski	Michael	DMD		1650 Huntingdon Pike	Suite 219	Meadowbrook	PA	19046	(215) 938-7860	Oral Surgery
Dachowski	Michael	DMD		1980 South Easton Road	Suite 130	Doylestown	PA	18901	(215) 938-7860	Oral Surgery
Eichen	Matthew	DMD, PA		17 West Ormond Avenue		Cherry Hill	NJ	08002-3041	(856) 428-4445	Oral Surgery
Eichen	Matthew	DMD, PA		83 South State Street		Vineland	NJ	08360	(856) 205-9922	Oral Surgery
Eichen	Matthew	DMD, PA		1200 Route 9	Suite 2D	Lakewood	NJ	08701	(732) 905-9990	Oral Surgery
Farole	Anthony	DMD		191 Presidential Boulevard	Suite W-2	Bala Cynwyd	PA	19004	(610) 668-3300	Oral Surgery
Funt	Mark	DDS	S. Phila. Oral and & Max Surg.	1613 South Broad Street		Philadelphia	PA	19148	(215) 389-2511	Oral Surgery
Funt	Mark	DDS	S. Phila. Oral and & Max Surg.	401 East Township Line Rd, #C		Elkins Park	PA	19027	(215) 379-3382	Oral Surgery

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Gretzula	Chad		Schwartz & Schelkun Associates	158 York Road		Warminster	PA	18974	(215) 672-6560	Oral Surgery
Gretzula	Chad		Schwartz & Schelkun Associates	467 Pennsylvania Avenue	Suite 106	Fort Washington	PA	19034	(215) 591-3590	Oral Surgery
Gretzula	Chad		Schwartz & Schelkun Associates	853 Second St. Pk., Suite A-106	Office Complex	Richboro	PA	18954	(215) 355-4500	Oral Surgery
Huy	Louis A.	DMD	Oral & Maxillofacial Surgeons, P.C.	755 York Road	Suite 206	Warminster	PA	18974	(215) 675-1080	Oral Surgery
Huy	Louis A.	DMD	Oral & Maxillofacial Surgeons, P.C.	249 South West End Boulevard		Quakertown	PA	18951	(215) 538-2122	Oral Surgery
Huy	Louis A.	DMD	Oral & Maxillofacial Surgeons, P.C.	1500 Horizon Drive	Suite 108	Chalfont	PA	18914	(215) 996-1990	Oral Surgery
Huy	Louis A.	DMD	Oral & Maxillofacial Surgeons, P.C.	66 North Main Street		Sellersville	PA	18960	(215) 257-3232	Oral Surgery
Huy	Louis A.	DMD	Oral & Maxillofacial Surgeons, P.C.	101 Progress Drive		Doylestown	PA	18901	(215) 345-7373	Oral Surgery
Jones	Bryant	DDS	Oasis Oral Surgery	8957 Roosevelt Boulevard		Philadelphia	PA	19151	(215) 673-0808	Oral Surgery
Kazemi	A.	DMD		1500 N Kings Highway	Suite 100	Cherry Hill	NJ	08034	(856) 428-4445	Oral Surgery
Kazemi	A.	DMD		83 South State Street		Vineland	NJ	08360	(856) 205-9922	Oral Surgery
Kim	David	DMD	Elkins Park Dental Group	Briar House, Suite C-200	6302 Old York Road	Elkins Park	PA	19027	(215) 576-1770	Oral Surgery
Kim	Myung S.		Dr. Bernard Rothman, DDS, PA	1335 West Tabor Road		Philadelphia	PA	19141	(215) 224-7757	Oral Surgery
Land	Michael	DMD	Oral & Maxillofacial Surgeons, P.C.	1500 Horizon Drive	Suite 108	Chalfont	PA	18914	(215) 996-1990	Oral Surgery
Land	Michael	DMD	Oral & Maxillofacial Surgeons, P.C.	249 South West End Boulevard		Quakertown	PA	18951	(215) 538-2122	Oral Surgery
Land	Michael	DMD	Oral & Maxillofacial Surgeons, P.C.	101 Progress Drive		Doylestown	PA	18901	(215) 345-7373	Oral Surgery
Land	Michael	DMD	Oral & Maxillofacial Surgeons, P.C.	66 North Main Street		Sellersville	PA	18960	(215) 257-3232	Oral Surgery
Land	Michael	DMD	Oral & Maxillofacial Surgeons, P.C.	755 York Road	Suite 206	Warminster	PA	18974	(215) 675-1080	Oral Surgery
Levy	Jaime		American Dental Care, PA	61 South Black Horse Pike		Blackwood	NJ	08012	(856) 227-2740	Oral Surgery
Levy	Jaime		American Dental Care, PA	1450 Clements Bridge Road		Woodbury	NJ	08096	(856) 845-6222	Oral Surgery
Levy	Jaime		American Dental Care, PA	2 Sheppard Drive		Voorhees	NJ	08043	(856) 751-6546	Oral Surgery
Lucyk	Danial	DDS	Southeastern PA Oral Surgery Central PA Oral & Maxillofacial Surgeons	100 East Lehigh Avenue	Episcopal Hospital	Philadelphia	PA	19125	(215) 427-7000	Oral Surgery
Meyers	Harry P.	DDS		220 Cumberland Parkway	Suite 5	Mechanicsburg	PA	17055	(717) 697-7000	Oral Surgery
Mogyoros	Robert		South Phila. Oral & Max Surg.	401 East Township Line Road	Suite C	Elkins Park	PA	19027	(215) 379-3382	Oral Surgery
Mulligan	Joseph		Carp Dental Associates, PC	1325 West Airy Street		Norristown	PA	19401	(610) 275-1565	Oral Surgery
Patel	T.	DMD		1500 N Kings Highway	Suite 100	Cherry Hill	NJ	08034	(856) 428-4445	Oral Surgery

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Patel	T.	DMD		83 South State Street		Vineland	NJ	08360	(856) 205-9922	Oral Surgery
Patel	Tejal	DMD	Tap Dentistry, LLC	2001 Liberty Place		Sicklerville	NJ	08081	(856) 875-9595	Oral Surgery
Pepper	Larry	DMD	Oral & Maxillofacial Surgery Institute	4700 Union Deposit Road	Suite 260	Harrisburg	PA	17111	(717) 909-3239	Oral Surgery
Richmand	Brad	DDS	Oral Surgery Consultants of Pennsylvania	151 South Springfield Road		Clifton Heights	PA	19018	(610) 622-5454	Oral Surgery
Richmand	Brad	DDS	Oral Surgery Consultants of Pennsylvania	2546 South Broad Street		Philadelphia	PA	19145	(215) 463-4141	Oral Surgery
Richmand	Brad	DDS	Oral Surgery Consultants of Pennsylvania	720 MacDade Boulevard		Folsom	PA	19033	(610) 461-4600	Oral Surgery
Richmand	Brad	DDS	Oral Surgery Consultants of Pennsylvania	1601 Walnut Street		Philadelphia	PA	19102	(215) 558-2400	Oral Surgery
Rothman	Bernard	DDS		1701 Wynnwood Drive		Cinnaminson	NJ	08077	(856) 829-9666	Oral Surgery
Rothman	Bernard	DDS	Carp Dental Associates, PC	1325 West Airy Street		Norristown	PA	19401	(610) 275-1565	Oral Surgery
Rothstein	David H.	DDS		400 North Buckstown Road	Suite 2-A	Langhorne	PA	19047	(215) 750-0200	Oral Surgery
Sacks	Fred		American Dental Care, PC	187 E. City Avenue		Bala Cynwyd	PA	19004	(610) 667-9713	Oral Surgery
Sacks	Fred		American Dental Care, PC	9229 Roosevelt Boulevard		Philadelphia	PA	19114	(215) 969-0900	Oral Surgery
Sacks	Fred		American Dental Care, PC	722 Market Street		Philadelphia	PA	19106	(215) 922-5100	Oral Surgery
Sacks	Fred	DMD	American Dental Care, PC	1003 W. Baltimore Pike		Media	PA	19063	(610) 891-0940	Oral Surgery
Sacks	Frederick	DMD		817 North Easton Road		Doylestown	PA	18901	(215) 348-4041	Oral Surgery
Schelkun	P. Michael	DDS		853 2nd Street Pike	Brownstone Office Complex,	Richboro	PA	18954	(215) 355-4500	Oral Surgery
Schelkun	P. Michael	DDS		467 Pennsylvania Avenue	Suite 106	Fort Washington	PA	19034	(215) 591-3590	Oral Surgery
Schelkun	P. Michael	DDS		158 York Road		Warminster	PA	18974	(215) 672-6560	Oral Surgery
Schwartz	Lewis J.	DMD		467 Pennsylvania Avenue	Suite 106	Fort Washington	PA	19034	(215) 591-3590	Oral Surgery
Schwartz	Lewis J.	DMD		158 York Road		Warminster	PA	18974	(215) 672-6560	Oral Surgery
Schwartz	Lewis J.	DMD		853 2nd Street Pike	Brownstone Office Complex,	Richboro	PA	18954	(215) 355-4500	Oral Surgery
Sicilia	Ronald F.	DMD	Oral & Maxillofacial Surgery Assoc.	5170 Oxford Avenue		Philadelphia	PA	19124	(215) 535-2255	Oral Surgery
Slade	Edwin	DMD	Oral & Maxillofacial Surgeons, P.C.	249 South West End Boulevard		Quakertown	PA	18951	(215) 538-2132	Oral Surgery
Slade	Edwin	DMD	Oral & Maxillofacial Surgeons, P.C.	66 North Main Street		Sellersville	PA	18960	(215) 257-3232	Oral Surgery
Slade	Edwin	DMD	Oral & Maxillofacial Surgeons, P.C.	755 York Road	Suite 206	Warminster	PA	18974	(215) 675-1080	Oral Surgery
Slade	Edwin	DMD	Oral & Maxillofacial Surgeons, P.C.	1500 Horizon Drive	Suite 108	Chalfont	PA	18914	(215) 996-1990	Oral Surgery

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Slade	Edwin	DMD	Oral & Maxillofacial Surgeons, P.C.	101 Progress Dr	Suite 101	Doylestown	PA	18901	(215) 345-7373	Oral Surgery
Smith	Brian M.	DMD, MD	Southeastern PA Oral Surgery	100 East Lehigh Avenue	Episcopal Hospital	Philadelphia	PA	19125	(215) 427-7000	Oral Surgery
Tamaroff	James L.		Oral & Maxillofacial Surgeons, P.C.	755 York Road	Suite 206	Warminster	PA	18974	(215) 675-1080	Oral Surgery
Tamaroff	James L.		Oral & Maxillofacial Surgeons, P.C.	66 North Main Street		Sellersville	PA	18960	(215) 257-3232	Oral Surgery
Tamaroff	James L.		Oral & Maxillofacial Surgeons, P.C.	249 South West End Boulevard		Quakertown	PA	18951	(215) 538-2132	Oral Surgery
Tamaroff	James L.		Oral & Maxillofacial Surgeons, P.C.	1500 Horizon Drive	Suite 108	Chalfont	PA	18914	(215) 996-1990	Oral Surgery
Tamaroff	James L.		Oral & Maxillofacial Surgeons, P.C.	101 Progress Drive	Suite 101	Doylestown	PA	18901	(215) 345-7373	Oral Surgery
Torchinsky	Warren M.	DDS		223 East Main Street		Maple Shade	NJ	08052	(856) 665-9222	Oral Surgery
Voiner	Jonathan L.	DMD, MD		700 South Chester Road		Swarthmore	PA	19081	(610) 328-0773	Oral Surgery
Wohar	Robert	DMD	S. Phila. Oral & Max Surg.	401 East Township Line Rd, #C		Elkins Park	PA	19027	(215) 742-4422	Oral Surgery
Wohar	Robert	DMD	S. Phila. Oral & Max Surg.	1613 South Broad Street		Philadelphia	PA	19148	(215) 389-2511	Oral Surgery
Yudell	Robert M.	DDS		158 York Road		Warminster	PA	18974	(215) 672-6560	Oral Surgery
Yudell	Robert M.	DDS		467 Pennsylvania Avenue	Suite 106	Fort Washington	PA	19034	(215) 591-3590	Oral Surgery
Yudell	Robert M.	DDS		853 Second Street Pike	Suite A-106	Richboro	PA	18954	(215) 355-4500	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	2230 N. 5th St. Highway		Reading	PA	19605	(610) 371-8844	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	456 School Lane	Suite 102	Harleysville	PA	19438	(215) 513-7172	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	1247 S. Cedar Crest Blvd.	Suite 300	Allentown	PA	18109	(610) 628-1228	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	8355 Loretto Avenue	Suite 104	Philadelphia	PA	19152	(215) 342-5750	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	35-B Woodland Avenue		Morton	PA	19070	(610) 544-3630	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	8 Pond's Edge Drive	Suite 2	Chadds Ford	PA	19317	(610) 388-4466	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	1901 Union Boulevard		Allentown	PA	18109	(610) 437-5353	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	1950 Street Road	Suite 200	Bensalem	PA	19020	(215) 638-4696	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	479 Thomas Jones Way	Suite 600	Exton	PA	19341	(610) 280-7222	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	301 City Line Avenue	Suite G-5	Bala Cynwyd	PA	19004	(610) 660-9510	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	1555 Highlands Drive	Suite 190	Lititz	PA	17543	(717) 303-3051	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	6100-02 5th Street		Philadelphia	PA	19120	(215) 224-4343	Oral Surgery

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			A+ Oral Surgery Specialty Care, PC	24 South 14th Street		Quakertown	PA	18951	(215) 536-3210	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	404 Middletown Blvd., Ste. 300		Langhorne	PA	19047	(215) 757-4400	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	260 New York Drive, Ste. 401		Fort Washington	PA	19034	(858) 432-3410	Oral Surgery
			A+ Oral Surgery Specialty Care, PC	60 West Walnut Street		Lancaster	PA	17602	(717) 394-4466	Oral Surgery
			Oral Surgery Consultants of Pennsylvania	1601 Walnut Street		Philadelphia	PA	19102	(215) 558-2400	Oral Surgery
			Oral Surgery Consultants of Pennsylvania	2546 South Broad Street		Philadelphia	PA	19145	(215) 463-4141	Oral Surgery
			Oral Surgery Consultants of Pennsylvania	151 South Springfield Road		Clifton Heights	PA	19018	(610) 622-5454	Oral Surgery
			Oral Surgery Consultants of Pennsylvania	720 MacDade Boulevard		Folsom	PA	19033	(610) 461-4600	Oral Surgery
			American Dental Care, LLC	817 North Easton Road		Doylestown	PA	18901	(215) 348-4041	Orthodontics
			Articolo Orthodontics, PA	63 North Lakeview Drive		Gibbsboro	NJ	08026	(856) 784-7977	Orthodontics
			Articolo Orthodontics, PA	989 North Main Street		Williamstown	NJ	08094	(856) 728-0300	Orthodontics
			Articolo Orthodontics, PA	233 South Black Horse Pike		Blackwood	NJ	08012	(856) 227-2666	Orthodontics
			Orchestr & DemGarr Orthodontics, PC	928 Jaymor Road, Suite 130A	Southampton Office Park	Southampton	PA	18966	(215) 942-7300	Orthodontics
			Orchestr & DemGarr Orthodontics, PC	260 New York Drive		Ft. Washington	PA	19034	(215) 653-0420	Orthodontics
			Orchestr & DemGarr Orthodontics, PC	6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Orthodontics
			Delaware Maryland Dental	1653 Elkton Road		Elkton	MD	21921	(302) 368-1710	Orthodontics
			Fairless Hills Dental Center	532 South Oxford Valley Road		Fairless Hills	PA	19030	(215) 946-3655	Orthodontics
			Mongiovi Orthodontics, Inc.	4 Woodland Drive		Glen Mills West Long Branch	PA	19342	(610) 358-5003	Orthodontics
			Ortho One, LLC	121 Highway 36	Suite 100		NJ	07764	(732) 222-6446	Orthodontics
			Ortho One, LLC	700 Haddonfield-Berlin Road	Suite 26	Voorhees	NJ	08043	(856) 566-1240	Orthodontics
Addiego	Anthony J.	DDS		101 Center Square Road	Suite 200	Swedesboro	NJ	08085	(856) 467-0077	Orthodontics
Addiego	Anthony J.	DDS		410 Kings Highway		Moorestown	NJ	08057	(856) 235-7775	Orthodontics
Addiego	Anthony J.	DDS		188 Fries Mill Road	Suite F3	Turnersville	NJ	08012	(856) 848-6100	Orthodontics
Addiego	Ben T.	DDS, MS		7215 Passyunk Avenue		Philadelphia	PA	19142	(215) 727-1800	Orthodontics
Apollon	Warren J.	DMD DDS,		586 Middletown Boulevard	Suite C-10	Langhorne	PA	19047	(215) 750-7779	Orthodontics
Appel	Steven	PC		8950 Krewstown Road		Philadelphia	PA	19115	(215) 676-3070	Orthodontics

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Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Appel	Steven	DDS, PC		57 Street Road, Suite D		Southampton	PA	18966	(215) 357-2570	Orthodontics
Arshna	Anil P.	DMD	The Dennis Center	63 Garrett Lane		Willingboro	NJ	08046	(609) 871-0900	Orthodontics
Articolo	Laurence C.	DDS	Articolo Orthodontics, PA	233 South Black Horse Pike		Blackwood	NJ	08012	(856) 227-2666	Orthodontics
Articolo	Laurence C.	DDS	Articolo Orthodontics, PA	989 North Main Street		Williamstown	NJ	08094	(856) 728-0300	Orthodontics
Articolo	Laurence C.	DDS	Articolo Orthodontics, PA	63 North Lakeview Drive		Gibbsboro	NJ	08026	(856) 784-7977	Orthodontics
Bresler	David	DDS	Bresler-Richmond Dental Center	6801 Ridge Avenue		Philadelphia	PA	19128	(215) 483-6633	Orthodontics
Bresler	David	DDS	Childrens Dental Specialists	240 Geiger Road		Philadelphia	PA	19115	(215) 677-0380	Orthodontics
Brightman	Laurie	DMD		6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Orthodontics
Brown	Allen C.	DDS		191 Presidential Blvd.	Suite W-4	Bala Cynwyd	PA	19004	(610) 668-0610	Orthodontics
Bulucea	Irina	DMD, MSD		3731 Walnut Street		Harrisburg	PA	17109	(717) 545-3187	Orthodontics
Cestone	Michael J.		CFH Ortho, LLC	118 Dickerson Road	Suite D	North Wales	PA	19454	(215) 699-0650	Orthodontics
Cestone	Michael J.		CFH Ortho, LLC	1995 Swamp Road	Suite 110	Gilbertsville	PA	19525	(610) 326-4448	Orthodontics
Chichetti	Michael	DMD	Chichetti & DelliGatti Orthodontics, PC	260 New York Drive		Ft. Washington	PA	19034	(215) 653-0420	Orthodontics
Chichetti	Michael	DMD	Chichetti & DelliGatti Orthodontics, PC	6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Orthodontics
Chichetti	Michael	DMD	Chichetti & DelliGatti Orthodontics, PC	928 Jaymor Road, Suite 130A	Southampton Office Park	Southampton	PA	18966	(215) 942-7300	Orthodontics
Cichetti	Michael	DDS		6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Orthodontics
Cichetti	Michael	DDS		6801 Ridge Avenue		Philadelphia	PA	19128	(215) 483-6633	Orthodontics
Cichetti	Michael	DDS		928 Jaymor Road, Suite 13A	Southampton Office Park	Southampton	PA	18966	(215) 942-7900	Orthodontics
Cichetti	Michael	DDS	Pediatric Dental Associates, Ltd.	7 E Skippack Pike	Suite 100	Ambler	PA	19002	(215) 653-0420	Orthodontics
Cullen	Vincent		My Orthodontist	532 S. Oxford Valley Road		Fairless Hills	PA	19030	(215) 946-0800	Orthodontics
DeFelice	Gregory	DMD		5429 Harding Highway	Suite 101	Mays Landing	NJ	08330	(609) 625-0505	Orthodontics
DeFelice	Gregory J.	DMD	Cedar Run Orthodontics, PA	1064 South Main Street	Suite 2A	West Creek	NJ	08092	(609) 978-4411	Orthodontics
DelliGatti	Steve	DMD	Chichetti & DelliGatti Orthodontics, PC	260 New York Drive		Ft. Washington	PA	19034	(215) 653-0420	Orthodontics
DelliGatti	Steve	DMD	Chichetti & DelliGatti Orthodontics, PC	928 Jaymor Road, Suite 130A	Southampton Office Park	Southampton	PA	18966	(215) 942-7300	Orthodontics
DelliGatti	Steve	DMD	Chichetti & DelliGatti Orthodontics, PC	6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Orthodontics
Dewey	Mark B.	DDS		3731 Walnut Street		Harrisburg	PA	17109	(717) 545-3187	Orthodontics



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Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Elfman	Joel E.	DDS	Elfman Orthodontics, LLC	302 Haddonfield-Berlin Road		Voorhees	NJ	08043	(856) 429-1900	Orthodontics
Euksuzian	Sarkis	DMD		30 Jackson Road	Jackson Commons,	Medford	NJ	08055	(609) 654-0600	Orthodontics
Euksuzian	Sarkis	DMD		78 East Second Street		Moorestown	NJ	08057	(856) 234-2992	Orthodontics
Farrow	Anthony L.	DMD, MS		1510 Wadsworth Avenue		Philadelphia	PA	19150	(215) 247-9060	Orthodontics
Farrow	Anthony L.	DMD, MS		1601 Walnut Street	Suite 1315	Philadelphia	PA	19102	(215) 569-9060	Orthodontics
Hayes	Richard	DDS		3920 Pyle Road		Chadds Ford	PA	19317	(610) 459-2545	Orthodontics
Hayes	Richard	DDS		101 Dutton Street		Ridley Park	PA	19078	(610) 521-2222	Orthodontics
Hodges	Kellyn	DMD, MS		411 Doylestown Road	Suite D	Montgomeryville	PA	18936	(215) 412-9810	Orthodontics
Hodges	Kellyn	DMD, MS	Bala Orthodontics, LLC	One Belmont Avenue	Suite 414	Bala Cynwyd	PA	19004	(610) 617-0700	Orthodontics
Hodges	Kellyn	DMD, MS	Orthodontic Specialists	2212 Street Road	Second Floor	Bensalem	PA	19020	(215) 245-5100	Orthodontics
Issa	Aajax	DMD DMD,		817 North Easton Road		Doylestown	PA	18901	(215) 348-4041	Orthodontics
Kadan	Sam	PC DMD,		15 Presidential Boulevard	Suite 302	Bala Cynwyd	PA	19004	(610) 667-5789	Orthodontics
Kadan	Sam	PC		1500 Horizon Drive	Suite 107	Chalfont	PA	18914	(215)997-0599	Orthodontics
Kadan	Sam	DMD, F	Harleysville Orthodontics	444 Main Street		Harleysville	PA	19438	(215) 256-6444	Orthodontics
Kane	Edwin	DMD		1131 Olive Street		Coatesville	PA	19320	(610) 384-5891	Orthodontics
Karkenny	Malko	DDS		3920 Pyle Road		Chadds Ford	PA	19317	(610) 459-2545	Orthodontics
Karkenny	Malko	DDS		101 Dutton Street		Ridley Park	PA	19078	(610) 521-2222	Orthodontics
Klatt	Kevin J.	DDS	Associated Orthodontics	670 Woodbourne Road	Suite 701	Langhorne	PA	19047	(215) 741-0501	Orthodontics
Klatt	Kevin J.	DDS	Associated Orthodontics	1220 West Chester Pike		Havertown	PA	19083	(610) 789-0158	Orthodontics
Klatt	Kevin J.	DDS	Associated Orthodontics	6814 Castor Avenue		Philadelphia	PA	19149	(215) 745-9443	Orthodontics
Koff	Howard		American Dental Care, PA	2 Sheppard Drive		Voorhees	NJ	08043	(856) 751-6546	Orthodontics
Koff	Howard		American Dental Care, PA	1450 Clements Bridge Road		Woodbury	NJ	08096	(856) 845-6222	Orthodontics
Koff	Howard		American Dental Care, PC	9229 Roosevelt Boulevard		Philadelphia	PA	19114	(215) 969-0900	Orthodontics
Koff	Howard		American Dental Care, PC	515 Baltimore Pike		Springfield	PA	19064	(610) 543-4900	Orthodontics
Koff	Howard		American Dental Care, PC	1003 West Baltimore Pike		Media	PA	19063	(610) 891-0940	Orthodontics
Koff	Howard		American Dental Care, PC	187 East City Avenue		Bala Cynwyd	PA	19004	(610) 667-9713	Orthodontics

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Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Koff	Howard		American Dental Care, PC	722 Market Street		Philadelphia	PA	19106	(215) 922-5100	Orthodontics
Marcus	Harold	DDS	Harold H. Marcus Associates	7215 Passyunk Avenue	Eastwick Professional	Philadelphia	PA	1525	(215) 727-1800	Orthodontics
Mele	Mark	DMD		2826 Mount Carmel Avenue		Glenside	PA	19038	(215) 886-7880	Orthodontics
Mele	Mark	DMD		712 Haddonfield Road		Cherry Hill	NJ	08002	(856) 662-1155	Orthodontics
Moore	Brian	DDS		7156 Stenton Avenue		Philadelphia	PA	19150	(215) 242-5797	Orthodontics
Murray	Robert J.	DDS	Murray Orthodontics	1077 Rydal Road	Suite 301	Jenkintown	PA	19046	(215) 886-2274	Orthodontics
Murray, Jr.	Robert J.	DMD	Murray Orthodontics	1077 Rydal Road	Suite 301	Jenkintown	PA	19046	(215) 886-2274	Orthodontics
Nero	Benjamin	DDS		4401 Conshohocken Avenue		Philadelphia	PA	19131	(215) 473-3543	Orthodontics
Nero	Benjamin	DMD		215 Sunset Road	Suite 308	Willingboro	NJ	08046	(609) 835-4038	Orthodontics
Nero	Benjamin	DMD	Browns Mills Dental Center	55 Pemberton Browns Mill Road		Browns Mills	NJ	08015	(609) 893-7700	Orthodontics
Nicolaescu	Serban A.	DMD		1653 Elkton Road		Elkton	MD	21921	(302) 368-1710	Orthodontics
O'Reilly	Maria		Family Dental Care	626 Snyder Avenue	Suite 200	Philadelphia	PA	19148	(215) 391-4100	Orthodontics
Perlot	Robert	DMD	Orthodontics & Dentistry, PC	6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Orthodontics
Perlot	Robert	DMD	Orthodontics & Dentistry, PC	928 Jaymor Road, Suite 130A	Southampton Office Park	Southampton	PA	18966	(215) 942-7300	Orthodontics
Perlot	Robert	DMD	Orthodontics & Dentistry, PC	260 New York Drive		Ft. Washington	PA	19034	(215) 653-0420	Orthodontics
Persichetti	Joseph	DMD		295 Buck Road		Holland	PA	18966	(215) 364-1480	Orthodontics
Persichetti	Joseph	DMD		1096 Washington Crossing Road		Washington Crossing	PA	18977	(215) 493-7700	Orthodontics
Rich	Jeremy Scott	DMD	Rich Orthodontics, LLC	1022 East Baltimore Pike		Media	PA	19063	(215) 244-9505	Orthodontics
Rich	Jeremy Scott	DMD	Rich Orthodontics, LLC	3554 Hulmeville Road	Suite 110	Bensalem	PA	19020	(215) 244-9505	Orthodontics
Rich	Jeremy Scott	DMD	Rich Orthodontics, LLC	370 Middletown Boulevard	Suite 509	Langhorne	PA	19047	(267) 560-5512	Orthodontics
Segall	Robert	DDS	Eastern Ortho. Assoc. of Burlington	202 Route 130 North	Pep Boys Plaza	Cinnaminson	NJ	08077	(856) 786-2753	Orthodontics
Segall	Robert	DDS	Eastern Ortho. Assoc. of Ewing	1330 Parkway Avenue		Trenton	NJ	08628	(609) 883-6207	Orthodontics
Segall	Robert	DDS	Eastern Ortho. Assoc. of Hamilton	2103 Whitehorse-Mercerville Rd.		Trenton	NJ	08619	(609) 587-0600	Orthodontics
Segall	Robert	DDS	Eastern Ortho. Assoc. of Ocean/Monmouth	2770 Hooper Avenue, #4	Kennedy Plaza	Brick	NJ	08723-4108	(732) 477-0352	Orthodontics
Segall	Robert	DDS	Eastern Ortho. Assoc. of Old Bridge	960 US Highway 9 North	Sayreville Plaza	Sayreville	NJ	08872	(732) 727-3336	Orthodontics
Segall	Robert	DDS	Eastern Ortho. Assoc. of Passaic/Essex	251 Clifton Avenue		Clifton	NJ	07011	(973) 478-9300	Orthodontics

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Segall	Robert	DDS	Eastern Ortho. Assoc. of Toms River	1228 Route 37 West		Toms River	NJ	08755	(732) 286-0464	Orthodontics
Segall	Robert	DDS	Eastern Ortho. Assoc. of Union	2115 Route 22 West		Union	NJ	07083-8403	(908) 964-5406	Orthodontics
Segall	Robert	DDS	Eastern Ortho. Assoc. of Woodbridge	1030 St. Georges Avenue	Suite 1407	Avenel	NJ	07001	(732) 750-3830	Orthodontics
Siegel	Philip	DDS		928 Jaymor Road, Suite 13A	Southampton Office Park	Southampton	PA	18966	(215) 942-7900	Orthodontics
Siegel	Philip	DDS	Bresler-Richmond Dental Center	6801 Ridge Avenue		Philadelphia	PA	19128	(215) 483-6633	Orthodontics
Siegel	Philip	DDS	Pediatric Dental Associates, Ltd.	7 E Skippack Pike	Suite 100	Ambler	PA	19002	(215) 653-0420	Orthodontics
Siegel	Philip	DDS	Pediatric Dental Associates, Ltd.	6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Orthodontics
Slutsky	Howard	DMD		7100 Frankford Avenue		Philadelphia	PA	19135	(215) 335-2500	Orthodontics
Slutsky	Howard	DMD		3103 Hulmeville Road	Suite 206	Bensalem	PA	19020	(215) 638-0500	Orthodontics
			Allied Orthodontics, P.C.	479 Thomas Jones Way	Suite 600	Exton	PA	19341	(610) 280-7222	Orthodontics
			Allied Orthodontics, P.C.	456 School Lane	Suite 101	Harleysville	PA	19438	(215) 513-7172	Orthodontics
			Allied Orthodontics, P.C.	24 South 14th Street		Quakertown	PA	18951	(215) 536-3210	Orthodontics
			Allied Orthodontics, P.C.	402 Middletown Boulevard	Suite 200	Langhorne	PA	19047	(215) 757-4400	Orthodontics
			Allied Orthodontics, P.C.	8355 Loretto Avenue	Suite 104	Philadelphia	PA	19152	(215) 342-5752	Orthodontics
			Allied Orthodontics, P.C.	4259 West Swamp Road	Suite 104	Doylestown	PA	18902	(215) 230-4550	Orthodontics
			Allied Orthodontics, P.C.	1555 Highlands Drive	Suite 190	Lititz	PA	17543	(717) 303-3051	Orthodontics
			Allied Orthodontics, P.C.	301 City Avenue	Suite G-5	Bala Cynwyd	PA	19004	(215) 230-4550	Orthodontics
			Allied Orthodontics, P.C.	1247 S. Cedarcrest Blvd.	Suite 300	Allentown	PA	18103	(610) 628-1228	Orthodontics
			Cedar Run Orthodontics, PA	1064 South Main Street	Suite 2A	West Creek	NJ	08092	(609) 978-4411	Orthodontics
			Cestone Orthodontics, P.C.	829 Second Street Pike		Richboro	PA	18954	(215) 364-1900	Orthodontics
			CFH Ortho, LLC	118 Dickerson Road	Suite D	North Wales	PA	19454	(215) 699-0650	Orthodontics
			CFH Ortho, LLC	1995 Swamp Road	Suite 110	Gilbertsville	PA	19525	(610) 326-4448	Orthodontics
			Harleysville Orthodontics	444 Main Street		Harleysville	PA	19438	(215) 256-6444	Orthodontics
			Murray Orthodontics	1077 Rydal Road	Suite 301	Jenkintown	PA	19046	(215) 886-2274	Orthodontics
			My Orthodontist	532 S. Oxford Valley Road		Fairless Hills	PA	19030	(215) 946-0800	Orthodontics
			Rich Orthodontics, LLC	1022 East Baltimore Pike		Media	PA	19063	(215) 244-9505	Orthodontics

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Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			Rich Orthodontics, LLC	3554 Hulmeville Road	Suite 110	Bensalem	PA	19020	(215) 244-9505	Orthodontics
			Rich Orthodontics, LLC	370 Middletown Boulevard	Suite 509	Langhorne	PA	19047	(267) 560-5512	Orthodontics
			Rich Orthodontics, LLC	900 Magee Avenue		Philadelphia	PA	19111	(267) 388-5040	Orthodontics
			Star Care Dental	1102 Baltimore Pike	Suite 203	Glen Mills	PA	19342	((610) 358-5151	Orthodontics
			ABC Children's Dentistry, LLC	1001 Laurel Oak Road	Suite C-2	Voorhees	NJ	08043	(856) 783-3515	Pediatric Dentistry
			Pediatric Dental Associates	928 Jaymor Road, Ste. A130	Office Park	Southampton	PA	18966	(215) 942-7300	Pediatric Dentistry
			Signature Smiles	7 E Shellbay Avenue		Cape May Court House	NJ	08210	(609) 461-1700	Pediatric Dentistry
			Signature Smiles	27-29 South New York Avenue		Atlantic City	NJ	08401	(609) 345-6600	Pediatric Dentistry
			Signature Smiles	266 Georgetown Road		Carneys Point	NJ	08069	(856) 299-0030	Pediatric Dentistry
Annuzzi	Mary Kay		ABC Children's Dentistry, LLC	1001 Laurel Oak Road	Suite C-2	Voorhees	NJ	08043	(856) 783-3515	Pediatric Dentistry
Bresler	David	DDS		1430 Snyder Avenue		Philadelphia	PA	19145	(215) 467-6000	Pediatric Dentistry
Bresler	David	DDS		1244 Ft. Wshington Avenue	Suite M-1	Ft. Washington	PA	19034	(215) 643-1300	Pediatric Dentistry
Bresler	David	DDS		101 Old York Road, Suite 301		Jenkintown	PA	19046	(215) 884-2900	Pediatric Dentistry
Bresler	David	DDS	Doc Bresler's Cavity Busters	4659 West Chester Pike		Newtown Square	PA	19073	(484) 444-0700	Pediatric Dentistry
Chianese	Dana	DMD	Holdbrook Pediatric Dental, LLC	250 Haddonfield-Berlin Road		Gibbsboro	NJ	08026	(856) 783-0444	Pediatric Dentistry
Chianese	Dana	DMD	Holdbrook Pediatric Dental, LLC	553 Beckett Road	Suite 604	Swedesboro	NJ	08085	(856) 556-4020	Pediatric Dentistry
Corsi, Jr.	Gerald	DMD	Holdbrook Pediatric Dental, LLC	553 Beckett Road	Suite 604	Swedesboro	NJ	08085	(856) 556-4020	Pediatric Dentistry
DelGaiso	John	DDS		2010 South Juniper Street		Philadelphia	PA	19148	(215) 334-3490	Pediatric Dentistry
Goldstein	Mark S.	DDS	Pediatric Dental Associates, Ltd.	6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Pediatric Dentistry
Goldstein	Mark S.	DDS	Pediatric Dental Associates, Ltd.	7 E Skippack Pike	Suite 100	Ambler	PA	19002	(215) 653-0420	Pediatric Dentistry
Holdbrook	Wendell	DMD	Holdbrook Pediatric Dental, LLC	250 Haddonfield -Berlin Road		Gibbsboro	NJ	08026	(856) 783-0444	Pediatric Dentistry
Holdbrook	Wendell	DMD	Holdbrook Pediatric Dental, LLC	553 Beckett Road	Suite 604	Swedesboro	NJ	08085	(856) 556-4020	Pediatric Dentistry
Iyer	Sathish	DDS	The Little Teeth Workshop	3333 US Highway 9N	2nd Floor	Old Bridge	NJ	08857	(732) 737-7336	Pediatric Dentistry
Jacobson	Irving W.	DMD	Brushie-Land Dental	1916 Welsh Road		Philadelphia	PA	19115	(215) 676-2311	Pediatric Dentistry
Kaur	Suhjit		Signature Smiles	120 S. 6th Street		Vineland	NJ	08360	(856) 692-5533	Pediatric Dentistry
Kaur	Suhjit		Signature Smiles	27-29 South New York Avenue		Atlantic City	NJ	08401	(609) 345-6600	Pediatric Dentistry

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Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Kaur	Suhjit		Signature Smiles	1103 West Sherman Avenue		Vineland	NJ	08360	(856) 692-9333	Pediatric Dentistry
Kaur	Suhjit		Signature Smiles	7 East Shell Bay Ave, #B		Cape May Court House	NJ	08210	(609) 463-1700	Pediatric Dentistry
LaTorre	Albert	DDS		2289 Street Road		Warrington	PA	18976	(215) 491-0502	Pediatric Dentistry
Mallozzi	Connie	DMD		20 North Laurel Street	Suite 2C	Hazleton	PA	18201	(570) 454-9600	Pediatric Dentistry
Miniman	Kenneth L.	DDS		1022 East Baltimore Pike		Media	PA	19063	(610) 565-7850	Pediatric Dentistry
Miniman	Kenneth L.	DDS	Smile Solutions	1381 E. Boot Road		West Chester	PA	19380	(610) 918-4995	Pediatric Dentistry
Murphy	James P.	DMD		10 South Clinton Street	Landmark Building	Doylestown	PA	18901	(215) 348-5778	Pediatric Dentistry
Rosenbaum	Michael	DMD	Pediatric Dental Associates, Ltd.	6404 Roosevelt Boulevard		Philadelphia	PA	19149	(215) 743-3700	Pediatric Dentistry
Rosenbaum	Michael	DMD	Pediatric Dental Associates, Ltd.	Front Street and Lehigh Avenue		Philadelphia	PA	19125	(215) 426-6760	Pediatric Dentistry
Singer	Jeffrey	DMD	ABC Children's Dentistry, LLC	1001 Laurel Oak Road	Suite C-2	Voorhees	NJ	08043	(856) 783-3515	Pediatric Dentistry
Suh	Yoosung	DMD	Charm Pediatric Dentistry, LLC	1040 DeKalb Pike	Suite 100	Blue Bell	PA	19422	(610) 277-4811	Pediatric Dentistry
Zurek	Jill		Signature Smiles	27-29 South New York Avenue		Atlantic City	NJ	08401	(609) 345-6600	Pediatric Dentistry
Zurek	Jill		Signature Smiles	120 S. 6th Street		Vineland	NJ	08360	(856) 692-5533	Pediatric Dentistry
Zurek	Jill		Signature Smiles	7 East Shell Bay Ave, #B		Cape May Court House	NJ	08210	(609) 463-1700	Pediatric Dentistry
Zurek	Jill		Signature Smiles	1103 West Sherman Avenue		Vineland	NJ	08360	(856) 692-9333	Pediatric Dentistry
			Charm Pediatric Dentistry, LLC	1040 DeKalb Pike	Suite 100	Blue Bell	PA	19422	(610) 277-4811	Pediatric Dentistry
			Doc Bresler's Cavity Busters	4659 West Chester Pike		Newtown Square	PA	19073	(484) 444-0700	Pediatric Dentistry
			Doc Bresler's Cavity Busters	1916 Welsh Road	Sutie 17	Philadelphia	PA	19115	(215) 676-2311	Pediatric Dentistry
			Holdbrook Pediatric Dental, LLC	250 Haddonfield -Berlin Road		Gibbsboro	NJ	08026	(856) 783-0444	Pediatric Dentistry
			Holdbrook Pediatric Dental, LLC	553 Beckett Road	Suite 604	Swedesboro	NJ	08085	(856) 556-4020	Pediatric Dentistry
			Fairless Hills Dental Center	532 South Oxford Valley Road		Fairless Hills	PA	19030	(215) 946-3655	Periodontics
			Greentree Periodontics	9002 Lincoln Drive West	Suite H	Marlton	NJ	08053	(856) 983-3450	Periodontics
			Signature Smiles	266 Georgetown Road		Carneys Point	NJ	08069	(856) 299-0030	Periodontics
Ayad	Maged G.	DDS	The Dennis Center	63 Garrett Lane		Willingboro	NJ	08046	(609) 871-0900	Periodontics
Berger	Marvin		American Dental Care, PC	9229 Roosevelt Boulevard		Philadelphia	PA	19114	(215) 969-0900	Periodontics
Bichera	Jean	DDS, MS		11621 Bustleton Avenue		Philadelphia	PA	19116	(215) 673-8887	Periodontics

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
Bichera	Jean	DDS, MS		333 N Oxford Valley Rd	Suite 507	Fairless Hills Washington	PA	19030	(215) 547-4215	Periodontics
Bichera	Jean	DDS, MS	Colonial Dental Associates	1091 General Knox Road		Crossing	PA	18977	(215) 493-9525	Periodontics
Delie	Robert		American Dental Care, PC	6162 Ridge Avenue		Philadelphia	PA	19128	(215) 483-1900	Periodontics
Delie	Robert		American Dental Care, PC	187 E. City Avenue		Bala Cynwyd	PA	19004	(610) 667-9713	Periodontics
Delie	Robert A.		Patelka Dental, LLC	8332 Bustleton Avenue	Unit C	Philadelphia	PA	19152	(215) 342-9000	Periodontics
Delie	Robert A.		Patelka Dental, LLC	8037 Frankford Avenue	Second Floor	Philadelphia	PA	19136	(215) 338-5454	Periodontics
Eisenstein	Ira		Dr. Harold Marcus & Associates	7215 Passyunk Avenue		Philadelphia	PA	19142	(215) 727-1800	Periodontics
Kaye	Ralph J.	DMD	Mayfair Dental Associates, Ltd.	3541 Ryan Avenue		Philadelphia	PA	19136	(215) 335-1889	Periodontics
Krochtengel	Alan L.	DMD	Bucks County Periodontics	809 Bethlehem Pike	Building C A-2	North Wales	PA	19454	(215) 628-8007	Periodontics
Krochtengel	Alan L.	DMD	Bucks County Periodontics	3554 Hulmeville Road	Suite 109	Bensalem	PA	19020	(215) 639-7770	Periodontics
Lu	John	DMD	American Dental Care, PC	437 Chestnut Street	Suite 500	Philadelphia	PA	19106	(215) 625-4865	Periodontics
Lu	John	DMD	American Dental Care, PC	1003 W. Baltimore Pike		Media	PA	19063	(610) 891-0940	Periodontics
Shamseddin	Seyed	DMD	American Dental Care, PA	2 Sheppard Drive		Voorhees	NJ	08043	(856) 751-6546	Periodontics
Shamseddin	Seyed	DMD	American Dental Care, PA	1450 Clements Bridge Road		Woodbury	NJ	08096	(856) 845-6222	Periodontics
Shamseddin	Seyed	DMD	American Dental Care, PC	437 Chestnut Street	Suite 500	Philadelphia	PA	19106	(215) 625-4865	Periodontics
Shamseddin	Seyed	DMD	American Dental Care, PC	2385 Cheltenham Avenue	Washington	Philadelphia	PA	19150	(215) 886-7177	Periodontics
Shamseddin	Seyed	DMD	American Dental Care, PC	6780 Market Street		Upper Darby	PA	19082	(610) 352-7600	Periodontics
Shamseddin	Seyed	DMD	American Dental Care, PC	722 Market Street		Philadelphia	PA	19106	(215) 922-5100	Periodontics
Shamseddin	Seyed M.	DDS	Greentree Periodontics	9002 Lincoln Drive West	Suite H	Marlton	NJ	08053	(856) 983-3450	Periodontics
Shechtman	Alan	DDS, PC		255 South 17th Street	Suite 1901	Philadelphia	PA	19103	(215) 546-8868	Periodontics
Shechtman	Alan	DDS, PC		2417 Welsh Road	Suite 209	Philadelphia	PA	19114	(215) 671-0809	Periodontics
Uzel	Mehmet	DMD		817 North Easton Road		Doylestown	PA	18901	(215) 348-4041	Periodontics
			A+ Periodontic Specialty Care, PC	8355 Loretto Avenue	Suite 104	Philadelphia	PA	19152	(215) 342-5750	Periodontics
			A+ Periodontic Specialty Care, PC	8001 Roosevelt Boulevard	Suite 200	Philadelphia	PA	19152	(215) 268-9655	Periodontics
			A+ Periodontic Specialty Care, PC	24 South 14th Street		Quakertown	PA	18951	(215) 536-3210	Periodontics
			A+ Periodontic Specialty Care, PC	1950 Street Road	Suite 200	Bensalem	PA	19020	(215) 638-4696	Periodontics

Teamsters Health Welfare Fund  
Dental PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone	Dental Speciality
			A+ Periodontic Specialty Care, PC	404 Middletown Boulevard	Suite 300	Langhorne	PA	19047	(215) 757-4400	Periodontics
			A+ Periodontic Specialty Care, PC	1500 Horizon Drive	Suite 104	Chalfont	PA	18914	(215) 997-9980	Periodontics
			A+ Periodontic Specialty Care, PC	301 City Avenue	Suite G-5	Bala Cynwyd	PA	19004	(610) 660-9510	Periodontics
			A+ Periodontic Specialty Care, PC	456 School Lane	Suite 104	Harleysville	PA	19438	(215) 513-7172	Periodontics
			A+ Periodontic Specialty Care, PC	35-B Woodland Avenue		Morton	PA	19070	(610) 544-3630	Periodontics
			A+ Periodontic Specialty Care, PC	8 Pond's Edge Drive	Suite 2	Chadds Ford	PA	19317	(610) 388-4466	Periodontics
			A+ Periodontic Specialty Care, PC	479 Thomas Jones Way	Suite 600	Exton	PA	19341	(610) 280-7222	Periodontics
			A+ Periodontic Specialty Care, PC	1901 Union Boulevard		Allentown	PA	18109	(610) 437-5353	Periodontics
			A+ Periodontic Specialty Care, PC	1247 S. Cedar Crest Blvd.	Suite 300	Allentown	PA	18103	(610) 628-1228	Periodontics
			A+ Periodontic Specialty Care, PC	2230 N. 5th St. Highway		Reading	PA	19605	(610) 371-8844	Periodontics
			A+ Periodontic Specialty Care, PC	1555 Highlands Drive	Suite 190	Lititz	PA	17543	(717) 303-3051	Periodontics
			Patelka Dental, LLC	8037 Frankford Avenue	Second Floor	Philadelphia	PA	19136	(215) 338-5454	Periodontics
			Patelka Dental, LLC	8332 Bustleton Avenue	Unit C	Philadelphia	PA	19152	(215) 342-9000	Periodontics
Cerato	Stuart	DDS		11621 Bustleton Avenue		Philadelphia	PA	19116	(215) 673-8887	Prosthodontics
Hertzog	Charles F.	DMD	Hanover Family Dental Group, Inc.	1885 Swamp Pike	Suite 110	Gilbertsville	PA	19525	(610) 326-4448	Prosthodontics
Shafagh	Iraj	DDS		109 North Eagle Road		Havertown	PA	19083	(610) 446-6688	Prosthodontics

Teamsters Health Welfare Fund  
Vision PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone
			Eye Care Associates	1015 Chestnut Street	Suite 417	Philadelphia	PA	19107	(215) 627-4448
			Eye Site	30 S. MacDade Boulevard		Glenolden	PA	19036	(610) 586-0651
			Galman & Friedberg Eye Assoc.	661 North Broad Street		Woodbury	NJ	08096	(856) 845-7968
			JMAM, Inc.	3550 Paxton Street		Harrisburg	PA	17111	(717) 564-7015
			Linsey Eyecare	1901 Ridgewood Road		Wyomissing	PA	19610	(610) 373-2300
			Phila. Eyeglass Labs	1863 Street Road		Bensalem	PA	19020	(215) 638-8448
			Phila. Eyeglass Labs	1030 Arch Street		Philadelphia	PA	19107	(215) 238-1444
			Phila. Eyeglass Labs	411 MacDade Boulevard		Glenolden	PA	19036	(610) 237-1600
			Phila. Eyeglass Labs	1547 West Passyunk Avenue		Philadelphia	PA	19145	(215) 334-3652
			Phila. Eyeglass Labs	32 E. Germantown Pike		Norristown	PA	19401	(610) 272-1440
			Soffer Eye Care Center	217 West Main Street		Norristown	PA	19401	(610) 279-0431
			Tristate Eyecare Associates	928 North Route 73		Marlton	NJ	08053	(856) 596-8883
			Warrington Eye Care	1432 Easton Road	Suite 3E	Warrington	PA	18976	(215) 491-6000
Berger	William S.	OD		825 South Delsea Drive		Vineland	NJ	08360	(856) 794-3007
Berger	William S.	Dr.		743 North Delsea Drive		Glassboro	NJ	08028	(856) 582-0098
Byrne	William	Dr.		333 N. Oxford Valley Road	Suite 101	Fairless Hills	PA	19030	(215) 945-3535
Cluff	Elizabeth	Dr.	Middletown Eye Care	401 East Main Street	Unit B, Building 3	Middletown	DE	19709	(302) 378-8818
Davis	Lawrence	Dr.		108 East Girard Avenue		Philadelphia	PA	19125	(215) 739-8775
Diering	John		Dr. Valerie DiPietro-Longo	900 Route 168	Suites E5-6	Blackwood	NJ	08012	(856) 881-4949
Fanelli	Gregory	Dr.	University Executive Campus	151 Fries Mill Road	Suite 306	Turnersville	NJ	08012	(856) 227-3340
Fleming	Theresa	Dr		101 North Broadway		Pennsville	NJ	08070	(856) 678-2288
Foxman	Norman	Dr		1266 Providence Road		Secane	PA	19018	(610) 543-1219
Fuchs	Milton	Dr.		1333 Buck Road	Suite 6	Feasterville	PA	19053	(215) 357-1479
Galanter	Robert	Dr	Dr. Joel Laveson	508 Broadway		Camden	NJ	08103	(856) 541-6131
Hirshorn	Carl	OD	Bayside Eye Center	2004 Bayshore Road		Villas	NJ	08251	(609) 886-1578
Kaistha	Arun	Dr.	Cooper River Eye Associates, LLC	6981 North Park Drive	Suite 101	Pennsauken	NJ	08109	(856) 488-4404



Teamsters Health Welfare Fund  
Vision PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone
Karliner	Michael	Dr.		590 Oregon Avenue		Philadelphia	PA	19148	(215) 334-2424
Kovens	Arthur S.	Dr.		111 Mt. Carmel Road	Suite 600	Parkton	MD	21120	(410) 329-6700
Kron	Brian	Dr.		1414 South 5th Street		Philadelphia	PA	19147	(215) 339-0991
Kueny	Timothy S.	Dr.	Warrington Eye Care	1432 Easton Road	Suite 3E	Warrington	PA	18976	(215) 491-6000
Landrum	Henry	Dr.		1808 Shunk Street		Philadelphia	PA	19145	(215) 334-2020
Lipsitz	Jacob		Dr.	303 Avon Street		Philadelphia	PA	19116	(215) 676-7755
Magro	Michael F.	Dr.	Dr.Uptown Optometric Center	929 Penn Street		Reading	PA	19601	(610) 376-7872
Melman	Edward	Dr.		22 Eagle Plaza		Voorhees	NJ	08043	(856) 783-1041
Monteleone	Anthony	Dr.		1302 North Delsea Drive		Vineland	NJ	08360	(856) 696-3904
Murphy	Jonathan	Dr.	JMAM, Inc.	3550 Paxton Street		Harrisburg	PA	17111	(717) 564-7015
Page	Scott	Dr.	Dr. Peter Sheridan	7601 Castor Avenue	The Paul Biggans Ctr. 2nd Fl.	Philadelphia	PA	19132-4026	(215) 725-4418
Page	Scott	Dr.	Dr. Peter Sheridan	1015 Chestnut Street	Suite 417	Philadelphia	PA	19107	(215) 627-4448
Parker	Henry	Dr.		8595 Bustleton Avenue		Philadelphia	PA	19152	(215) 722-1133
Parker	Jacob	Dr.		8595 Bustleton Avenue		Philadelphia	PA	19152	(215) 722-1133
Patel	Jignesh	Dr.	Optical @ 309	1250 Bethlehem Pike	Unit J	Hatfield	PA	19440	(215) 996-1445
Patel	Rupal	Dr.	Cooper River Eye Associates, LLC	6981 North Park Drive	Suite 101	Pennsauken	NJ	08109	(856) 488-4404
Reda	Joseph	Dr.		2401 S Rt. 130		Cinnaminson	NJ	08077	(856) 786-1616
Salth	Robert	Dr.		123 East Laurel Road		Stratford	NJ	08084	(856) 784-0935
Semmel	William J.	Dr.	Total Eye Care	3323 Hamilton Boulevard		Allentown	PA	18103	(610) 776-6600
Shapiro	Amiram	Dr.		1115 Roseglen Road		Gladwyne	PA	19035	(610) 896-8870
Sheridan	Peter	Dr.	Eye Care Associates	7601 Castor Avenue	The Paul Biggans Ctr. 2nd Fl.	Philadelphia	PA	19111	(215) 725-4418
Sheridan	Peter	Dr.	Eye Care Associates	1015 Chestnut Street	Suite 417	Philadelphia	PA	19107	(215) 627-4448
Soffer	Allen	Dr.	Soffer Eye Care Center	217 West Main Street		Norristown	PA	19401	(610) 279-0431
Staab	Albert	Dr.	Evesham Eye Associates	151 Greentree Road	Suite B	Marlton	NJ	08053	(856) 985-0066
Staab	Albert	Dr.	Evesham Eye Associates	709 Stokes Road		Medford	NJ	08055	(609) 654-4988
Tan	Imelda		Dr.	3166 Kensington Avenue		Philadelphia	PA	19134	(215) 425-3937

Teamsters Health Welfare Fund  
Vision PPO Providers

Last Name	First Name	Degree	Office	Address 1	Address 2	City	State	Zip	Phone
Walker	Nathan	Dr.	Eye Site	30 S. MacDade Boulevard		Glenolden	PA	19036	(610) 586-0651
Wolbransky	Harvey	Dr.	Cooper River Eye Associates	6981 North Park Drive	Suite 101	Pennsauken	NJ	08109	(856) 488-4404
Young	Roger	OD	Bayside Eye Center	2004 Bayshore Road		Villas	NJ	08251	(609) 886-1578
Zimmerman	James	Dr.		Deptford Mall, 1172	(Lower Level near Strawbridges)	Deptford	NJ	08096	(609) 848-6400
			Bayside Eye Center	2004 Bayshore Road		Villas	NJ	08251	(609) 886-1578
			Bonds Eye Care, Inc.	1227 Horseshoe Pike 410 West Linfield Trappe		Downingtown	PA	19335	(610) 269-3177
			Brandywine Vision Associates, PC	Road	Suite 130	Royersford	PA	19468	(610) 495-7050
			Cooper River Eye Associates, LLC	6981 North Park Drive	Suite 101	Pennsauken	NJ	08109	(856) 488-4404
			Eye Care Associates	7601 Castor Avenue	The Glenview Business Center	Philadelphia	PA	19111	(215) 725-4418
			Phila. Eyeglass Labs	44 Rittenhouse Pl.		Ardmore	PA	19003	(610) 649-1767
			Philadelphia Eyeglass Lab	752 Horsham Road		Montgomeryville	PA	18936	(215) 368-1600
			Town Vision Associates, LLC	38 Washington Avenue		Williamstown	NJ	08094	(856) 318-1062

# Welcome to the Health Care Solutions Corporation (HCSC) alternative outpatient testing program for PPO participants

The Teamsters Health and Welfare Fund has contracted with HCSC to provide an alternative, cost effective outpatient testing program that will save our members valuable health care dollars. The program covers all outpatient x-ray, medical imaging procedures, laboratory, pathology and cardiac stress testing. If your doctor has prescribed a covered outpatient medical test, you can save yourself money by using the HCSC outpatient testing benefit program. It's easy, simple and a substantial savings for you and your family.

## “So what’s covered?”

Computerized Tomography (CT)  
Magnetic Resonance (MRI)  
Magnetic Resonance (MRA)  
Ultrasound's  
Mammography  
General X-ray  
Nuclear Medicine scans  
PET scans  
Bone density scanning

## “What do I do to use the HCSC program and where do I go?”

### For outpatient laboratory testing

Take your lab prescription to any **Labcorp, Quest, or Health Network Lab** draw site for your outpatient lab procedure. If your doctor draws your blood at his office, specify your desired laboratory provider. Use your primary insurance card. You do not need an authorization number. For any outpatient lab services there is no copay, member deductible, or coinsurance. To find a lab near you, go to [www.hcsolutionscorp.com](http://www.hcsolutionscorp.com) where you will be linked to draw sites. *If asked for a credit card, under no circumstances offer your credit card. Decline this request! You are 100% covered.*



## “How about x-ray, Cardiology testing or medical imaging like Cat Scan, MRI and Ultrasound?”

### For any outpatient x-ray or medical imaging procedures

You need to contact HCSC at 1-800-655-8125. You will be given a choice of network providers near your home or work. You may also access [www.hcsolutionscorp.com](http://www.hcsolutionscorp.com). A procedure authorization number will be issued to you. There is no waiting for your doctor’s office to call you! You are already preapproved for your procedure. You contact the provider and schedule your appointment. It’s that easy! Instead of deductibles and co-insurance, you can have the x-ray or medical imaging procedure you need for a \$20 copay and nothing else.



## Where to place your new Health Care Solutions Corporation ID sticker

Health Care Solutions Corporation,  
14 Mystic Lane, Malvern, Pennsylvania, 19355  
Phone: 1-800-655-8125

**Labcorp, Quest, HNL** X-ray precertification required

Health Care Solutions Corporation,  
14 Mystic Lane, Malvern, Pennsylvania, 19355  
Phone: 1-800-655-8125

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14 Mystic Lane, Malvern, Pennsylvania, 19355  
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**Labcorp, Quest, HNL** X-ray precertification required

Remove a sticker and place it on your primary health insurance card.

Do not block important ID numbers. You may place a sticker on either side of your insurance card.

If you have any questions, contact HCSC at 1-800-655-8125.

# Health Care Solutions Corporation: **Diabetic Supply Program**

*“A special Teamsters Health Fund benefit for your Type I, or type II diabetic testing supplies”*



If your doctor is treating you for Type I or Type II diabetes, you need to contact *HCSC* for your important diabetic supplies. Your Teamsters Health Fund has arranged for the very best **brand name** diabetic testing products to manage your diabetes testing care.

**Contact HCSC at:  
1-800-655-8125**

## Abbott Freestyle Meters and Test Strips



### Your new program has:

**Diabetic test strips, Starter kits, Test meters (free), Syringes, Lancets, Alcohol swabs, Replacement pen needles, Sharps container, Free shipping, Renewal notices, Toll free number.**

### Look at your savings!

**Freestyle test strips: No copy**  
**New Test meter: Free**  
**Starter Kits: Free**  
**Syringes: No copy**  
**Fits all pens lancets: No copy**  
**Pen Needles: No copy**  
**Test Solution: No copy**  
**Alcohol swabs: Free**  
**Shipping: Free**  
**Toll Free reorder**



100 Ulticare pen needles fits any prefilled pen. Includes sharps container



Ultrasharp lancets



100 syringes w/sharps container



*“Another cost saving product brought to you by your health and welfare fund.”*

Teamsters Health Fund  
of Philadelphia and Vicinity  
6981 N. Park Drive, Suite 400  
Pennsauken, New Jersey 08109  
Tel. 1-800-523-2846

### Why your health fund is providing this new diabetic supply benefit

Your health fund recognizes the financial strain your diabetic supplies are placing on your budget. If you participate in the diabetic supply program, you will receive the best brand name diabetic testing products delivered to your door. This new benefit comes to you with a minimum, or no-copy responsibility.

**Yes! You can switch from your existing diabetic testing supply to the Abbott Laboratories Freestyle products. Test meters are free to you.**

**TEAMSTERS HEALTH and WELFARE FUND**  
**6981 NORTH PARK DRIVE**  
**SUITE 400**  
**PENNSAUKEN, NJ 08109**

**SEE INSTRUCTIONS ON BACK**

FUND USE ONLY

WEEKLY BENEFITS (COMPANY STATEMENT ON BACK MUST BE COMPLETED)

**PATIENT INFORMATION (TO BE COMPLETED BY MEMBER)**

1 PATIENT'S NAME (First name, middle initial, last name)		2A PATIENT'S DATE OF BIRTH	2B PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3 MEMBER'S NAME (First name, middle initial, last name)	
4 PATIENT'S ADDRESS (Street, city, state, zip code)		5 MEMBER'S EMPLOYER		6 MEMBER'S SOCIAL SECURITY NO	
		7 PATIENT'S RELATIONSHIP TO INSURED (CIRCLE ONE) SELF SPOUSE CHILD OTHER		8 MEMBER'S LOCAL NO RETIRED YES <input type="checkbox"/> NO <input type="checkbox"/>	
9 IS PATIENT FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO  SCHOOL _____ IS PATIENT EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/>  EMPLOYER _____  PHONE _____		10 WAS CONDITION RELATED TO:  A PATIENT'S EMPLOY YES <input type="checkbox"/> NO <input type="checkbox"/> B AN ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES to either of the above questions give DATE _____ 19__ TIME _____ DESCRIPTION HOW WHERE		11 MEMBER'S ADDRESS (Street, city, state, zip code)  _____  _____  PHONE _____	
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <i>1. Authorize the Release of any Medical Information Necessary to Process this Claim</i> SIGNED _____ DATE _____				13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW SIGNED (Insured or Authorized Person) _____	

**PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)**

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM? <input type="checkbox"/> YES <input type="checkbox"/> NO			
17 DATE PATIENT ABLE TO RETURN TO WORK		18 DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	19 IN YOUR OPINION WAS THE DISABILITY DUE TO OCCUPATIONAL SICKNESS OR ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
19 NAME OF REFERRING PHYSICIAN			20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____			
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)			22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO charges			
23 ICD-CM CODE		23A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 OR DX CODE				
1 _____	1 _____					
2 _____	2 _____					
3 _____	3 _____					
A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURE MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE* (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*		D DIAGNOSIS CODE	E CHARGES	F
25 YOUR PATIENT'S ACCOUNT NO				26 TOTAL CHARGE	27 AMOUNT PAID	28 BALANCE DUE
29 SIGNATURE OF PHYSICIAN OR SUPPLIER		DATE	SOCIAL SECURITY NO	ADDRESS		
30 COMPLETE THE FOLLOWING AS IT SHOULD APPEAR FOR TAX PURPOSES:						
PHYSICIAN'S OR SUPPLIER'S NAME		TAXPAYER IDENTIFICATION NUMBER (1099 REPORTING PURPOSES)		ADDRESS _____		
PHONE _____						

- \*PLACE OF SERVICE CODES
- 1 - (IH) - INPATIENT HOSPITAL
- 2 - (HO) - OUTPATIENT HOSPITAL
- 3 - (O) - DOCTOR'S OFFICE
- 4 - (H) - PATIENT'S HOME
- 5 - (PSY) - DAY CARE FACILITY
- 6 - (PSY) - NIGHT CARE FACILITY
- 7 - (NH) - NURSING HOME
- 8 - (SNF) - SKILLED NURSING FAC.
- 9 - (AMB) - AMBULANCE
- 0 - (OL) - OTHER LOCATIONS
- A - (IL) - INDEPENDENT LABORATORY
- B - (M) - OTHER MEDICAL/SURGICAL FACILITY

**COMPANY STATEMENT:**  
(TO BE COMPLETED BY  
EMPLOYER ONLY)

Complete this section along with the information on reverse side of the form, only if you are applying for Weekly Disability benefits (Loss of Time). Do not attach Physician bills to a Weekly benefit claim, it will result in a delay of payment of your Weekly benefits.

1. Employee's Name _____	2. Date Employed _____
3. Employee's Occupation _____	
4. Date Employee Last Worked _____ / _____ / _____ Time of Day _____	
Reason for Stopping Work _____	
5. Is any of this time after employee last worked Paid Vacation? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, specify dates _____	
Is any of this time after employee last worked Paid Sick Time? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, specify dates _____	
6. Date Employee Returned to Work _____ / _____ / _____	
7. Is this Accident or Sickness Due to Employment? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, has Employee applied for Workman's Compensation? _____	
8. Prior to this Disability was the Employee <input type="checkbox"/> Laid Off <input type="checkbox"/> On Leave <input type="checkbox"/> Retired <input type="checkbox"/> Discharged	
Company name & address _____	
Date _____ Signed by _____	
Phone No. _____ Extension _____	

## "QUICK PAYMENT" INSTRUCTIONS

1. YOU MUST USE A SEPARATE CLAIM FORM FOR EACH DIFFERENT TYPE CLAIM. FOR EXAMPLE — IF YOU ARE SUBMITTING A HOSPITAL CLAIM, PHYSICIAN CLAIM AND A WEEKLY BENEFIT CLAIM, YOU MUST COMPLETE 3 OF THESE CLAIM FORMS.
2. COMPLETE THE "PATIENT AND MEMBER (INSURED INFORMATION" ITEMS 1 THROUGH 12) ON THE REVERSE SIDE OF THIS FORM.  

If you wish your medical benefits paid directly to your doctor, sign item 13. A separate form should be submitted for each family member.
3. HAVE YOUR DOCTOR COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION" (ITEMS 14 THROUGH 30) OR SUBMIT COMPLETELY ITEMIZED BILLS. NOTE — IF PAYMENT IS BEING MADE TO THE MEMBER, AN ITEMIZED BILL MUST BE ATTACHED TO EACH CLAIM.  

An itemized bill is one that shows the patient's name, date of service, the type of service, the charge for each type of service and the nature of the condition being treated.
4. PLEASE FURNISH FULL AND COMPLETE DETAILS, IF ANY REQUIRED INFORMATION IS NOT GIVEN IT WILL BE NECESSARY TO RETURN THE FORM FOR COMPLETION BEFORE THE CLAIM CAN BE PROCESSED.

NOTE: This form is not to be used to obtain Vision or Dental Benefits.

### FOR DOCTOR/HOSPITAL

For your convenience, the Fund will accept computer generated invoices that contain essentially the information requested on this claim form. To maintain control, dated signatures for release of medical information and authorization of payment must be attached to the computer generated form and the computer should print signature attached in the appropriate spaces

Do not attach Physician bills when providing information on a weekly disability claim (Loss of time benefits)

# Pharmacy Reimbursement Claim Form.

Please read the back for instructions. Complete all information.  
**An incomplete form may delay your reimbursement.**

## Member/Subscriber Information

Member ID

Member Name (First, Last) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Patient Information

Patient Name (First, Last) \_\_\_\_\_

Patient Date of Birth (Month/Day/Year)

Gender	Relationship to Member/Subscriber	
<input type="checkbox"/> Female	<input type="checkbox"/> <sub>1</sub> Self	<input type="checkbox"/> <sub>4</sub> Dependent Student
<input type="checkbox"/> Male	<input type="checkbox"/> <sub>2</sub> Spouse	<input type="checkbox"/> <sub>5</sub> Disabled Dependent
	<input type="checkbox"/> <sub>3</sub> Eligible Child	<input type="checkbox"/> <sub>6</sub> Dependent Parent

## Pharmacy Information

Name of Pharmacy \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Include Area Code)

**X** \_\_\_\_\_

Signature of Pharmacist or Representative NCPDR#NPI# (Pharmacy Acct. #)  
(11 Digit Number)

## Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

**X** \_\_\_\_\_  
 Signature of Member/Subscriber

\_\_\_\_\_  
 Date

## Claim Receipts

(Please read Section A on back for details.)

Check the appropriate box if your receipts are for a:

- Compound prescription**  
 Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and ingredients and quantities on the receipt.
- Medication purchased outside of the United States**  
 Please indicate:  
 Country \_\_\_\_\_  
 Currency Used \_\_\_\_\_

## Allergy medication

## Coordination of Benefits

(Another Health Plan has paid a portion)

Is this a coordination of benefits claim?

Yes  No

If yes, please read Section B on back for details, and mark the appropriate box for your primary coverage method.

- <sub>1</sub> You are submitting an Explanation of Benefits (EOB) from another Health Plan or from Medicare
- <sub>3</sub> You are submitting a copay receipt

Any person who knowingly and with intent to defraud, injure or deceive the Teamsters Health and Welfare Fund, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.

**Please tape receipts on the back.**

**Instructions**

**Read carefully before completing this form**

1. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed below. Your pharmacist can provide the necessary information if your claim is not itemized.
2. The member/subscriber should read the acknowledgment carefully, then sign and date this form.
3. **Return the completed form and receipt(s) to:** **Teamsters Health and Welfare Fund of Philadelphia and Vicinity**  
6981 North Park Drive, Suite 400  
Pennsauken, NJ 08109

**Section A - Claim Receipts**

Please tape your pharmacy receipts (not the cash register receipt) to this side of the claim form. **Please do not staple.**

**Receipts must contain the following information.**

- Date prescription filled
- Name of drug and strength
- DAW (Dispense as Written)
- Name and address of pharmacy
- Quantity and days' supply
- Total charge
- Doctor's name or ID number
- Prescription number (Rx number)
- Patient liability
- NDC number (drug number)

**TAPE YOUR PHARMACY RECEIPTS HERE**

If you have additional receipts, tape them to a separate piece of paper.

**PHARMACY INFORMATION (For Compound Prescriptions ONLY)**

- List the VALID 11 digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX#	Date Filled	Days' Supply	
Valid 11 digit NDC#		Quantity	
Total Quantity			
Total Charge			

**Section B - Coordination of Benefits**

- You must complete a **separate** claim for each pharmacy used and for each patient.
- You must submit claims within one year of date of purchase.

**You are submitting an Explanation of Benefits (EOB) from another Health Plan or from Medicare**

If you have not already done so, submit the claim to the Primary Plan. Once the EOB is received, complete this form, tape the original prescription receipt(s) in the spaces provided above, and attach the EOB from the Primary Plan, which clearly indicates the cost of the prescription and what was paid by the Primary Plan.

**You are submitting a copay receipt**

If your Primary Plan is one in which a copayment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s). The receipt(s) will serve as the EOB.



**TEAMSTERS HEALTH AND WELFARE FUND**  
*of Philadelphia and Vicinity*

**REPORT OF CONTINUED DISABILITY**

This report must be filled out and returned  
before any additional payments can be made to you.

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**I. CLAIMANT'S STATEMENT**

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1. Name \_\_\_\_\_ Social Security Number \_\_\_\_\_
  2. Are you still unable to work because of total disability? \_\_\_\_\_ Yes \_\_\_\_\_ No
  3. If not now disabled, on what date did you return to work? \_\_\_\_\_
  4. If not now working, when will you probably do so? \_\_\_\_\_
  5. Have you been attended by a physician since the date of last report? \_\_\_\_\_ Yes \_\_\_\_\_ No. If yes, give dates of attendance by physicians:
    - a. At hospital \_\_\_\_\_
    - b. At physician's office \_\_\_\_\_
    - c. At home \_\_\_\_\_
  6. Has there been any hospitalizations not covered in previous report? \_\_\_\_\_ If yes, give name and address of hospital \_\_\_\_\_
    - a. Date admitted \_\_\_\_\_
    - b. Date discharged \_\_\_\_\_
  7. Have you received, since the commencement of your disability, any payments from your employer for vacation, sick leave or any other form of paid leave? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, list dates and amounts received.  
\_\_\_\_\_
- Date \_\_\_\_\_ Signature \_\_\_\_\_
- 

**II. ATTENDING PHYSICIAN'S STATEMENT**

---

1. Name of patient \_\_\_\_\_
  2. Are there any new complications since date of last report? \_\_\_\_\_ If yes, give details  
\_\_\_\_\_  
\_\_\_\_\_
  3. Is the patient now physically unable to work because of injury or sickness? \_\_\_\_\_ Yes \_\_\_\_\_ No
  4. When, in your opinion, will he (she) be able to work? \_\_\_\_\_
  5. Is the patient able to do light duty work if available? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, give details \_\_\_\_\_
  6. Please give the dates of all calls since last report:
    - a. At hospital \_\_\_\_\_
    - b. At your office \_\_\_\_\_
    - c. Elsewhere (home, etc.) \_\_\_\_\_
- Date \_\_\_\_\_ Signature \_\_\_\_\_
- Address \_\_\_\_\_ Phone Number \_\_\_\_\_

(over)

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### III. EMPLOYER'S STATEMENT

---

1. Name of employer \_\_\_\_\_
2. If employee is back to work, give date of return \_\_\_\_\_
3. If employee is able to do light duty work, is it available? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, provide date light duty work is available \_\_\_\_\_
4. If employee is not back to work, when do you expect him back \_\_\_\_\_
5. Since the employee's last day of work, have any payments been made to the employee for vacation, sick leave or any other form of paid leave? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, list dates, type of paid leave and amounts.

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Date \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signed By: \_\_\_\_\_

**ADA Dental Claim Form**

**Teamsters Health and Welfare Fund**  
**6981 North Park Drive Suite 400**  
**Pennsauken, NJ 08109**  
**1-800-523-2846**

**HEADER INFORMATION**

1. Type of Transaction (Check all applicable boxes)  
 Statement of Actual Services - OR -  Request for Predetermination/Preauthorization  
 EPSDT/Title XIX

2. Predetermination/Preauthorization Number

**PRIMARY PAYER INFORMATION**

3. Name, Address, City, State, Zip Code

**OTHER COVERAGE**

4. Other Dental or Medical Coverage?  No (Skip 5-11)  Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)      7. Gender  M  F      8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number      10. Relationship to Primary Subscriber (Check applicable box)  
 Self  Spouse  Dependent  Other

11. Other Carrier Name, Address, City, State, Zip Code

**PRIMARY SUBSCRIBER INFORMATION**

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)      14. Gender  M  F      15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number      17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Primary Subscriber (Check applicable box)  
 Self  Spouse  Dependent Child  Other      19. Student Status  FTS  PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)      22. Gender  M  F      23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

1	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
2								
3								
4								
5								
6								
7								
8								
9								
10								

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J							
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K							
35. Remarks																																	33. Total Fee

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X \_\_\_\_\_  
 Patient/Guardian signature      Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X \_\_\_\_\_  
 Subscriber signature      Date

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment (Check applicable box)  
 Provider's Office  Hospital  ECF  Other      39. Number of Enclosures (00 to 99)  
 Radiograph(s)      Oral Image(s)      X-ray(s)

40. Is Treatment for Orthodontics?  
 No (Skip 41-42)  Yes (Complete 41-42)      41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining      43. Replacement of Prosthesis?  
 No  Yes (Complete 44)      44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)  
 Occupational illness/injury  Auto accident  Other accident

46. Date of Accident (MM/DD/CCYY)      47. Auto Accident State

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID      50. License Number      51. SSN or TIN

52. Phone Number ( ) -

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X \_\_\_\_\_  
 Signed (Treating Dentist)      Date

54. Provider ID      55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) -      58. Treating Provider Specialty

**VISION CARE FORM**

TEAMSTERS HEALTH AND WELFARE FUND  
6981 NORTH PARK DRIVE SUITE 400  
PENNSAUKEN, NJ 08109

IN ORDER TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLY WITH THE FUND'S ELIGIBILITY REGULATIONS AND MUST BE AT LEAST TWO YEARS FROM LAST USING THIS BENEFIT.

THIS FORM DOES NOT GUARANTEE PAYMENT

PLEASE CALL FUND OFFICE TO VERIFY 2 YEAR LIMIT AND ELIGIBILITY

CLAIM NUMBER

**PATIENT INFORMATION TO BE COMPLETED AND SIGNED BY MEMBER**

1. PATIENT'S NAME (First name, middle name, last name)	2. A. PATIENT'S DATE OF BIRTH	2. B. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3. MEMBER'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. MEMBER'S EMPLOYER		6. MEMBER'S SOCIAL SECURITY NO.
			MEMBER'S LOCAL NO.

WAS VISION CARE REQUIRED BECAUSE OF INJURY?  YES  NO IF YES, COMPLETE QUESTIONS BELOW

WAS INJURY CAUSED BY WORK?  YES  NO HAVE YOU FILED A CLAIM FOR THE DISABILITY WITH WORKMAN'S COMPENSATION?  YES  NO

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE MY DOCTOR OR ANY INDIVIDUAL OR ORGANIZATION TO RELEASE AND DISCLOSE ALL FACTS CONCERNING THIS VISION TREATMENT.

MEMBERS SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**TO BE COMPLETED BY DOCTOR**

HAS PATIENT WORN GLASSES BEFORE THIS EXAMINATION?  YES  NO PRESCRIPTION?  YES  NO

IF REPLACEMENT, INDICATE CHANGE IN DIOPTRER AND DEGREE OF AXIS FROM PREVIOUS PRESCRIPTION. \_\_\_\_\_

HAS CATARACT SURGERY BEEN PERFORMED?  YES  NO PATIENT'S NAME \_\_\_\_\_

IF YES, GIVE DATE OF SURGERY: \_\_\_\_\_

**PLEASE COMPLETE ONLY AFTER FITTING OF APPLIANCES**

INDICATE CHARGES FOR THE FOLLOWING SERVICES AND MATERIALS		FUND USE ONLY	
EXAMINATION: DATE: _____	\$ _____		
LENS: <input type="checkbox"/> SINGLE <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> LENTICULAR <input type="checkbox"/> GLASS <input type="checkbox"/> PLASTIC	\$ _____		
FRAMES: _____ (American Made Only)	\$ _____		
TOTAL COSTS TO PATIENT	\$ _____		

AN ITEMIZED BILL FOR THE ABOVE MUST BE ATTACHED TO THIS CLAIM FORM

SIGNATURE BY THE DOCTOR CERTIFIES THAT ALL SERVICE LISTED ABOVE HAVE BEEN COMPLETED		INDIVIDUAL PRACTITIONERS SOC. SEC. No.	— —
DOCTORS SIGNATURE: _____	DTE: _____	TAX I.D. NUMBER	—
TYPE OR PRINT DOCTORS NAME _____	DEGREE _____	LICENSE NUMBER	_____
PHONE NUMBER: _____	ADDRESS _____		
PARTICIPATING DOCTOR <input type="checkbox"/> YES <input type="checkbox"/> NO CITY _____		STATE _____	ZIP CODE _____

**AUTHORIZATION TO PAY DOCTOR**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO: (NAME OF DOCTOR) \_\_\_\_\_

VISION CARE BENEFITS OTHERWISE PAYABLE TO ME UNDER MY VISION CARE PLAN, BUT NOT TO EXCEED THE ELIGIBLE CHARGES DECLARED ON THIS FORM.

I UNDERSTAND I AM FINANCIALLY LIABLE TO THE DOCTOR FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

MEMBERS SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

## ADULT DEPENDENT COVERAGE CERTIFICATION FORM

**Note: Certification is required annually. All information requested below MUST be completed.**

### **MEMBER INFORMATION (Please print or type):**

1. Social Security Number: \_\_\_\_\_
2. Name (First, Middle, Last): \_\_\_\_\_
3. Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_
4. Telephone Number: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

### **APPLYING FOR ADULT DEPENDENT COVERAGE: (The Adult Dependent must be enrolled in the same plan in which the member is enrolled.)**

To apply for Adult Dependent Coverage, this form must be completed and returned to the Fund office.

### **ADULT DEPENDENT INFORMATION (Please print or type):**

5. Dependent's Social Security Number: \_\_\_\_\_
6. Dependent's Name ((First, Middle, Last): \_\_\_\_\_
7. Is Dependent's address the same as the member? Yes  No  (If address is not the same as the member's, please list address below)
8. Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_
9. Telephone Number: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_
10. Dependent's Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
11. Relationship to member:  Natural/Adopted Child  Stepchild  Other \_\_\_\_\_  
(If other, please explain)
12. Please indicate effective date of coverage: \_\_\_\_\_

### **Please answer the following questions:**

- Is adult dependent married? Yes  No
- Does adult dependent have any dependents? Yes  No
- Is adult dependent enrolled as a full-time student at an accredited educational institution? Yes  No
- Please indicate the name of the educational institution \_\_\_\_\_
- Is the adult dependent eligible for or provided coverage under any other group or individual health insurance? Yes  No
- If yes, indicate name of employer group and insurance company \_\_\_\_\_
- Is the adult dependent able to be enrolled in or entitled to benefits under any government health care benefit program (i.e., Medicare, Medicaid)? Yes  No

**AUTHORIZATION FOR APPLICATION FOR ENROLLMENT:** I hereby apply for enrollment in health care coverage. I understand this application will be submitted to, and is subject to approval by, the Teamsters Health and Welfare Fund of Philadelphia and Vicinity, providing these and/or other health related benefits and will be subject to the terms of the Fund's Plan. As condition precedent to payment of claims, and in consideration therefore, I also agree that the Fund shall have all legal rights of subrogation on my behalf and/or on behalf of my dependents for recovery against third parties and/or other providers legally obligated to pay such claims. Such subrogation rights shall be satisfied in full prior to the receipt by me or my dependent of any additional recovery or damages from third parties and/or other persons or entities legally obligated to pay such claims. I further agree that I will direct any attorney that I may retain to satisfy such subrogation interest in full and as a priority prior to the distribution of any recovery to me or my dependent. Any additional documents required for release of any such information or records, or for subrogation, will be promptly signed by me and/or my dependent. I further understand that, if at any time I fail to provide accurate information to the Fund, I will be required to repay any payments made as a result of such misinformation and I will be subject to being disqualified from receiving future benefits for such period of time as the Fund deems appropriate. I understand that if I knowingly and with intent to defraud the Fund, file an application for benefits which contains materially false information or conceals information containing a material fact for the purpose of misleading, such actions by me may be deemed to be fraudulent and subject me to criminal prosecution and civil penalties. Finally, I understand that the information contained in this application for enrollment may be used by the Fund for such administrative and actuarial purposes as it deems appropriate.

Member's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Adult Dependent's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Note:** Eligibility for benefit coverage as an adult dependent and continuation of this coverage is subject to periodic evaluation and recertification. Should adult dependent or any other information on this certification form change at any time, benefit coverage may be reconsidered by the Fund.



# 2012 Express Scripts High Performance Formulary

The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription-drug benefit plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

**PLEASE NOTE:** The symbol \* next to a drug signifies that it is subject to nonformulary status when a generic is available throughout the year. Not all the drugs listed are covered by all prescription-drug benefit programs; check your benefit materials for the specific drugs covered and the copayments for your prescription-drug benefit program. For specific questions about your coverage, please call the phone number printed on your ID card.

**A**

ABILIFY (EXCLUDING DISCMLT & SOLUTION)  
 ACCU-CHEK LANCETS; MULTICLIX, SOFT TOUCH, SOFTCLIX  
 acetaminophen/codeine  
 ACTOPLUS MET\*, XR  
 ACTOS\*  
 acyclovir  
 adapalene  
 ADCIRCA  
 ADVAIR DISKUS, HFA  
 AGGRENOLX  
 albuterol  
 alendronate sodium  
 alfuzosin er  
 allopurinol  
 ALPHAGAN P 0.1%\*  
 amiodarone  
 AMITIZA  
 amitriptyline  
 amlodipine, /benazepril  
 amox tr/potassium clavulanate  
 amoxicillin  
 amphetamine salt combo, er  
 AMPYRA  
 anastrozole  
 antipyrine/benzocaine  
 apri  
 APRISO  
 arbinoxa  
 ARIXTRA\* [INJ]  
 ASTEPRO  
 atenolol, /chlorthalidone  
 aviane  
 azathioprine  
 azelastine  
 azithromycin

**B**

baclofen  
 balsalazide disodium  
 benazepril, /hctz  
 benzonatate  
 BETASERON [INJ]  
 brimonidine tartrate

budesonide neb susp  
 bupropion, 12 hr, 24 hr  
 butalbital/apap/caffeine  
 BYETTA [INJ]

**C**

calcipotriene  
 CANASA  
 carbamazepine, er  
 carbidopa/levodopa, er  
 carvedilol  
 cefadroxil  
 cefdinir  
 cefprozil  
 cefuroxime  
 CELEBREX [ST]  
 cephalixin  
 cholestyramine  
 chorionic gonadotropin [INJ]  
 ciclopirox  
 CIMZIA [INJ]  
 CIPRODEX  
 ciprofloxacin, er  
 citalopram  
 clarithromycin, er  
 clindamycin hcl  
 clindamycin phosphate  
 clobetasol propionate  
 clomiphene citrate  
 clonazepam  
 clonidine  
 clotrimazole/  
 betamethasone dipropionate  
 COLCRYS  
 COPAXONE [INJ]  
 CREON  
 CRESTOR [ST]  
 cryselle  
 cyanocobalamin [INJ]  
 cyclobenzaprine  
 CYMBALTA [ST]

**D**

desonide  
 dexamethasone  
 dexmethylphenidate  
 diclofenac sodium  
 dicyclomine hcl

digoxin  
 diltiazem, 12 hr, 24 hr  
 DIOVAN\* [ST]  
 divalproex sodium, er  
 donepezil, odt  
 dorzolamide, /timolol  
 DOVONEX CRM  
 doxazosin  
 doxepin  
 DUETACT

**E**

EFFIENT  
 eliphos  
 ENDOMETRIN  
 enoxaparin [INJ]  
 EPIPEN, JR [INJ]  
 ergocalciferol  
 erythromycin  
 erythromycin/  
 benzoyl perox.  
 estradiol patches, tabs  
 estradiol/norethindrone  
 acetate  
 etodolac  
 EUFLEXA [INJ]  
 EURAX  
 EXFORGE, HCT [ST]

**F**

famciclovir  
 famotidine  
 felodipine er  
 fenofibrate  
 fentanyl citrate  
 finasteride  
 fluconazole  
 fluocinonide  
 fluoxetine, dr  
 fluticasone nasal spray  
 folic acid  
 FORADIL  
 FORTEO [INJ]  
 fosinopril, /hctz  
 FREESTYLE METERS/KITS; FREESTYLE, FREESTYLE FREEDOM LITE, FREESTYLE LITE

FREESTYLE TEST STRIPS; FREESTYLE, FREESTYLE LITE

**G**

gabapentin  
 galantamine, er  
 gemfibrozil  
 glimepiride  
 glipizide, er  
 GLUCAGEN [INJ]  
 glyburide, micronized  
 glyburide/metformin  
 GONAL-F, RFF [INJ]

**H**

HUMIRA [INJ]  
 hydralazine  
 hydrochlorothiazide  
 hydrocodone/  
 acetaminophen  
 hydrocodone/ibuprofen  
 hydrocortisone  
 hydromorphone  
 hydroxychloroquine

**I**

ibuprofen  
 imiquimod  
 INCIVEK  
 indomethacin  
 ipratropium, /albuterol  
 isosorbide mononitrate, er  
 isotretinoin

**J**

JANUMET  
 JANUVIA

**K**

ketoconazole  
 ketorolac

**L**

labetalol hcl  
 lamotrigine  
 lansoprazole, odt  
 LANTUS VIALS ONLY [INJ]  
 latanoprost  
 LETAIRIS  
 LEVEMIR, FLEXPEN [INJ]  
 levetiracetam  
 levofloxacin  
 levothyroxine sodium  
 levoxyl  
 LIDODERM  
 liothyronine  
 lisinopril, /hctz  
 lithium carbonate  
 losartan, /hctz  
 lovastatin  
 LOVAZA  
 LYRICA [ST]

**M**

MAKENA [INJ]  
 meclizine hcl  
 medroxyprogesterone acetate  
 meloxicam  
 MENEST  
 METADONE CD\*  
 metaxalone  
 metformin, er  
 methocarbamol  
 methotrexate  
 methylphenidate, er  
 methylprednisolone  
 metoclopramide hcl  
 metoprolol, /hctz  
 metronidazole  
 mirtazapine, odt  
 mometasone  
 morphine sulfate, er  
 mupirocin  
 MUSE  
 mycophenolate mofetil

**N**

nabumetone  
 nadolol  
 NAMENDA

naproxen,  
 naproxen sodium  
 naratriptan  
 nateglinide  
 necon  
 neomycin/polymyxin/  
 dexamethasone  
 neomycin/polymyxin/hc  
 NIASPAN  
 nifedipine er  
 nisoldipine er  
 nitrofurantoin  
 macrocrystal  
 nitroglycerin patches  
 nortriptyline  
 NOVOFINE  
 NOVOLIN [INJ]  
 NOVOLOG [INJ]  
 NUDEXTA  
 nystatin, /triamcinolone

**O**

ocella  
 ofloxacin  
 omeprazole  
 ondansetron, odt  
 OPANA ER\*  
 oxcarbazepine  
 oxybutynin, er  
 oxycodone,  
 /acetaminophen  
 OXYCONTIN

**P**

pantoprazole  
 paroxetine  
 peg 3350/electrolyte  
 PEGASYS [INJ]  
 PEG-INTRON, REDIPEN [INJ]  
 penicillin v potassium  
 PERFORMIST  
 phenytoin sodium,  
 extended  
 PLAVIX\*  
 polymyxin/trimethoprim  
 potassium chloride, er  
 PRADAXA  
 pramipexole  
 pravastatin

prednisolone  
 prednisolone acetate  
 prednisolone sodium phosphate  
 prednisone  
 PREMPHASE  
 PREMPRO  
 PROAIR HFA  
 prochlorperazine  
 PROCIT [INJ]  
 PRODIGY INSULIN SYR,  
 PEN NEEDLES  
 promethazine/  
 dextromethorphan  
 PROMETRIUM  
 propranolol, /hctz  
 PROTOPIC [ST]  
 PULMICORT FLEXHALER  
 PULMICORT RESPULES\*

**T**

TAMIFLU  
 tamoxifen  
 tamsulosin  
 TAZORAC\*  
 temazepam  
 terazosin  
 TESTIM  
 TEV-TROPIN [INJ]  
 timolol maleate  
 tizanidine  
 tobramycin/  
 dexamethasone susp  
 tobramycin sulfate  
 topiramate  
 TRACLEER  
 TRADJENTA  
 trazodone hcl  
 tretinoin  
 triamcinolone acetonide  
 triamterene/hctz  
 trinessa  
 tri-previfem  
 tri-sprintec  
 trospium

**Q**

quinapril, /hctz  
 QVAR

**R**

ramipril  
 ranitidine  
 REBIF [INJ]  
 RENVELA  
 reprexain  
 RESTASIS  
 ribavirin  
 RIOMET  
 risperidone, odt  
 rivastigmine caps  
 ropinirole

**U**

ULORIC

**V**

VAGIFEM  
 valacyclovir  
 venlafaxine, er  
 verapamil, er  
 veripred  
 VIAGRA\*  
 VICTRELIS  
 VIMPAT  
 VYVANSE

**W**

warfarin

**X**

XERESE  
 XIFAXAN

**Z**

zamicet  
 zarah  
 ZETIA  
 zolpidem, er  
 ZOMIG, ZMT  
 ZYCLARA  
 ZYLET  
 ZYPREXA 10 MG VIAL\*

### Examples of Nonformulary Medications With Selected Formulary Alternatives

The following is a list of some nonformulary brand-name medications with examples of selected alternatives that are on the formulary.

Column 1 lists examples of nonformulary medications.  
 Column 2 lists some alternatives that can be prescribed.

Thank you for your compliance.

Nonformulary	Formulary Alternative	Nonformulary	Formulary Alternative
ACCU-CHEK METERS/STRIPS	Freestyle	KOMBIGLYZE XR	metformin + Januvia or Tradjenta, Janumet
ACIPHEX [ST]	lansoprazole, omeprazole	LANTUS SOLOSTAR	Lantus Vials, Levemir/Flexpen
ACTONEL [ST]	alendronate	LATUDA	risperidone, Abilify (regular tabs), Seroquel*/XR
ALORA	generic estradiol patches	LESCOL, XL [ST]	lovastatin, simvastatin, Crestor [ST]
ALTOPREV [ST]	lovastatin, simvastatin, Crestor [ST]	LEVAQUIN	levofloxacin
ALVESCO	Pulmicort Flexhaler, Qvar	LEVITRA	Viagra*
ANDRODERM	Testim	LEXAPRO [ST]	citalopram, fluoxetine, paroxetine, sertraline
ANDROGEL	Testim	LIALDA	balsalazide, Apriso
ANTARA [ST]	fenofibrate	LIPITOR [ST]	lovastatin, simvastatin, Crestor [ST]
APIDRA	Novolog	LIPOFEN [ST]	fenofibrate
ARANESP	Procrit	LIVALO [ST]	lovastatin, simvastatin, Crestor [ST]
ASACOL, HD	balsalazide, Apriso	LOESTRIN 24 FE, LO LOESTRIN FE	generic oral contraceptives
ASMANEX	Pulmicort Flexhaler, Qvar	LOSEASONIQUE	generic oral contraceptives
ATACAND [ST]	losartan, Diovan* [ST]	LUMIGAN	latanoprost
ATACAND HCT [ST]	losartan/hctz, Diovan* [ST] + hctz	LUNESTA [ST]	zolpidem/er
ATELVIA [ST]	alendronate	MAXAIR AUTOHALER	ProAir HFA
AVALIDE [ST]	losartan/hctz, Diovan* [ST] + hctz	MAXALT, MLT	sumatriptan tab, Zomig/ZMT
AVAPRO [ST]	losartan, Diovan* [ST]	MENOSTAR	generic estradiol patches
AVELOX	ciprofloxacin/er, levofloxacin, ofloxacin	MICARDIS [ST]	losartan, Diovan* [ST]
AXERT	sumatriptan tab, Zomig/ZMT	MICARDIS HCT [ST]	losartan/hctz, Diovan* [ST] + hctz
AXIRON	Testim	MOXEZA	ciprofloxacin, levofloxacin, ofloxacin
AZOPT	brimonidine tartrate, dorzolamide, Alphagan P 0.1%*	NASONEX [ST]	fluticasone
AZOR [ST]	amlodipine + losartan or Diovan* [ST], Exforge [ST]	NATAZIA	generic oral contraceptives
BAYER ASCENSIA, BREEZE, CONTOUR	Freestyle	NEVANAC	generic oral contraceptives
BECONASE AQ [ST]	fluticasone	NEXIUM [ST]	esomeprazole
BENICAR [ST]	losartan, Diovan* [ST]	NORDITROPIN	Testim
BENICAR HCT [ST]	losartan/hctz, Diovan* [ST] + hctz	NOROXIN	ciprofloxacin/er, levofloxacin, ofloxacin
BESIVANCE	ciprofloxacin, levofloxacin, ofloxacin	NUTROPIN, AQ	Tev-Tropin
BEYAZ	generic oral contraceptives	NUVARING	generic oral contraceptives
BONIVA TABS [ST]	alendronate	OMNARIS [ST]	fluticasone
BRAVELLE	Gonal-F, RFF	OMNITROPE	Tev-Tropin
BROMDAY	diclofenac sodium, ketorolac	ONETOUCH	Freestyle
BROVANA	Perforomist	ONGLYZA	Januvia, Tradjenta
CARDURA XL	alfuzosin er, tamsulosin	ORTHO EVRA, ORTHO TRI-CYCLEN LO	generic oral contraceptives
CENESTIN	estradiol, Menest	OXYTROL [ST]	oxybutynin er, trospium
CETRAXAL	Ciprodex	PATANASE	azelastine, Astepro
CIALIS	Viagra*	PRANDIMET	nateglinide + metformin
CIPRO HC	Ciprodex	PRANDIN	nateglinide
DETROL, LA [ST]	oxybutynin/er, trospium	PREMARIN	estradiol, Menest
DEXILANT [ST]	lansoprazole, omeprazole	PRISTIQ [ST]	generic venlafaxine er, Cymbalta [ST]
DIIVAN HCT [ST]	losartan/hctz, Diovan* [ST] + hctz	PROQUIN XR	ciprofloxacin/er, levofloxacin, ofloxacin
DIVIGEL	generic estradiol patches	PROVENTIL HFA	ProAir HFA
DULERA	Advair Diskus/HFA, Symbicort	RAPAFLO	alfuzosin er, tamsulosin
EDARBI [ST]	losartan, Diovan* [ST]	RELPAK	sumatriptan tab, Zomig/ZMT
EDLUAR [ST]	zolpidem/er	REVATIO TABS	Adcirca
ELESTRIN	generic estradiol patches	RHINOCORT AQUA [ST]	fluticasone
ELIDEL [ST]	Protopix [ST]	SAFYRAL	generic oral contraceptives
ENABLEX [ST]	oxybutynin er, trospium	SAIZEN	Tev-Tropin
ENJUVA	estradiol, Menest	SANCTURA XR [ST]	oxybutynin er, trospium
EPOGEN	Procrit	SAPHRIS	risperidone, Abilify (regular tabs), Seroquel*/XR
ESTRADERM	generic estradiol patches	SEREVENT DISKUS	Foradil
ESTRASORB	generic estradiol patches	SUMATRIPTAN NASAL	Zomig Nasal
ESTROGEL	generic estradiol patches	TEVETEN [ST]	losartan, Diovan* [ST]
EVAMIST	generic estradiol patches	TEVETEN HCT [ST]	losartan/hctz, Diovan* [ST] + hctz
FACTIVE	ciprofloxacin/er, levofloxacin, ofloxacin	TOVIAZ [ST]	oxybutynin er, trospium
FANAPT	risperidone, Abilify (regular tabs), Seroquel*/XR	TRAVATAN Z	latanoprost
FEMTRACE	estradiol, Menest	TRIBENZOR [ST]	amlodipine + losartan/hctz, Exforge HCT [ST]
FENOGLIDE [ST]	fenofibrate	TRICOR [ST]	fenofibrate
FLOVENT DISKUS, HFA	Pulmicort Flexhaler, Qvar	TRIGLIDE [ST]	fenofibrate
FOLLISTIM AQ	Gonal-F, RFF	TRILIPIX [ST]	fenofibrate
FORTESTA	Testim	TWYNSTA [ST]	amlodipine + losartan or Diovan* [ST], Exforge [ST]
FROVA	sumatriptan tab, Zomig/ZMT	VENTOLIN HFA	ProAir HFA
GELNIQUE [ST]	oxybutynin er, trospium	VERAMYST [ST]	fluticasone
GENOTROPIN	Tev-Tropin	VESICARE [ST]	oxybutynin er, trospium
GEODON	risperidone, Abilify (regular tabs), Seroquel*/XR	VICTOZA	Byetta
HUMALOG	Novolog	VIGAMOX	ciprofloxacin, levofloxacin, ofloxacin
HUMATROPE	Tev-Tropin	VIBRYD [ST]	citalopram, fluoxetine, paroxetine, sertraline
HUMULIN	Novolin	VIVELLE-DOT	generic estradiol patches
IMITREX NASAL	Zomig Nasal	VYTORIN [ST]	Zetia + simvastatin
INVEGA	risperidone, Abilify (regular tabs), Seroquel*/XR	XALATAN	latanoprost
IQUIX	ciprofloxacin, levofloxacin, ofloxacin	XOPENEX HFA	ProAir HFA
		ZYMAXID	ciprofloxacin, levofloxacin, ofloxacin

#### KEY

The symbol [INJ] next to a drug name indicates that the drug is available in injectable form only.

The symbol [ST] next to a drug name indicates that Step Therapy may apply to some or all strengths of the drug.

**For the member:** Generic medications contain the same active ingredients as their corresponding brand-name medications, although they may look different in color or shape. They have been FDA-approved under strict standards.

**For the physician:** Please prescribe preferred products and allow generic substitutions when medically appropriate. Thank you.

Brand-name drugs are listed in CAPITAL letters.

Generic drugs are listed in lower case letters.

THIS DOCUMENT LIST IS EFFECTIVE JANUARY 1, 2012 THROUGH DECEMBER 31, 2012. THIS LIST IS SUBJECT TO CHANGE.

You can get more information and updates to this document at our website at [www.express-scripts.com](http://www.express-scripts.com).