NEW YORK STATE TEAMSTERS COUNCIL HEALTH & HOSPITAL FUND APPENDIX A – SCHEDULE OF BENEFITS SUPREME BENEFITS

PLAN BENEFIT GUIDE	IN NETWORK BENEFITS YOU PAY	OUT OF NETWORK BENEFITS YOU PAY	PAGE # MEDICAL PLAN
PLAN FEATURES			
Primary Care Physician	Not Required		2
Physician Referrals	Not R	lequired	2
Out of Area Benefits	Coverage provided throu	igh the BlueCard Network	2
Dependent Coverage	Qualified Depende	nt Children to age 26	Eligibility Book
Domestic Partner	Not C	Covered	Eligibility Book
PLAN COST SHARING			Doon
Copayment	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	4 / 10
Deductible	\$100 Individual / \$250 Family Applies ONLY to Durable Medical Equipment / External Prosthetic / Medical Supplies		4 / 10
Coinsurance	0% (20% coinsurance applies to Durable Medical Equipment / External Prosthetic / Medical Supplies)		4/9
In Network Providers	A provider that accepts the Allowable Amount as Payment in Full and you will not be balanced billed up to charge		6
Out of Network Providers	A provider that does not accept the Allowable Amount as Payment in Full, may balance bill the patient up to charge		6 / 10
Out of Pocket Maximum	None		10
Total Out-of-Pocket Maximum	None		10
Annual Yearly Limits "Essential Health Benefits"	None		10
Lifetime Maximum	None		10
PHYSICIAN / PROFESSIO	NAL SERVICES		1
Diagnostic Office Visits	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	22
Routine Physical Exam – Adult age 19 and older / 1 per calendar year	Covered in Full	Balance after Allowable Amount	22
Routine GYN Exam	Covered in Full	Balance after Allowable Amount	21

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Adult –	Covered in Full	Balance after	21
Preventive Care Benefits * See Below for Details		Allowable Amount	
Pregnant Women - Preventive Care Benefits *See Below for Details	Covered in Full	Balance after Allowable Amount	20
Newborns and Children - Preventive Care Benefits *See Below for Details	Covered in Full	Balance after Allowable Amount	21
Well Child Visits and Immunizations - up to age 18	Covered in Full	Balance after Allowable Amount	22
Diagnostic Imaging – X-rays/ Ultrasounds / CAT Scans / PET Scans / MRI	Covered in Full	Balance after Allowable Amount	23
Diagnostic Laboratory and Pathology	Covered in Full	Balance after Allowable Amount	22
Chemotherapy	Covered in Full	Balance after Allowable Amount	23
Radiation Therapy	Covered in Full	Balance after Allowable Amount	23
Kidney Dialysis	Covered in Full	Balance after Allowable Amount	23
Allergy Testing	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	23
Allergy Injections & Serum	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	23
Chiropractic 20 visits per calendar year	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	23
Diagnostic Vision & Hearing Examination	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	22
Routine Hearing Examination and Evaluation Once every calendar year	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	22
Diabetes Education	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	24 / 25
Surgical Care	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	18
Second Medical / Surgical Opinion	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	19 / 20

Office Consultation \$10 Copayment \$10 Copayment and Balance after Allowable Amount	PLAN BENEFIT GUIDE	IN NETWORK BENEFITS YOU PAY	OUT OF NETWORK BENEFITS YOU PAY	PAGE # MEDICAL PLAN
Balance after Allowable Amount	Office Consultation			
Allowable Amount S10 Copayment and 24	one constitution	φιστοραγιποπο		25
Injectable Drug				
Physicians Office INPATIENT HOSPITAL SERVICES Hospital Benefits ** Covered in Full Physician Visits in the Hospital Surgical Care Covered in Full Covered in Full Covered in Full Balance after Allowable Amount Covered in Full Physician Care Covered in Full Covered in Full Balance after Allowable Amount Anesthesia Covered in Full Covered in Full Covered in Full Physician Copayment and Balance after Allowable Amount Anesthesia Covered in Full Balance after Allowable Amount Balance after Allowable Amount Covered in Full Balance after Allowable Amount Covered in Full Balance after Allowable Amount Balance after Allowable Amount Covered in Full Covered in Full Balance after Allowable Amount Covered in Full Cove	Injectable Drug –	\$10 Copayment		24
Hospital Benefits ** Covered in Full Balance after Allowable Amount Allowable Amount Allowable Amount Surgical Care Covered in Full Covered in Full Balance after Allowable Amount Allo	Physicians Office	1 3		
Hospital Benefits ** Covered in Full Balance after Allowable Amount			Allowable Amount	
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Surgical Care Covered in Full Balance after Allowable Amount 19 / 20 Inpatient Consultation \$10 Copayment \$10 Copayment and Balance after Allowable Amount 23 MATERNITY SERVICES Inpatient Maternity Care ** (Facility) Covered in Full Balance after Allowable Amount Inpatient Maternity Care ** (Facility) Covered in Full Balance after Allowable Amount Inpatient Covered Dependent Covered Inpatient Maternity Care ** (Facility) Covered in Full Balance after Allowable Amount Inpatient Maternity Care ** (Facility) Covered in Full Balance after Allowable Amount Inpatient Maternity Care ** (Facility & Physician) Covered in Full Balance after Allowable Amount Inpatient Maternity Care ** (Facility & Physician) Covered in Full Balance after Allowable Amount Inpatient Maternity Care ** (Facility & Physician) Covered in Full Balance after Allowable Amount Inpatient Covered in Full Balance after Allowable Amount Inpatient Maternity Services Covered in Full Balance after Allowable Amount Inpatient Cover		Covered in Full	Covered in Full	21
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Diagnostic Imaging — Covered in Full Balance after Allowable Amount Scans / PET Scans / MRI Diagnostic Laboratory and Pathology Covered in Full Balance after Allowable Amount Surgical Care Covered in Full Balance after 14 / 19 (Facility & Physician) Anesthesia Covered in Full Covered in Full Covered in Full 19 Pre-Admission Exam \$10 Copayment \$10 Copayment and 14	(Facility & Physician)		Allowable Amount	
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X-rays/ Ultrasounds / CAT Scans / PET Scans / MRI Diagnostic Laboratory and Pathology Surgical Care (Facility & Physician) Anesthesia Covered in Full 14 / 19 Allowable Amount Covered in Full Covered in Full 19 Pre-Admission Exam \$10 Copayment \$10 Copayment and	Diagnostic Imaging –	Covered in Full	Ralance after	14
Scans / PET Scans / MRI Diagnostic Laboratory and Pathology Surgical Care Covered in Full Balance after Allowable Amount (Facility & Physician) Anesthesia Covered in Full Covered in Full Covered in Full 19 Pre-Admission Exam \$10 Copayment \$10 Copayment and 14				1-7
Diagnostic Laboratory and Pathology Covered in Full Balance after Allowable Amount Surgical Care Covered in Full Balance after 14 / 19 (Facility & Physician) Allowable Amount Covered in Full Covered in Full 19 Pre-Admission Exam \$10 Copayment \$10 Copayment and 14	<u> </u>		7 mowable 7 mount	
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Surgical Care Covered in Full Balance after 14 / 19 (Facility & Physician) Allowable Amount Covered in Full Covered in Full 19 Pre-Admission Exam \$10 Copayment \$10 Copayment and 14		Covered in 1 dir		11
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	Anesthesia	Covered in Full		19
	Pre-Admission Fxam	\$10 Conavment	\$10 Consyment and	14
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Allowable Amount				

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Pre-Admission Testing	Covered in Full	Balance after	14
(Facility)		Allowable Amount	
Injectable Drug –	\$10 Copayment	\$10 Copayment and	15
Outpatient Facility	+	Balance after	
		Allowable Amount	
THERAPY SERVICES			•
Chemotherapy	Covered in Full	Balance after	14
(Facility)		Allowable Amount	
Radiation Therapy	Covered in Full	Balance after	14
(Facility)		Allowable Amount	
Respiratory and Cardiac	\$10 Copayment	\$10 Copayment and	15
Therapy		Balance after	
(Facility)		Allowable Amount	
Physical Therapy – 24 visits	\$10 Copayment	\$10 Copayment and	15 / 19
per calendar year.		Balance after	
(Facility & Physician)		Allowable Amount	
Combined In and Out of			
Network	¢10.0	\$10 C	15 / 10
Occupational Therapy – 24	\$10 Copayment	\$10 Copayment and	15 / 19
visits per calendar year.		Balance after Allowable Amount	
(Facility & Physician) Combined In and Out of		Allowable Alllount	
Network			
Speech Therapy	\$10 Copayment	\$10 Copayment and	15 / 19
(Facility & Physician)	\$10 Copayment	Balance after	13/17
(Tuellity & Thysician)		Allowable Amount	
Kidney Dialysis	Covered in Full	Balance after	14
(Facility)		Allowable Amount	
EMERGENCY CARE			
Emergency Room Care –	\$100 Copayment	\$100 Copayment and	4 / 29
waived if Admitted		Balance after	
	440.5	Allowable Amount	
Physician Visit in	\$10 Copayment	\$10 Copayment and	29
Emergency Room		Balance after	
	* 100 m	Allowable Amount	
Observation Stay –	\$100 Copayment	\$100 Copayment and	13
up to 23 hours and in lieu of		Balance after	
Inpatient Admission	Φ10 G	Allowable Amount	20
Urgent Care Center	\$10 Copayment	\$10 Copayment and	28
(Facility & Physician)		Balance after	
A 1 1 C	0 11 7 11	Allowable Amount	07 / 20
Ambulance - Ground	Covered in Full	Covered in Full	27 / 28
A 1 1 A:	0 11 7 11	Up to Charge	27 / 20
Ambulance – Air	Covered in Full	100% up to	27 / 28
Medical Necessity Applies		Allowable Amount	
		UPON REVIEW	

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MENTAL HEALTH AND CHEMICAL DEPENDENCE			
Inpatient Mental Health **	Covered in Full	Balance after Allowable Amount	3/6/11
Outpatient Mental Health (Facility & Physician)	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	3/6/14/23
Inpatient Chemical Dependence **	Covered in Full	Balance after Allowable Amount	12
Outpatient Chemical Dependence (Facility & Physician)	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	15
Inpatient Detoxification **	Covered in Full	Balance after Allowable Amount	12
Physician visits for Inpatient Mental Health, Chemical Dependence & Detoxification	\$10 Copayment	\$10 Copayment and Balance after Allowable Amount	21
OTHER SERVICES			
Home Health Care ** 40 visits per calendar year Combined In and Out of Network	Covered in Full	Balance after Allowable Amount	16
Skilled Nursing Facility **	Covered in Full	Balance after Allowable Amount	7 / 12
Hospice	Covered in Full	Balance after Allowable Amount	17
Durable Medical Equipment Deductible Combined In & Out of Network	\$100 Individual Deductible \$250 Family Deductible then processed at 80%	\$100 Individual Deductible \$250 Family Deductible then processed at 80% and Balance up to Charge	25
Prosthetic Devices Deductible Combined In & Out of Network	\$100 Individual Deductible \$250 Family Deductible then processed at 80%	\$100 Individual Deductible \$250 Family Deductible then processed at 80% & Balance up to Charge	13 / 26
Medical Supplies Deductible Combined In & Out of Network	\$100 Individual Deductible \$250 Family Deductible then processed at 80%	\$100 Individual Deductible \$250 Family Deductible then processed at 80% and Balance up to Charge	27
Wigs	\$300 Limit per Lifetime Balance up to Charge	\$300 Limit per Lifetime Balance up to Charge	26
Hearing Aids (Allowance combined between in network, out-of-network, and TruHearing providers)	\$5,000 Allowance Adult - every 3 years Children under 13-Allowed every calendar year per EAR	\$5,000 Allowance and Balance up to Charge Adult - every 3 years Children under 13-Allowed every calendar year per EAR	27

	Option to buy TruHearing Aids (subject to Allowance and frequency): • TruHearing Advanced Aids- \$0 copayment per aid • TruHearing Premium Aids- \$300 copayment per aid	
PRESCRIPTION DRUG		
DETAILED INFORMATION II	N THE PRESCRIPTION DRU	JG BENEFIT PLAN
BOOKLET		
RETAIL PHARMACY		If a Brand name medication is
ACUTE 30 DAY SUPPLY		received and a generic
		equivalent is available, the
Generic	\$5.00 Copayment	participant must pay the
Brand – Preferred	\$10.00 Copayment	Brand name copay PLUS the
Brand – Non- Preferred	\$25.00 Copayment	difference in the cost between
		the generic equivalent and the
		Brand name medication.
MAIL ORDER PHARMACY		If a Brand name medication is
MAINTENANCE 90 DAY		received and a generic
SUPPLY		equivalent is available, the
		participant must pay the
Generic	\$2.00 Copayment	Brand name copay PLUS the
Brand – Preferred	\$20.00 Copayment	difference in the cost between
Brand – Non- Preferred	\$50.00 Copayment	the generic equivalent and the
		Brand name medication.

<u>MAIL ORDER – MAINTENANCE PRESCRIPTIONS –</u> Mail Order is Mandatory on all Maintenance Prescriptions otherwise you will be responsible for the full cost of the prescription if purchased at the Retail Pharmacy.

TERMS AND PROCEDURES USED FOR PROCESSING BENEFITS

TERM	PAGE NUMBER LOCATED
	IN MEDICAL BENEFIT PLAN
ALLOWABLE AMOUNT / EXPENSE	3
IN NETWORK BENEFITS	6
IN NETWORK PROVIDER	6
MEDICAL NECESSITY	8 - SECTION 4
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OUT OF NETWORK PROVIDER	6
** SERVICES NEEDING PRIOR APPROVAL**	8/9
All Services for Organ and Tissue Transplants	
All Inpatient Admissions, including Maternity	
Skilled Nursing Facility Admissions	
Home Care Services	
PRIOR APPROVAL PENALTY	9
A penalty of \$500 or 50% of the benefits payable whichever is less, will be imposed if you do not comply with the pre-approval requirements.	
PRIOR APPROVAL PROCEDURE	9
FAILURE TO SEEK APPROVAL	9
COURTESY AUTHORIZATION	9

PREVENTIVE HEALTH CARE BENEFITS SUBJECT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

ADULTS - PREVENTIVE CARE BENEFITS – We will provide coverage for the following preventive care services whether performed in a Facility or in a Professional Provider's office:

- Abdominal Aortic Aneurysm Screening in men aged 65 75
- Adult Prevention Exam
- Adult Immunizations-Zoster(Shingles) vaccine age 50 and older
- Alcohol Misuse Screening & Behavioral Counseling Interventions
- Bone Density (Osteoporosis) for women 60 and older
- Breast and Ovarian Cancer Susceptibility & Genetic Risk Assessment and BRCA Mutation Testing
- Breast Cancer Screening Mammography
- Cervical Cancer Screening Pap Smear

- Chlamydia Screening for women and pregnant women
- Colorectal Cancer Screening Colonoscopy, Signomoidoscopy age 50-75
- Prostate Cancer Screening Exam and PSA Laboratory
- Depression Screening
- Type II Diabetes Screening
- Diet, Behavioral Counseling in Primary Care to promote a healthy diet Dietician & Physician
- Gonorrhea Screening for women and pregnant women
- High Blood Pressure Screening
- HIV Screening
- Lipid Screening
- Obesity Screening
- Sexually Transmitted Infections Counseling
- Syphilis Infection Screening
- Tobacco Use and Tobacco-Caused Disease Counseling

PREGNANT WOMEN - PREVENTIVE CARE BENEFITS — We will provide coverage for the following preventive care services whether performed in a Facility or in a Professional Provider's office:

- Asymptomatic Bacteriuria Screening (UTI)
- RH (D) Incompatibility Screening
- Daily folic acid supplements for women capable of becoming pregnant
- Hepatitis B Virus Infection Screening
- Breastfeeding, Primary Care Interventions
- Iron Deficiency Anemia Screening
- Sexually Transmitted Infections Counseling
- STD Testing based on risk (other than Chlamydia, HIV)
- Syphilis Infection Screening

NEWBORNS AND CHILDREN - PREVENTIVE CARE BENEFITS — We will provide coverage for the following preventive care services whether performed in a Facility or in a Professional Provider's office:

- Congenital Hypothyroidism Screening in newborns
- Dental Caries in Preschool Children Prevention less than 6 years
- Major Depressive Disorder Screening in Children and adolescents
- Gonorrhea, Prophylactic Medication for newborns
- Hearing Loss for Newborns
- Iron Supplements for at risk infants 6 12 months
- Phenylketonuria Screening in newborns
- Childhood Obesity Screening and Interventions
- Sickle Cell Disease Screening in newborns
- Tuberculosis screening

• Visual Impairment Screening in Children younger than 5 years

<u>PREVENTIVE HEALTH CARE BENEFITS</u> SUBJECT TO THE PROVISIONS OF THE CONTRACT

- Gestational Diabetes Screening
- Human Papillmoavirus Testing female 30 and over
- Breast Feeding Support, Breast Pump and Counseling
- Contraceptive Methods and Counseling covered under the Prescription Drug Program

NOTE: If the above services are Routine and billed as Preventive then they are subject to the Patient Protection and Affordable Care Act and may be covered in full with no member responsibility. If the above services are billed with a non-preventive diagnosis then these services will be subject to the provisions of the contract, such as copayments, deductible and coinsurance.