Total Rewards

NEW YORK STATE | NY Power Authority

2025 Teamster Plan Benefit Summary
Retirees

Plan Features	Description
In-Network	
Copayments	$25
Out-of-Network	
Annual Deductible	
Employee	$140
Family	$420
Coinsurance	80% of R&C after deductible
Annual Out-of-Pocket Maximum	$500 per covered family member
Lifetime Maximum Benefits	Unlimited
Reasonable & Customary (R&C) Limits	Applies to all out-of-network services
Physician Visits	
Physician Office Visits	In-network: $25 copayment Out-of-network: 80% of R&C after deductible
Virtual Visits	In-Network: $15 copayment per call Out-of-Network: Not Covered Talk to a doctor from your mobile device or computer and get help for minor health issues.
Hospital Benefits	
Hospital In-Patient Acute Care	Up to 365 days covered at 100%. Another 365 days become available after 90-day separation. Semi-private room. Pre-certification mandatory for inpatient hospital admissions. A $250 penalty is assessed for each confinement that is not pre-certified.
Hospital Outpatient Care	100% up to maximum benefit amount of $500 in any 12 consecutive month period to begin when the first date of service is applied to the maximum. Any amount over the $500 will be covered under the major medical, subject to copay or deductible and coinsurance, depending on whether the provider is in-network or out-of-network.

Hospital Benefits	
Emergency Room Coverage	Treatment in emergency room within 5 days of illness or injury, paid in full up to the $500 outpatient, then a $25 copay regardless of in-network or out-of-network.
	ER physician fees, when used for emergency situation or accident, are covered in full up to $25, then a $25 copay regardless of in-network or out-of-network.
Inpatient Physician Visits	In-network: 100% of network allowance up to $1,800. Charges in excess are paid under major medical, subject to $25 co-payment per visit.
	Out-of-network: Paid at 100% of R&C up to $1,800. Charges in excess of $1,800 are paid under major medical, subject to deductible and 80% of R&C.
Inpatient Diagnostic X-Ray and Laboratory Services	Paid at 100% under hospitalization.
Home Health Care	Must be ordered in writing by a doctor. Paid at 75%, subject to a separate $50 deductible. 40 visits allowed per calendar year.
Alcohol/Substance Abuse Treatment	
Inpatient	100% for treatment in a hospital, approved facility, or treatment center. Pre-certification required
Outpatient	100% of either network allowance or R&C, depending on whether provided is in-network or out-of-network, for up to 60 visits per calendar year, not subject to copay or deductible.
Other Medical Services	
Outpatient Diagnostic X-ray and Laboratory Services	In-network: 100% of network allowance
	Out-of-network paid at 100% of R&C charges.
	If performed on an outpatient basis, tests and physician's fees are applied to the $500 outpatient services maximum benefit. Any amount of the $500 will be covered under the major medical, subject to copay or deductible and coinsurance, depending on whether the provide is in-network or out-of-network.
Outpatient Surgical Charges	In-network: 100% of network allowance (subject to second surgical opinion and ambulatory care guidelines.
	Out-of-network paid at 100% of R&C charges (subject to second surgical opinion and ambulatory care guidelines).
Ambulance Service	Charges paid in full up to $50 for transportation to and from the hospital by a professional ambulance service. After the first $50, the remaining balance paid at 80% under the major medical portion of the plan.
Chiropractic Care	In-network: $25 copayment. Covers up to 30 visits for active treatment. Maintenance care is not covered.
	Out-of-network: 80% of R&C after deductible. Covers up to 30 visits for active treatment. Maintenance care is not covered.

Outpatient Mental Health Coverage	In-network: $25 copayment per visit
	Out-of-network: 80% of R&C after deductible
Other Medical Services	
Vision Care	Not covered
Hearing Aids	Not covered
Prescription Drugs	
Retail Copays	$0 generic $2 brand-name $8 for brand name with generic available. Non-participating pharmacy - reimbursed the cost of the prescription less the applicable copayment amount, if any. Must use out-of-network form for reimbursement.
Mail Order Copay	$0 copay, 3-month supply
Contact Information	
UHC Customer Service Number	866-633-2446
Website	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 Teamster 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.