

Benefit Type	Proposed Plan for TCCOG Benefit Description		N.Y.S. Teamsters Council Health & Hospital Fund (Town of Dryden) Benefit Description	
WHO IS COVERED				
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 th Birthday Student to 25 th 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	
COST SHARING EXPENSES				
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		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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BASIC COVERAGE				
Inpatient Hospital Services • 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
Acute Mental Health Care 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
Acute Mental Health Care 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.	
Residential Treatment	Not Covered	Not Covered		
Inpatient Detoxification (7 days per Calendar Year)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount		
Skilled Nursing Facility	Covered in Full 365 days per calendar year	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 365 Days		
Inpatient Physical Rehabilitation	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount		
Inpatient Chemical Dependence and Abuse Rehabilitation (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)
Inpatient Maternity Care (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
Newborn Nursery 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
Internal Prosthetics	Included in Inpatient services		Included in Inpatient services	

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MEDICAL/SURGICAL COVERAGE				
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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<i>MEDICAL/SURGICAL COVERAGE (Continued)</i>				
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 40 Visits	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 40 Visits
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%	Deductible/80%	Deductible/80%
Urgent Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<i>MAJOR MEDICAL COVERAGE</i>	<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

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Major Medical Coverage (Continued)				
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
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	Covered in Full 10 Days/Year Balance Paid at 80%	
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		

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Major Medical Coverage (Continued)				
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	Deductible/Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
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

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Major Medical Coverage (Continued)				
Office Consultations	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
Home Care	Deductible/Coinsurance (325 Visit Max)	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/Coinsurance (325 Visit Max)	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
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	Deductible/Coinsurance	Deductible/Coinsurance - 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	Deductible/Coinsurance	Deductible/Coinsurance - 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	Deductible/Coinsurance	Deductible/Coinsurance - 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.	

	Retail	Mail-Order	Retail	Mail-Order
Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at \$2,500 annually.)	Tier 1 – \$5.00 Tier 2 - \$10.00 Tier 3 - \$25.00	Tier 1 – \$10.00 Tier 2 - \$20.00 Tier 3 - \$50.00	Tier 1 – \$5.00 Tier 2 - \$10.00 Tier 3 - \$25.00	Tier 1 – \$10.00 Tier 2 - \$20.00 Tier 3 - \$50.00
EXCLUSIONS:				
Acupuncture		Excluded		Excluded
Blood products		Excluded		Excluded
Certification Examinations		Excluded		Excluded
Cosmetic Services		Excluded		Excluded
Custodial Care		Excluded		Excluded
Dental (non-accidental services)		Excluded		Excluded
Developmental Delay		Excluded		Excluded
Experimental and Investigational Services		Excluded		Excluded
Free Care		Excluded		Excluded
Hypnosis/Biofeedback		Excluded		Excluded
Military Service-Connected Conditions		Excluded		Excluded
No-Fault Automobile Insurance		Excluded		Excluded
Nutritional Therapy		Excluded		Excluded
Private Duty Nursing		Excluded		Excluded
Reproductive Procedures		Excluded		Excluded
Reversal of elective sterilization		Excluded		Excluded
Routine Care of the Feet		Excluded		Excluded
Self-Help Diagnosis, Training, and Treatment		Excluded		Excluded
Smoking Cessation Programs		Excluded		Excluded
Transsexual Surgery and Related Services		Excluded		Excluded
Weight Loss Services		Excluded		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.