

Benefit Type	Proposed Plan for TCCOG Benefit Description		New York State Teamsters Council Health & Hospital Fund Benefit Description	
<b>WHO IS COVERED</b>				
Type of Premium Tiers • individual • family	2-Tier (Individual and Family)		3-Tier (Individual, Two Person, Family)	
Dependent Coverage • Age to which dependents covered • Age to which students covered	Dependent to 19 <sup>th</sup> Birthday Student to 25 <sup>th</sup> Birthday			
Domestic Partner	Covered			
WAITING PERIODS Pre-Existing Condition Waiting Period	No – waived			
Pre-Certification	Not Required		Pre-certification required for all Inpatient Admissions and as soon as possible after an Emergency Admission – Penalty may be imposed for Non-Compliance	
<b>COST SHARING EXPENSES</b>				
Deductible Individual / Family	\$100/\$250 for Designated Services	When services are rendered by an Out of Network Provider, member is responsible for difference between in-network Allowed Amount and the Out of Network provider charge.	\$100/\$250 for Designated Services	When services are rendered by an Out of Network Provider, member is responsible for difference between in- network Allowed Amount and the Out of Network provider charge.
Deductible Carry-Over Y/N	Yes			
Coinsurance	20% of Allowed Amount		20% of Allowed Amount	
Annual Out-of-Pocket Maximum (excludes deductible, and co-payments)	\$400.00			

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<b>BASIC COVERAGE</b>				
<b>Inpatient Hospital Services</b> • Inpatient Admission for mastectomy must be covered for as long as attending physician deems medically necessary) (365 days per Calendar Year)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
<b>Acute Mental Health Care</b> Includes Partial Hospital 3:1 days. (Mandate: 30 days per calendar year, coverage equal to Inpatient Hospital Services)	Mandatory Rider Covered in Full – 30 Inpatient Days	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 30 Days	Mandatory Rider Covered in Full – 30 Inpatient Days	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 30 Days
<b>Acute Mental Health Care</b> Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Coverage is inclusive with Inpatient Hospital Services.		Coverage is inclusive with Inpatient Hospital Services.	
<b>Residential Treatment</b>	Not Covered	Not Covered		
<b>Inpatient Detoxification</b> (7 days per Calendar Year)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount		
<b>Skilled Nursing Facility</b>	Covered in Full 365 days per calendar year	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 365 Days		
<b>Inpatient Physical Rehabilitation</b>	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount		
<b>Inpatient Chemical Dependence and Abuse Rehabilitation</b> (49 days per Calendar Year)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full (42 Days – Lifetime)	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount (42 Days-Lifetime)
<b>Inpatient Maternity Care</b> (Mandated, 48 hrs regular delivery, 96 for c-section; one home care visit covered in full, not subject to any other home care visit limitations)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
<b>Newborn Nursery Care</b>	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
<b>Internal Prosthetics</b>	Included in Inpatient services		Included in Inpatient services	

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<b>MEDICAL/SURGICAL COVERAGE</b>				
Surgical Care including Surgicenters/Freestanding	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Pre-admission/Pre-Operative Testing (Mandated benefit; same as inpatient)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Diagnostic Imaging, Diagnostic Testing, X-ray, CAT, MRI	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Diagnostic Laboratory and Pathology	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Radiation Therapy and Chemotherapy	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Hemodialysis	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Routine Mammogram	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Cervical Cytology (Pap Smear, does not include exam)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Chemical Dependency (Mandated 60 visits, includes 20 family visits; should be on par with inpatient)	Covered in Full 60 Visits	Covered in full – 60 Visits Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full 60 Visits	Covered in full – 60 Visits Member responsible for difference between Provider Charge and Allowed Amount
Physical Therapy/Respiratory Therapy	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Surgery/Assistant Surgeon	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount

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<b>MEDICAL/SURGICAL COVERAGE (Continued)</b>				
Cardiac Rehabilitation	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount		
Home Health Care	Covered in Full – 40 Visits	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 40 Visits	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Hospice Care (Includes 5 bereavement counseling visits) (210 visits per Calendar Year)	Covered in Full	80% – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Emergency Room	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Ambulance	Deductible/80%	Deductible/80%	Covered in Full	Covered in Full
Urgent Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<b>MAJOR MEDICAL COVERAGE</b>	<i>In Network</i>	<i>Out of Network</i>	<i>In Network</i>	<i>Out of Network</i>
Inpatient Hospital – Additional Days	Covered in Full	Coinsurance	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Skilled Nursing – Additional Days	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Elective Sterilization	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Surgery – IP Physician	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Surgery – OP Physician	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Consultation - Inpatient	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount

Anesthesia	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Additional Surgical Opinion (mandate)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount

<b>Major Medical Coverage (Continued)</b>	<b><i>In Network</i></b>	<b><i>Out of Network</i></b>		
In Hospital Medical Care	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Emergency Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Adult Routine Physical 1 Per Calendar Year	Covered in Full	Not Covered		
X-rays	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Lab Tests	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Maternity	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
In-Hospital Physician Visits (IHM for mastectomy must be covered for as long as attending physician deems medically necessary)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Skilled Nursing Care	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount		
Well Child Visits and Immunizations (mandated visits/immunizations full coverage)	Covered in full	Covered in full	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Adult Immunizations	Not Covered	Not Covered		
Cervical Cancer Screen	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Chemotherapy	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Office Visits	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount

<b>MAJOR MEDICAL COVERAGE (Continued)</b>	<b><i>In Network</i></b>	<b><i>Out of Network</i></b>		
Chiropractic Visits	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount		
Eye Exams - Diagnostic	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount		
Hearing Evaluations Routine	Not Covered	Not Covered		
Hearing Aids	Not Covered	Not Covered		
Durable Medical Equipment	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Prosthetics	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Medical Supplies – including Diabetic Equipment and Supplies	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Office Consultations	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Home Care	Deductible/Coinsurance (325 Visit Max)	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount

<i>MAJOR MEDICAL COVERAGE (Continued)</i>	<i>In Network</i>	<i>Out of Network</i>		
Prostate Cancer Screenings (Mandated if office visits covered; coverage must be equal to office visits)	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Routine GYN Visits including Pap Smear (Mandated; same as other basic physician services; co-payment allowed on PPO)	Covered In Full, including Lab	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Diagnostic GYN Visits	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Speech Therapy	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount		
Allergy Testing and Treatment (Injections are inclusive)	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Mental Health Care (Federal Mandate – Unique financial limits not imposed on other benefits prohibited. NYS Mandate – 20 visits per calendar year combined with physician, coverage equal to diagnostic office visit.)	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/Coinsurance (30 visits annually)	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Coverage is equivalent to Diagnostic Office visits.		Coverage is equivalent to Diagnostic Office visits.	

Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at \$2,500 annually.)	Covered – see RX options	Not covered
<b>EXCLUSIONS:</b>		
Acupuncture	Excluded	
Blood products	Excluded	
Certification Examinations	Excluded	
Cosmetic Services	Excluded	
Custodial Care	Excluded	
Dental (non-accidental services)	Excluded	
Developmental Delay	Excluded	
Experimental and Investigational Services	Excluded	
Free Care	Excluded	
Hypnosis/Biofeedback	Excluded	
Military Service-Connected Conditions	Excluded	
No-Fault Automobile Insurance	Excluded	
Nutritional Therapy	Excluded	
Private Duty Nursing	Excluded	
Reproductive Procedures	Excluded	
Reversal of elective sterilization	Excluded	
Routine Care of the Feet	Excluded	
Self-Help Diagnosis, Training, and Treatment	Excluded	
Smoking Cessation Programs	Excluded	
Transsexual Surgery and Related Services	Excluded	
Weight Loss Services	Excluded	

**Note:** This benefit grid provides a summary of benefits only and does not, nor is it intended to, replace the legal contract.

\*Payments for all out-of-network benefits are based on participating provider allowances. Any difference between the allowance and the out-of-network provider's actual charge is the responsibility of the member, in addition to any applicable deductible, copayment or coinsurance amounts.