NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND
APPENDIX A – SCHEDULE OF BENEFITS
CLASSIC 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 Required		2
Out of Area Benefits	Coverage provided through the BlueCard Network		2
Dependent Coverage	Qualified Dependent Children to age 26		Eligibility Book
Domestic Partner	Not Covered		Eligibility Book
PLAN COST SHARING			
Copayment	$25 Copayment	None	4 / 10
Deductible	$250 Individual $500 Family Separate Deductible applies In Network	$750 Individual $1,500 Family Separate Deductible applies Out of Network	4 / 10
4th Quarter Rollover Deductible	Any deductible that is applied in the months of October / November / December will be credited to your deductible in the next calendar year deductible		
Coinsurance	20%	30%	4 / 10
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	$1,500 Individual $3,000 Family Separate Out of Pocket applies In Network	$2,000 Individual $4,000 Family Separate Out of Pocket applies Out of Network	10
Total Out-of-Pocket Maximum (includes Deductible /excludes copayments)	$1,750 Individual $3,500 Family Separate Out of Pocket applies In Network	$2,750 Individual $5,500 Family Separate Out of Pocket applies Out of Network	10
Annual Yearly Limits “Essential Health Benefits”	None		10
Lifetime Maximum	None		10
PHYSICIAN / PROFESSIONAL SERVICES			
Diagnostic Office Visits	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	22

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Routine Physical Exam – Adult age 19 and older / 1 per calendar year	Covered in Full	Deductible / Coinsurance Balance after Allowable Amount	22
Routine GYN Exam	Covered in Full	Deductible / Coinsurance Balance after Allowable Amount	21
Adults – Preventive Care Benefits *See Below for Details	Covered in Full	Deductible / Coinsurance Balance after Allowable Amount	21
Pregnant Women - Preventive Care Benefits *See Below for Details	Covered in Full	Deductible / Coinsurance Balance after Allowable Amount	20
Newborns and Children - Preventive Care Benefits *See Below for Details	Covered in Full	Deductible / Coinsurance Balance after Allowable Amount	21
Well Child Visits and Immunizations – up to age 18	Covered in Full	Deductible / Coinsurance Balance after Allowable Amount	22
Diagnostic Imaging – X-rays/ Ultrasounds / CAT Scans / PET Scans / MRI	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	23
Diagnostic Laboratory and Pathology	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	22
Chemotherapy	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	23
Radiation Therapy	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	23
Kidney Dialysis	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	23
Allergy Testing	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	23
Allergy Injections & Serum	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	23
Chiropractic 20 visits per calendar year	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	23
Diagnostic Vision & Hearing Examination	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	22
Routine Hearing Examination and Evaluation – Once every calendar year	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	22

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Diabetes Education	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	24 / 25
Surgical Care	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	18
Second Medical / Surgical Opinion	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	19 / 20
Office Consultation	$25 Copayment	Deductible / Coinsurance Balance after Allow. Amount	23
Injectable Drug – Physicians Office	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	24
INPATIENT HOSPITAL SERVICES			
Hospital Benefits **	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	5 / 11
Physician Visits in the Hospital	Deductible/ Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	21
Surgical Care	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	19
Anesthesia	Deductible / Coinsurance	Match in-network deductible of $250 then Coinsurance	19 / 20
Inpatient Consultation	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	23
MATERNITY SERVICES			
Inpatient Maternity Care ** (Facility) (Eligible Member / Spouse / Dependent Covered)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	13 / 21
Maternity Care-Prenatal and Postpartum Care – (Physician) (Eligible Member and Spouse ONLY-No Benefits for eligible Dependents)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	20
Newborn Nursery Care (Facility & Physician)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	13 / 20

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OUTPATIENT HOSPITAL SERVICES			
Diagnostic Imaging – X-rays/ Ultrasounds / CAT Scans / PET Scans / MRI	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Diagnostic Laboratory and Pathology	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Surgical Care (Facility & Physicians)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14 / 19
Anesthesia	Deductible / Coinsurance	Deductible / Coinsurance	19
Pre-Admission Testing (Physician & Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Injectable Drug – Outpatient Facility	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	15
THERAPY SERVICES			
Chemotherapy (Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allow. Amount	14
Radiation Therapy (Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Respiratory and Cardiac Therapy (Facility)	$25 Copayment-Physician Deductible / Coinsurance-Outpatient Hospital	Deductible / Coinsurance Balance after Allowable Amount	15
Physical Therapy – 24 visits per calendar year. (Facility & Physicians) Combined In and Out of Network	$25 Copayment-Physician Deductible / Coinsurance-Outpatient Hospital	Deductible / Coinsurance Balance after Allowable Amount	15 / 19
Occupational Therapy – 24 visits per calendar year. (Facility & Physician) Combined In and Out of Network	$25 Copayment-Physician Deductible / Coinsurance-Outpatient Hospital	Deductible / Coinsurance Balance after Allowable Amount	15 / 19
Speech Therapy (Facility & Physician)	$25 Copayment-Physician Deductible / Coinsurance-Outpatient Hospital	Deductible / Coinsurance Balance after Allowable Amount	15 / 19
Kidney Dialysis (Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14

PLAN BENEFIT GUIDE	IN NETWORK BENEFITS YOU PAY	OUT OF NETWORK BENEFITS YOU PAY	PAGE # MEDICAL PLAN
EMERGENCY CARE			
Emergency Room Care – waived if Admitted	$125 Copayment	$125 Copayment	4 / 29
Physician Visit in Emergency Room	$25 Copayment	$25 Copayment	29
Observation Stay – up to 23 hours and in lieu of Inpatient Admission	Deductible/ Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	13
Urgent Care Center (Facility & Physician)	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	28
Ambulance – Ground	$125 Copayment	$125 Copayment	27 / 28
Ambulance – Air Medical Necessity Applies	$125 Copayment	$125 Copayment	27 / 28
MENTAL HEALTH AND CHEMICAL DEPENDENCE			
Inpatient Mental Health **	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	3 / 6 / 11
Outpatient Mental Health (Facility & Physician)	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	3 / 6 / 14 / 23
Inpatient Chemical Dependence **	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	12
Outpatient Chemical Dependence (Facility & Physician)	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	15
Inpatient Detoxification **	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	12
Physician visits for Inpatient Mental Health, Chemical Dependence & Detoxification	$25 Copayment	Deductible / Coinsurance Balance after Allowable Amount	21
OTHER SERVICES			
Home Health Care ** 40 visits per calendar year	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	16
Skilled Nursing Facility **	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	7 / 12

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Hospice	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	17
Durable Medical Equipment	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	25
Prosthetic Devices	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	13 / 26
Medical Supplies	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	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 IN THE PRESCRIPTION DRUG BENEFIT PLAN BOOKLET			
RETAIL PHARMACY ACUTE 30 DAY SUPPLY Generic Brand – Preferred Brand – Non- Preferred	 $8.00 Copayment $16.00 Copayment $33.00 Copayment	If a Brand name medication is received and a generic equivalent is available, the participant must pay the Brand name copay PLUS the difference in the cost between the generic equivalent and the Brand name medication.	
MAIL ORDER PHARMACY MAINTENANCE 90 DAY SUPPLY Generic Brand – Preferred Brand – Non- Preferred	 $2.00 Copayment $32.00 Copayment $66.00 Copayment	If a Brand name medication is received and a generic equivalent is available, the participant must pay the Brand name copay PLUS the difference in the cost between the generic equivalent and the Brand name medication.	

MAIL ORDER – MAINTENANCE PRESCRIPTIONS – 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
OUT OF NETWORK BENEFITS	6 / 10
OUT OF NETWORK PROVIDER	6
** SERVICES NEEDING PRIOR APPROVAL** • All Services for Organ and Tissue Transplants • All Inpatient Admissions, including Maternity • Skilled Nursing Facility Admissions • Home Care Services	8 / 9
PRIOR APPROVAL PENALTY **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.**	9
PRIOR APPROVAL PROCEDURE	9
FAILURE TO SEEK APPROVAL	9
COURTESY AUTHORIZATION	9

PREVENTIVE HEALTH CARE BENEFITS

PREVENTIVE CARE BENEFITS FOR ADULTS – 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 Immunizations
- Adult Immunizations-Zoster(Shingles) vaccine age 50 and older
- Alcohol Misuse Screening & Behavioral Counseling Interventions
- Bone Density (Osteoporosis) for women
- 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, Laboratory & Pathology

- Depression Screening
- 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 for at risk populations
- Syphilis Infection Screening in at risk populations
- Tobacco Use and Tobacco-Caused Disease, Counseling

PREVENTIVE CARE BENEFITS FOR PREGNANT WOMEN – 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 to Promote
- Iron Deficiency, Anemia, Prevention – Screening
- Sexually Transmitted Infections Counseling
- STD Testing based on risk (other than Chlamydia, HIV)
- Syphilis Infection Screening

PREVENTIVE CARE BENEFITS FOR NEWBORNS AND CHILDREN – 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
- Major Depressive Disorder in Children and adolescents, Screening
- Gonorrhea, Prophylactic Medication for newborns
- Hearing Loss, Newborns
- Iron Supplements for at risk infants 6 – 12 months
- Phenyketonuria Screening in newborns
- Screening and interventions for childhood obesity
- Sickle Cell Disease Screening in newborns
- Tuberculosis screening for at risk children
- Visual Impairment in Children younger than age 5 years, Screening

PREVENTIVE HEALTH CARE BENEFITS
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.