NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND
APPENDIX A – SCHEDULE OF BENEFITS
ROYALE 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	None		4 / 10
Deductible	$750 Individual $1,500 Family Combined In and Out of Network		4 / 10
4th Quarter Deductible Rollover	Any deductible amounts incurred during the 4th quarter of the calendar year will apply against the next year's deductible		
Coinsurance	20% Same both In and Out of Network		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	$2,000 Individual / $4,000 Family Combined In and Out of Network		10
Total Out-of-Pocket Maximum (includes Deductible)	$2,750 Individual $5,500 Family Combined In and Out of Network		10
Annual Yearly Limits "Essential Health Benefits"	None		10
Lifetime Maximum	None		10
PHYSICIAN / PROFESSIONAL SERVICES			
Diagnostic Office Visits	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	22
Routine Physical Exam – Adult age 19 and older / 1 per calendar year	Covered in Full	Deductible / Coinsurance Balance after Allowable Amount	22

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Routine GYN Exam	Covered in Full	Deductible / Coinsurance Balance after Allowable Amount	21
Adult – 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 Tests	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	23
Allergy Injections & Serum	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	23
Chiropractic 20 visits per calendar year	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	23
Diagnostic Vision & Hearing Examination	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	22
Routine Hearing Exam and Evaluation – Once every calendar year	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	22
Diabetes Education	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	24 / 25

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Surgical Care	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	18
Second Medical / Surgical Opinion	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	19 / 20
Office Consultation	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	23
Injectable Drug in Physicians Office	Deductible / Coinsurance	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	Deductible / Coinsurance	19 / 20
Inpatient Consultation	Deductible / Coinsurance	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
OUTPATIENT HOSPITAL SERVICES			
Diagnostic Imaging – X-rays/ Ultrasounds / CAT Scans / PET Scans / MRI	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14

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Diagnostic Laboratory and Pathology	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Surgical Care (Facility & Physician)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14 / 19
Anesthesia	Deductible / Coinsurance	Deductible / Coinsurance	19
Pre-Admission Exam (Physician)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Pre-Admission Testing (Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Injectable Drug – Outpatient Facility	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	15
THERAPY SERVICES			
Chemotherapy (Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Radiation Therapy (Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
Respiratory and Cardiac Therapy (Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	15
Physical Therapy – 24 visits per calendar year. (Facility & Physician) Combined In and Out of Network	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	15 / 19
Occupational Therapy – 24 visits per calendar year. (Facility & Physician) Combined In and Out of Network	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	15 / 19
Speech Therapy (Facility & Physician)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	15 / 19
Kidney Dialysis (Facility)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	14
EMERGENCY CARE			
Emergency Room Care – waived if Admitted	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	4 / 29

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Physician Visit in Emergency Room	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	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)	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	28
Ambulance – Ground	Deductible / Coinsurance	Deductible / Coinsurance Up to Charge	27 / 28
Ambulance – Air Medical Necessity Applies	Deductible / Coinsurance	Deductible / Coinsurance Up to Allowable Amount UPON REVIEW	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)	Deductible / Coinsurance	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)	Deductible / Coinsurance	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	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	21
OTHER SERVICES			
Home Health Care ** 40 visits per calendar year Combined In and Out of Network	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	16
Skilled Nursing Facility **	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	7 / 12
Hospice	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	17

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Durable Medical Equipment Combined In and Out of Network	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	24
Prosthetic Devices Combined In and Out of Network	Deductible / Coinsurance	Deductible / Coinsurance Balance after Allowable Amount	13 / 26
Medical Supplies Combined In and Out of Network	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	 $9.00 Copayment $18.00 Copayment $35.00 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 $36.00 Copayment $70.00 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 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

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.