Health & Wellness

NEW YORK STATE OF OPPORTUNITY. | NY Power Authority

2021 IBEW NYPA Plan Benefit Summary
Retired Prior to 01/01/2007

Hospital & Major Medical Coverage		
Plan Features	**In-Network Benefits**	**Out-of-Network Benefits**
Cost Management Services Program/Pre-Certification	For employees who retired from NYPA after January 1, 2002, pre-certification is required for all inpatient admissions.	
	If pre-certification requirements are not met, there is a $250 penalty for each confinement that is not pre-certified.	
Inpatient Acute Care General Hospital Services (facility charges)	Paid at 100% (Semi-Private Room and Board Charge and Miscellaneous Charges)	Paid at 100% (Semi-Private Room and Board Charge and Miscellaneous Charges)
	Limited to 365 days for each cause. A Medically Necessary private room is covered.	
Hospital Outpatient Care (Facility Charges)	Paid at 100%	Paid at 100%
	Charges for out-patient treatment and services are covered up to a maximum benefit amount of $1,500 in any 12 consecutive month period, starting with, to begin when the first date of service is applied to the maximum. Any amount over the $1,500 will be covered under the Major Medical portion of the plan, subject to copay or deductible and coinsurance, depending on whether the provider is in-network or out-of-network.	
Blood and Plasma Charges	100% up to $25.00. Charges in excess are paid under the Major Medical portion of the plan, subject to copay or deductible and coinsurance, depending on whether the provider is in-network or out-of-network.	
	For retirees who retire on or after July 1, 2006, 100% up to $75. Charges in excess are paid under the Major Medical portion of the plan, subject to copay or deductible and coinsurance, depending on whether the provider is in-network or out-of-network.	
Emergency Room (Physician Fees)	Emergency Room treatment (physician fees) is not applied toward the outpatient maximum. When used for an emergency situation or accident, the treatment is covered in full up to $50. Any amount over the $50 will be covered under the Major Medical portion of the plan, subject to copay or deductible and coinsurance, depending on whether the provider is in-network or out-of-network.	
Home Health Care	Paid at 75% subject to a separate $50 annual deductible.	Paid at 75% subject to a separate $50 annual deductible.
Inpatient Diagnostic X-Ray and Laboratory Services (including interpretations)	Paid at 100%	Paid at 100%

Plan Features	In-Network Benefits	Out-of-Network Benefits
Physician Visits (While confined as an inpatient)	100% of Network Allowance	100% of the Reasonable and Customary (R&C) Charges.
	There is a $1,800 benefit maximum for each confinement. Charges in excess of $1,800 are paid at 80% under the Major Medical portion of the plan, subject to copay or deductible, depending on whether the provider is in-network or out-of-network.	
Inpatient Treatment of Alcohol and Substance Abuse	Paid at 100% for approved facility's semi-private room rate. Pre-certification required.	Paid at 100% for approved facility's semi-private room rate. Pre-certification required.
Outpatient Treatment of Alcohol and Substance Abuse	100% of Network Allowance Not subject to copay.	100% of Reasonable and Customary (R&C) Charges. Not subject to deductible.
Medical/Surgical Services and Supplies		
Plan Features	**In-Network Benefits**	**Out-of-Network Benefits**
Outpatient Diagnostic X-Ray and Laboratory Services (Interpretation Fee)	100% of Network Allowance	100% of Reasonable and Customary (R&C) Charges.
	If performed on an out-patient basis, tests and physician's fees are applied to the $1,500 outpatient services maximum benefit. Any amount over the $1,500 will be covered under the Major Medical portion of the plan, subject to copay or deductible, depending on whether the provider is in-network or out-of-network.	
Surgical Charges (including physician fees and associated expenses)	100% of Network Allowance	100% of Reasonable and Customary (R&C) Charges.
	You must receive a Second Surgical Opinion for the following surgeries: Back Surgery — Gynecological Cardiovascular Surgery — Hip Surgery Gall Bladder Surgery — Urological Surgery If a second opinion is not obtained when required, payment will be limited to 50% of the charges for the procedure.	
Second Surgical Opinion	100% of Network Allowance	100% of Reasonable and Customary (R&C) Charges.
Anesthesia (including administration)	Paid at 100%	Paid at 100%
Ambulatory Surgery (Surgery performed while not confined as an inpatient)	100% of Network Allowance	100% of Reasonable and Customary (R&C) Charges.
	Certain surgical procedures must be performed while not confined in a hospital as an inpatient (see Employee Handbook for details).	
	If one of the listed surgical procedures is performed while admitted as an inpatient, the surgery will be payable at 80% of the allowed amount or the Reasonable and Customary (R&C) Charges.	
Emergency Transportation	100% of Network Allowance up to $50. Any remaining balance is subject to copay under the Major Medical portion of the plan.	100% of Reasonable & Customary (R&C) Charges up to $50. Any remaining balance is subject to deductible and coinsurance under Major Medical.

Preventive Care		
Plan Features	**In-Network Benefits**	**Out-of-Network Benefits**
Routine Pap Smears (Laboratory Fee)	100% of Network Allowance, not subject to deductible and coinsurance. (Limited to one per year)	100% of Reasonable and Customary (R&C) Charges, not subject to deductible and coinsurance. (Limited to one per year)
Mammography (Test and Interpretation Fee)	If performed in a hospital - 100% of the Network Allowance (benefit payment applies toward the $1,500 outpatient treatment maximum benefit).	If performed in a hospital - 100% of Reasonable and Customary (R&C) Charges (benefit payment applies toward the $1,500 outpatient treatment maximum benefit).
	If performed in a doctor's office or private lab - $25 Network Copayment	If performed in a doctor's office or private lab – 80% of Reasonable and Customary (R&C) Charges, subject to deductible.
	Preventive mammography is covered once every three years if age 20-39, and once every year if over age 40. Diagnostic mammography, done because of suspected disease, is covered regardless of age.	

Major Medical Expense Benefits		
Plan Features	**In-Network Benefits**	**Out-of-Network Benefits**
Annual Major Medical Deductible	Unless shown otherwise, does not apply.	**Retired Prior to 1992** $90 Employee Only $180 Employee + One $270 Family **Retired Between 1992 and 1/1/02** $100 Employee Only $200 Employee + One $300 Family **Retired on or After 1/1/02** $200 Employee Only $400 Employee + One $600 Family
Network Copayment	$25 Copayment	Does not apply
Percentage Coinsurance	100% of Network Allowance	80% of the Reasonable and Customary (R&C) Charges.
Maximum: Out of Pocket Cost per Calendar Year (Includes combined in and out of network costs)	Unless shown otherwise, does not apply.	**Retired Prior to 1992** After you have paid an annual total of $425 out of your pocket, the plan will begin to pay 100% of major medical expenses (R&C) for the remainder of the plan year. **Retired Between 1992 and 1/1/02** After you have paid an annual total of $475 out of your pocket, the plan will begin to pay 100% of major medical expenses (R&C) for the remainder of the plan year.

Plan Features	In-Network Benefits	Out-of-Network Benefits
		Retired on or after 1/1/02 After you have paid an annual total of $650 out of your pocket, the plan will begin to pay 100% of major medical expenses (UCR) for the remainder of the plan year. Out-of-pocket expenses do not include amounts paid toward deductibles or amounts in excess of Reasonable and Customary (R&C) Charges.
Physician Office Visits	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Virtual Visits	$15 Copayment per call Talk to a doctor from your mobile device or computer and get help for minor health issues.	Not Covered
Chiropractic Care	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
	Chiropractic Care is limited to 30 visits. After that, the chiropractor must certify that the treatment will result in a medical improvement in your condition. Maintenance care is not covered.	
Out-Patient Psychiatric Care	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges. Coinsurance amounts for out-patient psychiatric treatment are not applied to the out-of-pocket maximum.
Diagnostic X-Ray and Laboratory Services, including interpretation fees (Performed in a Doctor's Office)	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Diabetic Supplies	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Durable Medical Equipment	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Occupational Therapy	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Allergy Injections	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Cardiac Rehabilitation	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges
Foot Orthotics	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Physical Therapy	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.

Plan Features	In-Network Benefits	Out-of-Network Benefits
Speech Therapy	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Chemotherapy	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Kidney Dialysis	$25 Copayment	80% subject to deductible and Reasonable and Customary (R&C) Charges.
Prescription Drugs		
Plan Features	**Non-Participating Pharmacy**	**Participating Pharmacy**
Retail	File a Prescription Drug Reimbursement Form. Reimbursed the reasonable cost for a covered drug less the applicable copayment amount.	**Retired Prior to 1992** $1 copay for each prescription 30 day supply or 100 units **Retired Between 1992 and 12/31/01** $0 generic $2 brand, if no generic available $8 brand, if generic is available 30 day supply or 100 units **Retired Between 2002 and 12/31/06** $0 generic $5 brand, if no generic available $20 brand, if generic is available 30 day supply or 100 units.
Mail Order		**Retired Prior to 1992** $0 copay for each prescription 90 day supply **Retired Between 1992 and 12/31/01** $0 copay 90 day supply **Retired Between 2002 and 12/31/06** $0 generic $5 brand, if no generic available $20 brand, if generic is available 3 month supply

Contact Information		
UHC Customer Service Number	866-633-2446	866-633-2446
Website	www.myuhc.com	www.myuhc.com

NYPA has established that this plan or coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

This summary is meant to provide a general outline of the main provisions of the IBEW New York Power Authority Medical Plan. Details of these programs are contained in the benefits handbook and addendums. If there is a difference between this summary and the documents or contracts, the documents and contracts will govern in every instance.