SUMMARY PLAN DESCRIPTION
FOR

POUGHKEEPSIE PUBLIC SCHOOL TEACHERS' ASSOCIATION BENEFIT TRUST GROUP HEALTH & DENTAL PLAN

Medical Claims Administrator:

Prescription Drug Claims Administrator:

Effective: September 1, 2015

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INTRODUCTION

This document is a description of Poughkeepsie Public Teachers' Association (PPSTA) Benefit Trust Group Health & Dental Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions and eligibility.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, Medical Necessity, failure to timely file claims, or lack of coverage.

The Plan will pay benefits only for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated. An expense for a service or supply is Incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges Incurred before termination, amendment or elimination.

This document describes the Plan rights and benefits for covered Employees, Retirees and their covered Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning. If a word or phrase has a specific meaning, it starts with a capital letter and is either defined in the "Defined Terms" section or in the text of this document where it occurs.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE, AND TERMINATION PROVISIONS

ELIGIBILITY

The content in this section is not intended to constitute, or be validated as, the origin or basis for Plan eligibility requirements. The PPSTA Trust can provide details concerning your specific eligibility requirements for Plan enrollment.

Eligible Classes of Employees. All Active and Retired Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is an Active Employee of the Employer. An Employee is considered to be Active per the terms of their collective bargaining agreement(s).

(2) is a Retired Employee of the Employer.

(3) is in a class eligible for coverage.

Persons not Eligible for Benefits. Persons in the following categories are not eligible for Plan enrollment or coverage under the Plan:

(1) Any terminated or laid-off employee.

(2) Persons providing services to the Employer through a temporary agency or employer leasing organization.

(3) An independent contractor providing services to the Employer.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) **A covered Employee's Spouse.** The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state or other jurisdiction where the covered Employee lives or was married, and shall not include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the state or other jurisdiction in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

(2) **A covered Employee's Child(ren).** An Employee's "Child" includes his natural Child, stepchild, Foster Child, adopted Child, Legal Guardianship, or a Child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the Child reaches the applicable limiting age, coverage will end on the last day of the Child's birthday month.

The phrase "Child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any Child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(4) **"Young Adult Option".** An unmarried child over the limiting age can be covered under the Covered Employee's/Retiree's (parent's) employee health plan through age 29, even if he or she is not financially dependent on the parent, or does not live with the parent, or is a not a student. The following criteria must be met:

(a) the parent must be covered under the Plan as an Employee; and

(b) the Dependent cannot be covered under or be eligible for any other employer sponsored group health plan or policy or be covered under Medicare; and

(c) the Dependent must reside or work in New York State; and

(d) be under 29 years of age.

A Dependent Child or the Employee parent who elects to continue coverage under this "Young Adult Option" is responsible for the cost of single coverage, as designated by the Employer.

The Employee or Dependent Child must apply in writing (and submit the first month's full individual contribution):

- within 60 days following termination of coverage due to the Plan's limiting age for a Dependent Child;
- within 60 days of newly meeting the Plan's definition of Dependent Child;
- during the Plan's annual open enrollment period;
- if the child's coverage has already terminated due to limiting age, coverage may also be elected on a prospective basis within 12 months after the effective date of this provision.

If the Child enrolls within the time periods described above, the extension of coverage will be effective:

- retroactive to the date that coverage was terminated due to reaching the limiting age.
- otherwise, coverage will begin within 30 days following the date the Employer receives the application and full contribution for coverage.

This extension of coverage terminates when the Dependent Child becomes eligible under another group health policy or plan, is married, reaches age 29, or no longer resides or works in New York State. The Dependent Child is **not** eligible for COBRA continuation of coverage.

If a Child's extension of coverage terminates, he or she may be eligible to re-enroll under this provision if he or she meets the Plan's definition of a Dependent Child and either enrolls within 60 days or during an open enrollment period.

(5) **Grandchild.** A grandchild is eligible for a limited time only, unless the Employee or the Employee's Spouse has legal custody or guardianship over such child and legal documentation is provided to the Plan within 60 days of court approval (see number 3 above). The newborn must be enrolled within 30 days of birth. The COBRA date of the event will be the birth of the child and COBRA premiums will begin as of the first day of the month following the birth of the child. If COBRA is not elected and the newborn is timely enrolled, the newborn will be covered for the first 30 days of birth only.

(6) **A covered Dependent Child who reaches the limiting age and is Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the Child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee/Retiree; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person was covered under this Plan before the change in status, all amounts will be applied to the maximums. If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee and the person is covered continuously under the Plan before, during and after the change in status, credit will be given for Deductibles.

If a person covered under this Plan changes status from Active Employee/Dependent to Retired Employee/ Dependent, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums of the Retiree Plan.

If both parents are Employees, their Children will be covered as Dependents of one parent, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Young Adult or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

Failure to report enrollment changes could result in mispayment of Plan benefits. Should this happen, you may be required to reimburse the full amount of any benefit overpayment.

FUNDING

Cost of the Plan. PPSTA shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The enrollment application for coverage may include a payroll deduction authorization. This authorization should be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

Exceptions: A Dependent Child (or Employee parent) who elects to continue coverage under the “Young Adult Option” described in Eligible Classes of Dependents is responsible for the cost of single coverage, as designated by the Employer.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for Employee-only or Dependent coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization, if applicable.

If the covered Employee already has Dependent coverage, separate enrollment for a newborn Child is required.

Enrollment Requirements for Newborn Children. A newborn Child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan.

Charges for covered nursery care and Physician care will be applied toward the Plan of the covered newborn. If the newborn Child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

TIMELY ENROLLMENT

Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (Spouses) are covered under the Plan and the Employee covering any Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Employee; no Waiting Period is required if coverage has been continuous.

A Retiree who has single coverage at the time of retirement may enroll a Spouse and/or Dependent within 60 days of the date of acquiring new Dependents. If a Retiree's Spouse dies and the Retiree remarries, they can add the new Spouse and any Dependents within 60 days of the date of acquiring the new Dependents. Otherwise, new Dependents can only be added during open enrollment.

OPEN ENROLLMENT

The annual open enrollment period will be the month of May and is a time for covered Employees and their covered Dependents to change some of their benefit decisions based on which benefits and coverages are right for them. Open Enrollment is not applicable to dental; eligibility is determined by the collective bargaining agreement.

Benefit choices made during the open enrollment period will become effective July 1 and remain in effect until the next first day of the following July 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SPECIAL ENROLLMENT PERIODS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below.

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Losing Other Coverage May Create a Special Enrollment Right.** An Active Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all each of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was under COBRA and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage and the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a Lifetime limit on all benefits. This provision may no longer apply for certain Plan Years starting September 22, 2010.

(ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(iii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(v) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) **Acquiring a Newly Eligible Dependent May Create a Special Enrollment Right.** If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan. If the employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a Child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 31 days and begins after the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, not later than the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Eligibility Changes in Medicaid or State Child Health Insurance Programs May Create a Special Enrollment Right. An Employee or Dependent who is eligible for, but not enrolled in this Plan, may also enroll in this Plan when:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

WAIVER OF COVERAGE

If an Employee has other health coverage they may choose to “opt-out” of this Plan and receive a “buy-out” payment. This option is only available once a year during the open enrollment period, must be completed annually, and must be documented with proof of other group health coverage. If you choose to “opt-out” of the Plan during open enrollment, the “opt-out” period will be effective for the following Calendar Year. The PPSTA Trust can provide full details concerning the “opt-out” eligibility requirements. The level of the monetary incentive is set by the collective bargaining agreement.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

If the enrollment form is received by the Trust within 30 days following date of hire (or rehire), coverage is effective date of hire. However, if the enrollment form is received by the Trust more than 30 days from date of hire (or rehire), but within 60 days from date of hire, then coverage is effective as of the date the Trust receives the enrollment form. If the enrollment form is received more than 60 days from date of hire, then the Employee will have to wait for Open Enrollment.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The end of the month the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the Continuation Coverage Rights under COBRA.)

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Coverage Rules While on Leave of Absence. Employee status will be retained on any paid leave pursuant to the collective bargaining agreement(s) (cba) with this Plan or any approved leave, as follows:

(1) Family and Medical Leave Act (FMLA) under federal law (paid or unpaid) up to a maximum of 12 weeks when group health benefits are continued;

(2) Child care leave (without pay following FMLA leave) will be granted for up to two years. Benefits can only be continued under COBRA;

(3) Paid sick leave for any personal Illness or any other family situation, as approved by the District, and any paid leave from the sick bank that could be granted to teachers when group health or dental benefits are continued pursuant to the cba and/or the policies adopted thereunder;

(4) Any Workers' Compensation leave when group health or dental benefits are continued pursuant to the cba, and/or the policies adopted thereunder; or

(5) Any other District-approved leave including a disability leave of absence, in excess of that required under FMLA, pursuant with the cba.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if active work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: per the terms of the collective bargaining agreement.

For leave of absence or layoff only: per the terms of the collective bargaining agreement.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, to the extent permitted by applicable law.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason except death. (See Divorced/Widowed Spouses of Retirees; Continuation Coverage Rights under COBRA.)

(3) 30 days following the date the Employee/Retiree dies. (See Divorced/Widowed Spouses of Retirees; Continuation Coverage Rights under COBRA.)

(4) The last day of the month a covered Spouse loses coverage due to loss of dependency status (legal separation or divorce). (See Divorced/Widowed Spouses of Retirees; Continuation Coverage Rights under COBRA.)

(5) The end of the Calendar Year that a Dependent Child who is not a full-time student (see below) ceases to be a Dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)

(6) The last day of the month that a Dependent Child ceases to be a Dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)

(7) “Young Adult Option” Dependents will end the end of the month the Dependent turns 30.

(8) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(9) 30 days from date of birth of the grandchild or newborn of a covered Dependent un-married daughter. (See the Continuation Coverage Rights under COBRA.)

(10) The end of the month in which a disabled Dependent’s disability status changes or when eligible for Medicare. Once eligible for Medicare, a Dependent is required to enroll in Medicare parts A, B and D and coverage under this Plan will terminate as of the effective date of Medicare. Coverage terminates once the Dependent is no longer claimed as a dependent on your tax return.

(11) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan’s discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days’ advance written notice of such action.

Extended Coverage for Certain Divorced or Widowed Spouses of Retirees

Subject to COBRA rules, COBRA coverage is available for the first 36 months for any Spouse who would lose

coverage due to divorce or death. The initial COBRA period can be extended under this Plan subject to the following rules:

(1) If the divorced Spouse has been married to the Retiree for five or more years, been covered under the Plan for five or more years and is at least 55 years old or older, coverage can be continued at COBRA rates for the Spouse's lifetime, as long as the Plan remains in effect; or

(2) A widowed Spouse of a Retiree can continue COBRA coverage for his/her lifetime following the death of the Retiree, at COBRA rates.

If the Spouse remarries, additional dependents or a new spouse cannot be added after the initial COBRA period (36 months) expires. During the initial COBRA period, the Spouse can add a new spouse or dependents but they may only be covered during the initial COBRA period and are not eligible for extended coverage beyond the initial COBRA period. COBRA rules, with respect to payment and lapse of coverage will continue to apply to extended COBRA coverage under this paragraph. The Enrollee must request continued coverage under this option and make monthly payments to retain continued coverage, subject to COBRA rules. Dependent Children covered at the time of the event (Qualified Beneficiaries) would be eligible for continued coverage after the initial COBRA period only if family coverage is maintained.

The PPSTA Trust can provide full details concerning eligibility and Plan Participation costs.

Collective Bargaining Agreement (cba)

If this Plan covers Employees subject to a cba, that agreement will prevail over the terms of this Plan if there is a dispute. If the cba does not address the situation, Plan rules will apply.

SCHEDULE OF BENEFITS

Verification of Eligibility 1.866.227.9936.

Call this number to verify eligibility for Plan benefits **before** the charge is Incurred.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

The Plan is a plan which contains multiple Network Provider Organizations.

PPO name: POMCO Allied Network/Multiplan/PHCS
Address: 2425 James Street
Syracuse, New York 13206
Telephone: 1.866.227.9936
Web: www.ppsta.MyPOMCO.com (log on-click on provider finder)

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. The Plan agrees to reimburse the Provider directly for covered services.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment percentage and In-Network Deductible will be made for certain Out-of-Network services based on URC:

- If a Covered Person is out of the In-Network service area and has an Emergency Condition requiring immediate care.
- If a Covered Person receives Physician or anesthesia services by an Out-of-Network Provider at an In-Network facility (includes surgery, assistant surgery, diagnostic tests, and emergency room Physician charges).
- If a Covered Person is not able to locate an In-Network Provider for Preventive Care Services, there will be no cost sharing for the Out-of-Network Provider’s charges for those covered Preventive Care Services.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, upon request.

Transitional Care. If the Enrollee’s Provider leaves the Network while the Enrollee is undergoing a course of treatment, the Enrollee may be able to continue to receive treatment from that Provider. The Provider must agree to continue to accept the negotiated fees that were in effect prior to termination from the Network and all other policies and procedures that were required prior to termination. Transitional Care will not be an option if the Provider was terminated due to a quality of care issue. Only certain medical conditions are eligible for transition of care. Upon your request, generally, treatment can be continued from your Provider when the following conditions are met and you are receiving ongoing treatment for the any of the following:

- **Acute Condition** – is a medical condition with a sudden onset of symptoms due to Injury, Illness, or other medical problem that requires prompt medical attention for a limited duration. Transition of care services are provided for the duration of the acute condition.

- **Serious Chronic Condition** – is a medical condition due to disease, Illness, or other medical problem or disorder that is serious in nature and that continues without cure, or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Transition services must be provided for a period of time long enough to complete your course of treatment and arrange for a safe transfer to another Provider, up to a period of 12 months.

- **Pregnancy** – includes the three trimesters of Pregnancy and the immediate postpartum period. The immediate postpartum period is the first six weeks after the birth of the child. Transition services must be provided for the duration of the Pregnancy and postpartum period.

- **Terminal Illness** – is an incurable or irreversible condition that has a high probability of causing death within one year or less. Transition services must be provided for the duration of the terminal Illness.

- **Care of a Newborn Child** – is a Child between the ages of birth and 36 months. Transition services must be provided for the care of a newborn Child for a period not to exceed 12 months.

- **Scheduled Surgery** – includes a surgery or other procedure that is authorized by the Plan as part of a documented course of treatment and scheduled to occur within 180 days of the contract termination date or the effective date of coverage for a new Enrollee.

Requests for transition of care service must be made within 60 days of the effective date of coverage under this Plan; or 30 days of Provider contract termination, unless not reasonably possible, the request must be the greater of 90 days following the Provider's termination.

Out of Country Care. This Plan will provide benefits for covered expenses Incurred outside the USA. Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. You may be required to pay the Provider at the time of service. If expenses outside the USA are Incurred, you must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where service are rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Plan Administrator reserves the right to reimburse the Enrollee directly.

Services provided outside the US, Canada, or Mexico will be subject to the Out-of-Network Deductible and Copay for each incident. The Deductible/Copay will not apply to the Out-of-Network Deductible or Out-of-Pocket limits. After the Deductible/Copay is met, the Covered Person will be responsible for the basic Out-of-Network coinsurance up to the Out-of-Network Out-of-Pocket limit for Emergency Services or for any other non-Emergency Services allowed by the Plan.

Non-emergency treatment such as a chronic Illness requiring Hospitalization outside the US will not be covered unless the treatment is preauthorized within 24 hours of admission (72 hours if Hospitalized over the weekend). No unapproved non-Emergency Services for medical services rendered outside the US are covered.

Emergency treatment in Canada or Mexico will be subject to the same emergency room Copay as treatment within the US.

Coordination of Benefits. When services and supplies are rendered and billed by an In-Network or Out-of-Network Provider and this Plan is the secondary payer of benefits according to the Coordination of Benefits provision and Medicare Secondary Payer rules. All benefits will still apply. Copayments still apply.

If Medicare is primary, any Medicare Provider is considered an In-Network Provider when this Plan is secondary. Once the Medicare Calendar Year Deductible has been met, no Copays will apply for the remainder of the Calendar Year.

Deductibles/Copayments Payable by Plan Participants. Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new Deductible amount is required.

A Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. Copayments accrue toward the 100% maximum Out-of-Pocket payment.

COST MANAGEMENT SERVICES

Precertification or preauthorization does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review based entirely on the limited information provided to the POMCO Benefit Management Department at the time of the requested service authorization. All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions in force at the time services are rendered.

Cost Management Services Phone Number

POMCO – 1.866.227.9936

Please refer to the Employee ID card for the Cost Management Services phone number.

This Cost Management program does not apply if your primary coverage is Medicare or another group health benefit plan.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least seven business days in advance of services being rendered or within two business days after an emergency.

Any costs Incurred because of reduced reimbursement due to failure to follow Cost Management procedures will not accrue toward the 100% maximum Out-of-Pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(1) Precertification of the Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided:

Home health care
Hospice
Hospitalizations
Mental Disorder/Substance Use Disorder inpatient admissions
Morbid Obesity surgery
Rehabilitation Facility stays
Skilled Nursing Facility stays
Transplants, including but not limited to organ and stem cell transplants

(2) Medical procedure review:

Breast reduction surgery
Dental surgery
Dialysis – hemodialysis and peritoneal dialysis (outpatient or home setting)
DME over $500
Eye lid surgery
Infertility procedures
Infusion (intravenous) services (separate from home health care)
MRA (magnetic resonance angiography)
MRI (magnetic resonance imaging), multiple scans same date of service
Panniculectomy surgery (to remove excess abdominal skin and fatty tissue)

PET scans
Thigh lift surgery
Varicose vein surgery

(3) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(4) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(5) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least 14 business days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Member ID number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within two business days** after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 50% up to a maximum of $250.

Concurrent Review, Discharge Planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with

the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital or Skilled Nursing Facility;
-- determining alternative care options; and
-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. ***Approved charges for alternative benefits will be subject to the Plan's Out-of-Pocket limitations.***

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SPECIAL PROGRAMS

Enrollees are encouraged to enroll in the following special programs prior to receiving special benefits. These programs are voluntary. If not enrolled, benefits will be payable the same as any other benefit if the service is covered by the Plan.

The Prenatal Program. Pregnant Enrollees must enroll in this program within the first trimester (first 14 weeks of Pregnancy or 60 days from Plan eligibility) by calling the Claims Administer and completing an enrollment form. Upon completion of the enrollment form, please submit it to the Claims Administrator. Once enrolled in the program, the following benefits will apply:

(1) Routine nursery care payable at 100% of Allowed Charges

(2) Maternity benefits payable at 100% of Allowed Charges after the first visit of $15, includes routine office visits, testing, delivery, and routine nursery and post-partum treatment. The Hospital Copay will be waived.

(3) Routine two-dimensional (2-D) standard obstetrical ultrasounds will be payable at 100% of Allowed Charges during Pregnancy. Three-dimensional (3-D) and four-dimensional (4-D) ultrasonography are not covered.

(4) The In- and Out-of-Network Deductibles are waived.

Pregnant Enrollees who do not enroll during the first trimester will be responsible for normal Copays; maternity services will be paid the same as any other benefit, depending on services rendered.

Diabetic Program. If the Covered Person is diagnosed with diabetes or borderline diabetes, you must enroll as a diabetic by calling the Claims Administrator. Once enrolled, the following benefits will apply:

(1) Insulin and testing equipment, plus Glucophage and Metformin will be covered at 100% of Allowed Charges for non-Medicare prime Enrollees.

(2) The following will be covered at 100% of Allowed Charges: testing strips and prick sticks (up to four per day or 125/month), glucose monitoring machine (once every three years if needed) and other supplies as approved by the Plan. Additional testing supplies will be covered if Medically Necessary.

(3) Other medications, including Glucophage kits, are covered the same as any other prescription and are subject to normal prescription Copay, except for items listed in (1) above.

(4) Diabetic training and education will be covered at 100% of Allowed Charges up to 20 visits per Calendar Year for a certified diabetic trainer or dietician.

(5) Nutritional counseling will be covered at 100% of Allowed Charges up to 20 visits per Calendar Year.

(6) Insulin pumps will be covered at 100% of Allowed Charges (includes infusion pump and supplies).

(7) Diabetic testing will be covered at 100% of Allowed Charges. This includes an annual eye exam and foot exam; urine protein measurement, as needed; lipid profile, as needed; HbA1c exams; and blood pressure exams, as needed.

Mail order is required for all maintenance drugs. Normal Generic Copay will apply to all maintenance drugs filled at retail level after the third refill, if mail order is not used. Covered Persons not enrolled in this program will pay normal prescription Copays for all drugs.

Covered Persons who have Medicare primary coverage must get their diabetic supplies through Medicare, then submit claims to this Plan for review. This Plan will reimburse you or the Provider for any portion of the cost not covered by Medicare Part B; claims must be submitted within one year from date of service.

Infertility Program. To enroll in this program, you must call the Claims Administrator. Covered Persons must be continuously covered under this Plan for 18 months or more prior to eligibility for this program. Patient must not have attained age 40 to be eligible for this program. No benefits are available outside of this program for Infertility or IVF treatment. Benefits and Copays under this program will not apply to the Plan's Deductible or Out-of-Pocket limits. Once enrolled, the Plan will cover 70% (80% for In-Network Providers) of Allowed Charges if pre-approved, up to a maximum of $10,000 per Calendar Year or $25,000 per Lifetime.

Prescription Drugs will be covered at 80% if pre-approved under the Prescription Drug Benefit.

Infertility benefits are subject to these conditions:

(1) Treatment rendered outside the approved treatment plan will result in immediate disqualification of any future benefits with this program.

(2) Failure to follow the treatment plan, to get approval of any change in the treatment plan, or failure to submit reports and updates as requested from the Claims Administrator will result in immediate termination from the program and services after that date will not be covered.

(3) Any surgical procedure, directly or indirectly related to Infertility, must be pre-approved. .

(4) Infertility treatment is not available if Infertility is the result of a previous sterilization procedure.

(5) The Covered Person is responsible for all excess charges in connection with the Infertility treatment.

(6) The Covered Person is responsible for enrolling in the prenatal program within 14 weeks of becoming Pregnant.

(7) The primary doctor must be board certified in gynecology with a sub-specialty in reproductive endocrinology. No benefits will be allowed for non-board certified specialists.

(8) The Covered Person must enroll in the program. A list of In-Network board certified specialists may be requested.

(9) The Provider must submit a treatment plan, as well as any subsequent changes, for approval. The Provider must agree to follow the Plan rules regarding any treatment, subject to Plan exclusions.

Weight Loss Program. Enrollee must be enrolled in a supervised weight loss program for a minimum of three months prior to approval of any bariatric, lap band, or other stomach bypass-type surgery and must undergo counseling regarding the procedure's possible side effects.

SUMMARY OF BENEFITS
Medical Benefits

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to **Covered Services**, **Plan Exclusions**, and **Defined Terms**.

Plan Features	In-Network Benefits (POMCO Allied/PHCS/MultiPlan Networks)	Out-of-Network Benefits
Outpatient Deductible per Calendar Year as of 1/1/2012	Shall be equal to the Medicare Deductible announced each January: $140 per individual $280 per two persons $420 per family of three or more	$1,000 per individual $3,000 per family
	Deductible applies to Outpatient Services only. For services where the Deductible applies, the Deductible must be met before Copays or coinsurance apply, except where benefits are paid at 100%. Deductible applies to Medicare primary Enrollees effective 01/01/2011.	
Network Copayment	**POMCO/PHCS/MultiPlan/ Medicare Prime Providers:** $25 per visit "Per visit" means per Provider per day. If two services are performed during a visit that has a Copayment, the higher Network Copayment will apply. When Medicare is prime: Once the Medicare Calendar Year Deductible has been met, no Network Copays will apply for the remainder of the Calendar Year.	Does not apply
Hospital Copayment	$500 Copay (maximum $1,000 Copay per Covered Person, per Calendar Year)	$500 (maximum $1,500 per Covered Person, per Calendar Year)
Foreign Copayment	$250 per Injury/spell of Illness Copay applies to the emergency room services outside Canada and Mexico in addition to the Emergency Room Copay. Foreign services must be preauthorized except for emergency treatment and extended treatment following an emergent, Medically Necessary admission.	
De minimis Copays	Copays of $15 or less for medical services and $10 or less for Prescription Drugs when this Plan is secondary will not be reimbursed.	
Benefits While Residing Outside of the USA	Please see the Foreign Copay for Emergency room services. The Allowed Charges for other services will be limited to what would have been allowed by Medicare (if the Enrollee is enrolled in Medicare or not) as if Medicare were primary. Medicare does not provide coverage for treatment outside the US, so benefits will be assumed and treated as if this Plan were secondary. Maximum benefit is limited to 35% of Allowed Charges based on as if Medicare were primary. **Exchange students/Dependents** living abroad are not covered, except for Emergency Services.	
Percentage Coinsurance	See individual plan features for details.	See individual plan features for details.

Plan Features	In-Network Benefits (POMCO Allied/PHCS/MultiPlan Networks)	Out-of-Network Benefits
Medical Out-of-Pocket (OOP) Limit Including Deductible, per Calendar Year	$1,250 per person + Deductible $2,500 per family + Deductible PPO inpatient and outpatient Copays and coinsurance combined	$2,500 per person + Deductible $5,000 per family + Deductible Inpatient and outpatient coinsurance.
	OOP limit does not apply to: Infertility, ancillary benefit (vision exam, wellness benefits, and hearing aids), refractive surgery, Prescription Drug OOP amounts, specific benefits as noted in the Schedule of Benefits, any expenses for which benefits were initially paid at 100% of Allowed Charges, and any expenses more than Plan Maximums or over URC amounts. In-Network and Out-of-Network OOP are separate; they are not combined. Once the OOP limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.	
Ancillary Charges	Under the following circumstances, the higher In-Network payment percentage and In-Network Deductible will be made for certain Out-of-Network services based on UCR: o If a Covered Person is out of the In-Network service area and has an Emergency Condition requiring immediate care. o If a Covered Person receives Physician or anesthesia services by an out-of-Network Provider at an In-Network facility (includes surgery, assistant surgery, diagnostic tests, emergency room Physician charges).	
The Prenatal Program	Pregnant Enrollees must enroll in this program within the first trimester (first 14 weeks of Pregnancy or 60 days from Plan eligibility) by calling the Claims Administer and completing an enrollment form. Upon completion of the enrollment form, please submit it to the Claims Administrator. **Once enrolled:** o Routine nursery care payable at 100% of Allowed Charges o Maternity benefits payable at 100% of Allowed Charges after the first visit of $15; includes routine office visits, testing, delivery, and routine nursery and post-partum treatment. The Hospital Copay will be waived. o Routine two-dimensional (2-D) standard obstetrical ultrasounds will be payable at 100% of Allowed Charges during Pregnancy. Three-dimensional (3-D) and four-dimensional (4-D) ultrasonography are not covered. Benefit is limited to one per Pregnancy unless additional tests are Medically Necessary. o The In- and Out-of-Network Deductibles are waived.	

Plan Features	In-Network Benefits (POMCO Allied/PHCS/MultiPlan Networks)	Out-of-Network Benefits
Diabetic Program	If the Covered Person is diagnosed with diabetes or borderline diabetes, you must enroll as a diabetic by calling the Claims Administrator. **Once enrolled:** o Insulin and testing equipment, plus Glucophage and Metformin will be covered at 100% of Allowed Charges for non-Medicare prime Enrollees. o The following will be covered at 100% of Allowed Charges: testing strips and prick sticks (up to four per day or 125/month), glucose monitoring machine (once every three years if needed) and other supplies as approved by the Plan. Additional testing supplies will be covered if Medically Necessary. o Other medications, including Glucophage kits, are covered the same as any other prescription and are subject to normal prescription Copay, except for items listed above. o Diabetic training and education will be covered at 100% of Allowed Charges up to 20 visits per Calendar Year for a certified diabetic trainer or dietician. o Nutritional counseling will be covered at 100% of Allowed Charges up to 20 visits per Calendar Year. o Insulin pumps will be covered at 100% of Allowed Charges (includes infusion pump and supplies). o Diabetic testing will be covered at 100% of Allowed Charges. This includes an annual eye exam and foot exam; urine protein measurement, as needed; lipid profile, as needed; HbA1c exams; and blood pressure exams, as needed.	
Infertility Program	Enrollee and Spouse must be continuously enrolled for a minimum of 18 months in the Plan. Patient must not have attained the age of 40. **Once enrolled:** o The Plan will cover 70% (80% for In-Network Providers) of Allowed Charges if pre-approved, up to a maximum of $10,000 per Calendar Year or $25,000 per Lifetime. o Prescription Drugs will be covered at 80% under the Prescription Drug Benefit.	
Weight Loss Program	**Once enrolled:** Enrollee must be enrolled in a supervised weight loss program for a minimum of 3 months prior to approval of any bariatric, lap band, or other stomach by-pass-type surgery and must undergo counseling regarding the procedure's possible side effects.	

Plan Features	In-Network Benefits (POMCO Allied/PHCS/MultiPlan Networks)	Out-of-Network Benefits
Cost Management Services Program/Pre-notification	This mandatory program requires a phone call before the Covered Person is admitted to a Hospital or before a surgical procedure is scheduled to be performed. Please contact the POMCO Benefit Management Program toll-free at 1.866.227.9936. A benefit reduction of 50% up to a maximum of $250 will be applied for non-compliance with this requirement. Pre-certification is required for the following services: Hospitalizations Substance Use Disorder/Mental Disorder inpatient admissions Skilled Nursing Facility stays Home health care Hospice care Infusion (intravenous) services (separate from home health care) Dialysis – hemodialysis and peritoneal dialysis (outpatient or home setting) DME over $500 Breast reduction surgery Dental surgery Eye lid surgery Infertility procedures MRA (magnetic resonance angiography) MRI (magnetic resonance imaging), multiple scans same date of service Panniculectomy surgery (to remove excess abdominal skin and fatty tissue) PET scans Thigh lift surgery Transplants, including but not limited to organ and stem cell transplants Varicose vein surgery Weight reduction surgical procedures	

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1-866-227-9936. See the section entitled Cost Management Services for details.
All services will be reviewed for Medical Necessity, except preventive and wellness benefits.

Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
Acupuncture	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Benefit is limited to $75 per visit. Limited to $2,500 combined with chiropractic and massage therapy per Covered Person per Calendar Year combined In- and Out-of-Network. Benefit limits do not apply if acupuncture is used as anesthesia.	
Allergy Injections	100% of Allowed Charges (when not part of office visit)	70% of Allowed Charges, after Deductible
Allergy Serum	100% of Allowed Charges	70% of Allowed Charges, after Deductible
Allergy Testing	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
Alternative Providers	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Limited to $500 per Covered Person, per Calendar Year, combined In- and Out-of-Network. Alternative Providers are Christian Science Practitioners and holistic medical Providers.	
Ambulance • **Air**	$500 Copay for an acute, life-threatening emergency, after Deductible. 50% of Allowed Charges for non- acute, life-threatening emergency, after Deductible.	
	Limited to $150 per air mile for medical support staff and equipment; $9,000 for the first 60 miles. Distances over 60 miles will be limited to Allowed Charges or as negotiated by the Plan.	
• **Professional and Volunteer, Including Paramedic Services** • Emergency Conditions	100% of Allowed Charges	100% of Provider charges
• Non-Emergency Conditions	50% of Allowed Charges, after Deductible	50% of Allowed Charges, after Deductible
• Medically Necessary Intra-Facility Transfers	90% of Allowed Charges, after Deductible	90% of Allowed Charges, after Deductible
	Professional and volunteer ambulance are covered. Ambulette and other transportation are not covered, except for intra-facility transfers.	
Ambulatory Surgical Center, Freestanding	100% of Allowed Charges	70% of Allowed Charges, after Deductible
Anesthesia	100% of Allowed Charges	
	Excludes services covered under the Infertility provisions of the Plan. Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.	
Autologous Conditioned Plasma (ACP) or Platelet-Rich Plasma (PRP)	$350 surgical Copay, after Deductible then 50% of Allowed Charges up to $1,500 per session.	Not covered
	Limited to treatment for injuries and arthritis only. This is an exception from the Investigational exclusion.	

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1-866-227-9936. See the section entitled Cost Management Services for details. All services will be reviewed for Medical Necessity, except preventive and wellness benefits.		
Service Type	**In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)**	**Out-of-Network Benefits**
Biofeedback	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Biofeedback provided via talk therapy will be paid as an out-patient mental health benefit.	
Blood and Blood Product Services	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Only allowed if required prior to scheduled surgery for an existing condition.	
BRCA (Breast CT scan)	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to one per Calendar Year combined In- and Out-of-Network or as Medically Necessary.	
Cardiac Rehabilitation • **Freestanding Facility**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Physician Office**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to 40 visits per Covered Person, per Calendar Year, combined In- and Out-of-Network.	
Chemotherapy • **Freestanding Facility**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Physician Office**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Physician office visit Copays are waived.	
Chiropractic Care	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Benefit is limited to $75 per visit. Limited to $2,500 combined with acupuncture and massage therapy per Covered Person per Calendar Year combined In- and Out-of-Network. Maintenance Care is not covered.	
Clinical Trials (Excludes the Actual Clinical Trial)	100% of Allowed Charges	Not covered
	Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-Network is only available if an In-Network Provider is unavailable.	
Cognitive Therapy	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Limited to 30 visits per Covered Person, per Calendar Year, combined In- and Out-of-Network, combined Cognitive, Occupational, Physical and Speech therapies. If approved an additional 20 visits (combined In- and Out-of-Network) could be allowed.	

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1-866-227-9936. See the section entitled Cost Management Services for details.
All services will be reviewed for Medical Necessity, except preventive and wellness benefits.

Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
Consultation		
• **Inpatient Consultation**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Outpatient/Office**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Second Surgical, Voluntary**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
Contact Lenses/Eyeglasses Following Intraocular/ Cataract Surgery	**Standard Lens:** 100% of Allowed Charges, after surgical Copay. **Premium Lens:** 80% of Allowed Charges after Deductible up to a maximum of $1,000 per lens.	70% of Allowed Charges, after Deductible
CT Low Radiation Lung Cancer Screening	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Limited to one every two years or as Medically Necessary per Covered Person, combined In- and Out-of-Network	
Dental Care, Limited	See type of service	70% of Allowed Charges, after Deductible
	☎ jaw surgery due to genetic defect or medical condition. Coverage available for services related to accidental Injuries treated within 12 months or impacted and/or wisdom teeth removal.	
Diabetic Education/ Counseling/Training	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to 10 visits (20 visits if enrolled in diabetic program) combined In- and Out-of-Network. Counseling/Training must be by a certified diabetic/nutritional trainer.	
Diabetic Supplies/Equipment	100% of Allowed Charges (if Medicare is not primary)	70% of Allowed Charges, after Deductible
	Medically Necessary glucometers and insulin pumps are covered under the "Durable Medical Equipment" benefit. Syringes are covered under the "Medical Supplies (home use)" benefit or "Prescription Drug Benefits". Additional diabetic supplies are covered under your "Prescription Drug Benefits".	
Diagnostic Testing (Includes Outpatient Hospital Facility)		
• **Genetic/Infertility/Impotence Testing**	See type of service rendered	70% of Allowed Charges, after Deductible
• **Laboratory (Including Independent and Free-standing)**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Machine Testing**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Professional Interpretation**	100% of Allowed Charges	70% of Allowed Charges, after Deductible

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
• **X-ray** • Less Than $2,500 (charged amount)	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• $2,500 or More (charged amount)	$100 Copay, after Deductible	70% of Allowed Charges, after Deductible
	☎ MRA, PET scans, multiple MRI. Copay applies to all tests combined on a daily basis by the same Provider. Excludes services covered under the Preventive Care and Infertility provisions of the Plan. Exception for services rendered by US Imaging Providers: Deductible, Copay, and precertification will be waived. Please call 1.866.227.9936 to locate a US Imaging Provider (this number is also listed on your POMCO member ID card). The US Imaging program will not apply if Medicare is primary.	
Dialysis • **Freestanding Facility**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Physician Office**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	☎home only	
Durable Medical Equipment	100% of Allowed Charges	70% of Allowed Charges, Deductible does not apply
• **Oxygen**	100% of Allowed Charges	70% of Allowed Charges, Deductible does not apply
	☎over $500. Excludes services covered under Preventive Care.	
Fitness/Wellness Benefit	100% of Charges	
	Limited to $100 per individual; $50 per Spouse for membership. Must be submitted within one year after 12 months of membership is completed. Must show proof of active participation.	
Food Products	90% of Allowed Charges, after Deductible, will not apply to Out-of-Pocket maximum	70% of Allowed Charges, after Deductible, will not apply to Out-of-Pocket maximum
	Limited to $2,500 per Covered Person, per Calendar Year, combined In- and Out-of-Network.	
Foot Care and Podiatry Services	See type of service rendered	70% of Allowed Charges, after Deductible
	Routine foot care is not covered. **Exception:** Routine foot care is covered for patients with a metabolic or peripheral vascular disease, such as diabetes. Foot Orthotics or Orthotic shoes are limited to one pair during any 18-month period, combined In- and Out-of-Network. Support hose is limited to six pairs per Calendar Year combined In- and Out-of-Network.	
Foreign Travel	Only emergency care is allowed after the Foreign Copay. If the Enrollee is admitted or if follow up care is Medically Necessary, claims will be allowed at 70% of Allowed Charges, after Deductible. Non-emergency care is not covered while traveling or residing outside of the US or any US Territory unless approved by the Plan.	

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
FTS (Down Syndrome Test)	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to one test in first trimester of Pregnancy combined In- and Out-of-Network.	
Hearing Aid	100% of charges	
	Hearing Aid limited to $750 (single) or $1,500 (pair) every five years combined In- and Out-of-Network. Includes adjustments and repair and exam for the hearing aid. Batteries not covered.	
Hearing Exam	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Limited to one routine exam per Covered Person, per Calendar Year, combined In- and Out-of-Network. Comprehensive hearing exams are covered as diagnostic testing and limited to one per Covered Person, per Calendar Year, combined In- and Out-of-Network.	
Holistic Prescriptions, Including Prenatal Vitamins Through a Pharmacy	80% of Allowed Charges, Deductible waived	
	Limit of $500 per Covered Person, per Calendar Year, combined In- and Out-of-Network.	
Home Health Care	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	☎ Limited to 200 visits per Covered Person per Calendar Year combined In- and Out-of-Network. If precertified and Medically Necessary, an additional 50 visits may be allowed per Lifetime, combined In- and Out-of-Network; and subject to OOP limits. Visits will be pro-rated when this Plan is secondary. <u>One HHC visit equals:</u> • Up to four hours of home health aide care; or • Each visit by other covered members of the HHC team. Services must be in lieu of Hospitalization or inpatient SNF care.	
Hospice Care	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	☎ Limited to 210 days for an approved plan of care per Covered Person per Lifetime combined In- and Out-of Network. 180 days must elapse between each Hospice confinement. Bereavement counseling visits limited to five visits for covered family members.	
Hospital Facility • **Inpatient Hospital**	Hospital Copay, then 100% of Allowed Charges	Hospital Copay, then 70% of Allowed Charges
	☎ Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered. Surgical Copay will also apply if surgery is performed on an inpatient basis.	

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
• **Outpatient Hospital** • Clinic	90% of Allowed Charges, after Deductible	70% of Allowed Charges, after Deductible
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).	
• Diagnostic Testing	See Diagnostic Testing benefit	See Diagnostic Testing benefit
• Emergency Room for Emergency Condition	$100 Copay, then 100% of Allowed Charges; Deductible does not apply. 90% of Allowed Charges for Medically Necessary transfers, after Deductible Ancillary services: Covered at the In-Network benefit Foreign Copay of $250 also apples to Emergency Room admissions outside the US, US territories, Canada, or Mexico.	
	Emergency Room Benefit Copay is waived if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room.	
• Emergency Room for non-Emergency Condition	$200 Copay, then 100% of Allowed Charges; Deductible does not apply. Ancillary services: see type of service rendered	
• Outpatient Surgical Center	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• Other Outpatient Hospital Services and Supplies	90% of Allowed Charges, after Deductible	70% of Allowed Charges, after Deductible
Impotency Treatment	See type of service rendered	See type of service rendered
Infertility Services (only available if enrolled in the Infertility Program)	80% of Allowed Charges, does not apply to Deductible; does not apply to Out-of-Pocket limits	70% of Allowed Charges, after Deductible; does not apply to Out-of-Pocket limits
	☎. Employee and Spouse must be continuously covered by Plan for 18 months or more prior to becoming eligible for this benefit and patient must not have attained age 40. Benefit is limited to $10,000 per Covered Person, per Calendar Year combined In- and Out-of-Network. Limited to $25,000 per Lifetime, combined In- and Out-of-Network.	
In-Hospital/Facility Physician's Care	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay.	
IV (Infusion) Therapy	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	☎ Physician office visit Copays are waived.	
Massage Therapy	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Limited to $50/hour visit or $25/half hour visit. Limited to 15 visits per Covered Person, per Calendar Year, combined In- and Out-of-Network. Limited to $2,500 combined with acupuncture and chiropractic per Covered Person per Calendar Year combined In- and Out-of-Network.	

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
Maternity Care • **Initial Diagnostic Office Visit, Physician Charge**	Network Copay applies, after Deductible ($15 Copay if enrolled in the Prenatal Program)	70% of Allowed Charges, after Deductible
• **Inpatient Hospital Facility**	Hospital Copay, then 100% of Allowed Charges (Copay waived if enrolled in the Prenatal Program)	Hospital Copay, then 70% of Allowed Charges
	☎ stays over 48 hours for a normal delivery or 96 hours for a c-section delivery. Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered. This benefit includes Certified Birthing Centers. Maternity is covered the same as any other Illness.	
• **Prenatal, Delivery and Postpartum Care of Pregnancy, Physician Charge**	See type of service rendered. (Copays waived if enrolled in the Prenatal Program)	70% of Allowed Charges, after Deductible
• Pre-natal Ultrasound	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Other related testing is covered separately per service type rendered. Pre-natal ultrasound limited to one per Pregnancy, unless Medically Necessary.	
Medical Marijuana for Pain Management	80% of Allowed Charges, after Out-of-Network Deductible, subject to Out-of-Network OOP limits	
	Limited to serious/chronic Illnesses (cancer, AIDS, MS, Muscular Dystrophy, etc.) based on Medical Necessity in states where it is legal and subject to the dispensing rules of that state. Subject to step therapy. Limited to $1,000 per Covered Person, per Calendar Year, combined In- and Out-of-Network.	
Medical/Surgical Supplies	100% of Allowed Charges	70% of Allowed Charges, Deductible does not apply
Mental Disorder Treatment • **Inpatient Facility** • General Hospital or Private Proprietary Psychiatric Facility • Partial Hospitalizations	Hospital Copay, then 100% of Allowed Charges	Hospital Copay, then 70% of Allowed Charges
	☎ Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations.	
• **Inpatient, Physician Charge**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible

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Service Type	**In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)**	**Out-of-Network Benefits**
• **Outpatient/Office, Including Intensive Outpatient Programs**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Services must be rendered and billed by a New York State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of New York State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician's corporation, or clinic for the services of a similarly licensed Provider will also be covered.	
• **Psychological Testing**	90% of Allowed Charges, after Deductible	70% of Allowed Charges, after Deductible
Newborn Care • **Circumcision**	See Surgical Charge Benefit (Copay waived if mom enrolled in the Prenatal Program)	70% of Allowed Charges, after Deductible
• **Hospital**	Hospital Copay, then 100% of Allowed Charges (Copay waived in mom enrolled in the Prenatal Program	Hospital Copay, then 70% of Allowed Charges
• **Physician**	Network Copay applies, after Deductible (Copay waived if mom enrolled in the Prenatal Program)	70% of Allowed Charges, after Deductible
	Limited to Allowed Charges made by a Physician for routine pediatric care after birth while the newborn child is Hospital-confined. If the baby's routine care is extended due to the mother's continued stay, benefits will not be paid even if the mother was needed to provide basic care, such as breastfeeding. Routine newborn care billed by an anesthesiologist or the delivering Physician is not covered.	
Nursing, Private Duty	90% of Allowed Charges, after Deductible	70% of Allowed Charges, after Deductible
	Charges are covered only when care is Medically Necessary and not Custodial in nature. The charges covered for outpatient nursing care are those shown billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional nurse services. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.	
Nutritional Counseling	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to 10 visits (20 visits if enrolled in the diabetic program) per Covered Person per Calendar Year combined In- and Out-of-Network. Limited to five visits per Covered Persons with a serious medical condition (other than diabetes), per Calendar Year, combined In- and Out-of-Network.	

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
Obesity, Morbid Treatment (only available in enrolled in the Weight Loss Program)	See type of service rendered	See type of service rendered
	☎weight reduction surgery. Enrollee must be enrolled in a supervised weight loss program for a minimum of *three months* prior to approval of any bariatric, lap band, or other stomach by-pass-type surgery and must undergo counseling regarding the procedure's possible side effects. Medically Necessary (as determined by the Claims Administrator) surgical and non-surgical charges for Morbid Obesity will be covered.	
Occupational Therapy • **Freestanding Facility**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Physician Office**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Limited to 30 visits per Covered Person, per Calendar Year, combined In- and Out-of-Network, combined Cognitive, Occupational, Physical and Speech therapies. If approved an additional 20 visits could be allowed. Maintenance Care is not covered.	
Orthotics	Network Copay applies, after Deductible (Copay waived if no office visit is billed)	70% of Allowed Charges, after Deductible
	Limited to $500 per Covered Person, per Calendar Year, In- and Out-of-Network combined	
Pain Management Therapy	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
Physical Rehabilitation Facility, Inpatient	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	☎ Limited to 30 visits limit per Calendar Year from admission date combined In- and Out-of-Network; an additional 20 visits may be allowed if Medically Necessary and precertified, combined in- and Out-of-Network. Room and Board charge limited to actual semi-private rate. Coverage for a private room will be limited to the facility's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered.	
Physical Therapy • **Freestanding Facility**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Physician Office**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Limited to 30 visits per Covered Person, per Calendar Year, combined In- and Out-of-Network, combined Cognitive, Occupational, Physical and Speech therapies. If approved an additional 20 visits could be allowed, combined in- and Out-of-Network. Maintenance Care is not covered.	

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
Physician Care • **Emergency Room** • Emergency Condition	100% of Allowed Charges Ancillary charges: 100% of Allowed Charges	
• Non-Emergency Condition	90% of Allowed Charges, after Deductible	70% of Allowed Charges, after Deductible
• **Home, Office, Clinic, or Elsewhere**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Single Copay applies to all charges billed during visit (including minor surgical charges up to $500 with no surgical Copay). Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home, or elsewhere. Outpatient Mental Disorder care, outpatient Substance Use Disorder care, outpatient consultations, surgical and obstetrical procedures, outpatient emergency room visits, rehabilitation therapy, Urgent Care Facility Physician charges and chiropractic care are not covered under this benefit.	
• **Urgent Care Facility (Physician Charges)**	See Urgent Care Facility	See Urgent Care Facility
Preadmission Testing	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Must be: ○ Performed on an outpatient basis within seven days before a scheduled Hospital confinement; ○ Your Physician ordered the tests; and ○ Physically present at the Hospital for the tests. Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.	
Prescription Drugs with COB	80% of Allowed Charges	
	Copays from the primary carrier that are $10 or less will not be covered.	
Preventive Care (Includes all Ancillary Charges) • **Bone Density Testing**	Please see www.HealthCare.gov/center/regulations/prevention.html for complete listing and frequencies, unless listed below. 100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to one per Covered Person over age 50, per Calendar Year, combined In- and Out-of-Network.	
• **Cholesterol Screen With No Office Visit**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to four per Covered Person, per Calendar Year, combined In- and Out-of-Network.	
• **Colonoscopy/ Sigmoidoscopy**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to every five years after age 45 combined In- and Out-of-Network or as Medically Necessary.	
• **Gyn Office Visit**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to one per Calendar Year combined In- and Out-of-Network	

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
• **Mammogram**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to one per Calendar Year prior to age 45, twice per Calendar Year after age 45 combined In- and Out-of-Network or as Medically Necessary.	
• **PAP Smear/Screening Cervical Cytology**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to two per Calendar Year combined In- and Out-of-Network	
• **Prostate-Specific Antigen (PSA)**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to two per Calendar Year combined In- and Out-of-Network.	
• **Routine Adult Physical (age 19 and older)**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Includes routine exam and related screening tests based on current medical standards for preventive care. Immunizations follow the recommendations set by the Department of Health and Human Services Centers for Disease Control (CDC). Limited to two exams per Calendar Year (including well woman and OB/Gyn care), per Covered Person for any combination of In- and Out-of-Network Providers. This maximum does not apply to other screening services listed above.	
• **Routine Eye Exam**	Network Copay applies, no Deductible	70% of Allowed Charges, after Deductible
	Limited to one exam per Covered Person, per Calendar Year, combined In- and Out-of-Network. This Plan will be secondary to any stand-alone vision exam.	
• **Well Child Care (up to age 19)**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Coverage for health care visits and related testing follows the guidelines of the American Academy of Pediatrics (AAP). Coverage for immunizations follows the recommendations set by AAP or as set by the Department of Health and Human Services Centers for Disease Control (CDC). Routine newborn care is covered as shown above.	
• **Well Woman** • **Breastfeeding Support, Supplies, and Counseling**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	In conjunction with each birth comprehensive breastfeeding support and counseling, by a trained Provider during Pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment (including related supplies) is covered (or purchasing if cost effective).	
• **Contraceptive Management**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Applies to all women with reproductive capacity. Oral contraceptives paid through ProAct only.	
• **Human Papillomavirus (HPV) DNA Testing**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	For women with normal cytology results; screening begins at age 30 years and occurs no more frequently than every 3 Plan Years.	

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Service Type	**In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)**	**Out-of-Network Benefits**
• **Routine Screening Cervical Cytology/ Pap Smear, Related Tests**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to two per Calendar Year combined In- and Out-of-Network to include collection and preparation of a pap smear, professional evaluation of the pap smear, and related tests.	
• **Well Woman Visit**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to one per Calendar Year combined In- and Out-of-Network for women to obtain the recommended preventive services that are age and developmentally appropriate.	
Prosthetics	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
Pulmonary Rehabilitation • **Freestanding Facility**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Physician Office**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Coverage is limited to a maximum of 36 visits per Covered Person per Lifetime for an approved plan of care combined In- and Out-of-Network. Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.	
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	100% of Allowed Charges	70% of Allowed Charges, after Deductible
Radiation Therapy • **Freestanding Facility**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• **Physician Office**	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Physician office visit Copays are waived.	
Refractive Surgery	100% of Allowed Charges	70% of Allowed Charges, after Deductible
	Limited to $1,000 per Covered Person, per Lifetime, combined In- and Out-of-Network	
Respiratory Therapy • **Freestanding Facility**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Physician Office**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
Skilled Nursing Facility (SNF), Inpatient	Hospital Copay, then 100% of Allowed Charges	Hospital Copay, then 70% of Allowed Charges Extended benefits are not available for Out-of-Network Providers
	☎ Limited to 100 day limit per Calendar Year from admission date combined In- and Out-of-Network. If patient is transferred directly from a Hospital to a SNF following an Illness or Injury, a second Hospital Copay will not apply. Days will be pro-rated when this Plan is secondary. When benefits are exhausted under primary plan (including Medicare) and this Plan becomes primary, benefits must be precertified. Extended benefits for In-Network Providers only: An additional 60 days (Lifetime maximum) may be allowed, if Case Management approves. The Medicare Skilled Nursing Facility Copay will apply for this extended benefit ($144.50 as of 1/1/2012) and will be credited to the Out-of-Pocket limit. Room and Board charge limited to actual semi-private rate. Coverage for a private room will be limited to the facility's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered.	
• **Outpatient Services**	See Home Health Care	
Smoking Cessation Counseling	100% of Allowed Charges	Not covered
	Limited to two attempts per Calendar Year combined In- and Out-of-Network. Each attempt includes a maximum of four intermediate or intensive sessions combined In- and Out-of-Network.	
Speech Therapy • **Freestanding Facility**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Outpatient Hospital**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Physician Office**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	Limited to 30 visits per Covered Person, per Calendar Year, combined In- and Out-of-Network, combined Cognitive, Occupational, Physical and Speech therapies. If approved an additional 20 visits could be allowed, combined In- and Out-of-Network.	
Substance Use Disorder Treatment • **Detoxification**	See type of service rendered.	

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Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
• **Inpatient Facility** • General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program • Partial Hospitalization	Hospital Copay, then 100% of Allowed Charges	Hospital Copay, then 70% of Allowed Charges
	☎ Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations.	
• **Inpatient Physician**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
• **Outpatient/Office, Including Intensive Outpatient Programs**	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
Surgical Charge Benefit • **Assistant Surgeon**	100% of Allowed Charges (limited to 25% of surgeon's charges)	70% of Allowed Charges, after Deductible (limited to 25% of surgeon's charges)
• **Surgeon** • Surgery under $500	100% of Allowed Charges	70% of Allowed Charges, after Deductible
• Surgery $500 and over	$250 Copay, after Deductible	70% of Allowed Charges, after Deductible
	☎See Benefit Management. Surgical Copay is in addition to the Hospital Copay, if surgery is performed inpatient. Excludes services covered under the Infertility provisions of the Plan.	
Therapeutic Injections	100% of Allowed Charges (network Copay applies if office visit is billed)	70% of Allowed Charges, after Deductible
TMJ	See Surgical Charge Benefit	70% of Allowed Charges, after Deductible
	Limited to Medically Necessary surgical procedures.	
Transplants ☎ • **Donor Expenses for Organ or Bone Marrow Transplants**	$500 Copay, then 80% of Allowed Charges up to a maximum of $25,000/procedure. If donor is a family member of recipient or both donor and recipient are Plan Enrollees, donor expenses will be paid at 100% of Allowed Charges.	**Inpatient:** Hospital Copay, then 70% of Allowed Charges **Outpatient:** 70% of Allowed Charges, after Deductible
	Recipient's plan will be the primary plan; payment under this Plan will be made only after primary plan has paid.	
• **Transplants (Donor Testing)**	100% of Allowed Charge	**Inpatient:** Hospital Copay, then 70% of Allowed Charges **Outpatient:** 70% of Allowed Charges, after Deductible
	Limit of four donors for bone marrow and stem cell testing per transplant, combined In- and Out-of-Network.	

☎ = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1-866-227-9936. See the section entitled Cost Management Services for details.
All services will be reviewed for Medical Necessity, except preventive and wellness benefits.

Service Type	In-Network Benefits (POMCO Allied/PHCS/ MultiPlan Networks)	Out-of-Network Benefits
• **Transplants (Surgery)**	**Centers of Excellence inpatient:** 100% of Allowed Charges **Other PPO Providers:** Hospital and surgical Copays apply. **Outpatient:** See type of service rendered	**Inpatient:** Hospital Copay, then 70% of Allowed Charges **Outpatient:** 70% of Allowed Charges, after Deductible
• **Transplants (Travel Expenses)**	**Centers of Excellence:** Travel expenses for Enrollee's family will be reimbursed at 100% while the Enrollee is confined. **Non-Centers of Excellence:** 80% of charges after Deductible while the Enrollee is confined	70% of charges, after Deductible
	Limited to $10,000 per recipient per transplant procedure, combined in- and Out-of-Network.	
Urgent Care Facility	Network Copay applies, after Deductible	70% of Allowed Charges, after Deductible
	One Copay applies to all services billed by the facility. Includes all covered facility/Physician charges performed in the Urgent Care Facility.	
Vision Therapy	Not covered	Not covered
Voluntary or Elective Abortion	Not covered	Not covered
	Covered only if Medically Necessary due to documented rape, incest, or when necessary due to mother's health, to preserve the life of the mother, or when the life, health, or "viability" of the fetus is in question. The abortion may be performed with impunity within the first 24 weeks on the advice of the MD and preapproved.	
Voluntary or Elective Sterilization (Female)	100% of Allowed Charges. Includes all related services such as anesthesia and facility charges.	**Inpatient:** Hospital and surgical Copays, then 70% of Allowed Charges **Outpatient:** 70% of Allowed Charges, after Deductible
Voluntary or Elective Sterilization (Male)	Subject to Hospital and/or surgery Copays depending on whether performed while inpatient or outpatient.	**Inpatient:** Hospital and surgical Copays, then 70% of Allowed Charges **Outpatient:** 70% of Allowed Charges, after Deductible
Wigs	See Prosthetic benefit	See Prosthetic benefit
	Limited to $250 per Spell of Illness, per Covered Person for hair loss due to chemotherapy, radiation or other medical treatment; combined In- and Out-of-Network.	

PRESCRIPTION DRUG BENEFITS SCHEDULE

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. Contact ProAct Customer Service Department toll-free at 1.877.635.9545 for details. Generic Prescription Drugs covered under ACA only will be reimbursed without a Copay. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by ProAct. Contact ProAct Customer Service Department toll-free at 1.800.818.6632 for details.

Any one retail Pharmacy prescription or refill is limited to a 31-day supply. Any one mail order prescription or refill is limited to a 93-day supply. Some covered Prescription Drugs have a quantity limit or step therapy under the Plan. For additional information on medications that have quantity limits or step therapy, you may call the POMCO Pharmacy Clinical Department at 1.800.836.0709.

Covered Drugs and Supplies	Network and Out-of-Network
Prescription Drug Benefit (ProAct)	**Note:** *You must pay applicable copayments. The Plan pays the balance of Allowed Charges.* Copayments per prescription: **Retail** / **Mail Order** **Generic** $10 / $20 **Brand Single Source** $35 / $70 **Brand Multi Source** $70 / $140 **Infertility Drugs** 20% / 20% **Certain Diabetic Drugs/Supplies*** $0 / $0 **Specialty** $50 / $100 * see Diabetic Program for complete list
Prescription Drug Out-of-Pocket Limit, Including Copays	$1,820 per individual $3,640 per family
	Benefit includes coverage for: Oral contraceptives Growth Hormone (if pre-approved) Infertility drugs (if pre-approved) Impotency drugs (limit $1,000/Calendar Year) Menopause drugs (limit $1,000/Calendar Year) Retin A (limited to Covered Persons under age 25 and for treatment of acne if pre-approved) Smoking Cessation

DENTAL CARE BENEFIT SCHEDULE

DENTAL CARE		
Benefit Year	**July 1 – June 30**	
MAXIMUM BENEFIT AMOUNT	**BENEFIT**	
For Class 1 - Preventive, Class 2 - Basic and Class 3 - Major Services		
Per Covered Person per Calendar Year	$2,000/Benefit Year	
For Class 4 - Orthodontia	$2,500/Lifetime	
TMJ Limit	$1,500/Lifetime	
COVERED CHARGES		
Dental Percentage Payable	**In-Network**	**Out-of-Network**
Class 1 Services - Preventive **Class 2 Services - Basic** **Class 3 Services - Major**	100% 85% 75%	85% 70% 60%
Class 4 Services - Orthodontia	60%	45%
TMJ Services	50%	50%

COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits apply when Covered Charges are Incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

This document is intended to describe the benefits provided under the Plan, but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Claims Administrator if you have questions about specific supplies, treatments or procedures.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the Deductible shown in the Summary of Benefits. This amount will accrue toward the 100% maximum Out-of-Pocket payment.

Once the Medicare-prime Enrollee meets the In-Network Individual Deductible (the In-Network Individual Deductible and the Medicare Deductible are one in the same), there is not another Individual Deductible for that Retiree that needs to be met and that Enrollee does not have any future Copays.

Family Unit Limit. When the maximum amount shown in the Summary of Benefits has been Incurred by members of a Family Unit toward their Calendar Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Payment will be made at the rate shown under reimbursement rate in the Summary of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the Summary of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Summary of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges Incurred by a Covered Person.

COVERED CHARGES

Covered Charges are the Allowed Charges that are Incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is Incurred on the date that the service or supply is performed or furnished.

MEDICAL SERVICES AND SUPPLIES

Acupuncture

Acupuncture is covered when used as anesthesia or for palliative pain relief and when performed by a certified acupuncturist. Acupuncture performed for any other reason is not covered.

Allergy Care

Benefits are available for allergy treatment including, but not limited to, office visits, serum, scratch testing and laboratory testing. Allergy serum covered under the Prescription Drug Benefit will not be covered as a Medical Services and Supplies Benefit.

Alternative Providers

Alternative Providers include Christian Science Practitioners and holistic medical Providers. Services are allowed for these Providers per the limits indicated in the Summary of Benefits.

Ambulance Charges

The Allowed Charges billed by a local land ambulance service for trips to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. In addition, land ambulance transportation from an Inpatient (or other facility) to another facility (or other location) will be considered when found Medically Necessary and ordered by a Physician. Such transfers cannot be for the convenience of the patient or family members.

Charges for pre-Hospital medical Emergency Services are covered regardless of whether or not the Covered Person is actually transported to a Hospital.

Air ambulance may be reimbursed only when the patient's condition was so serious that the patient could not be transported safely by land ambulance. Air ambulance may also be reimbursed if the location from which the patient required emergency transportation was inaccessible by land ambulance.

Professional and volunteer ambulance must charge for its services.

Ambulatory Surgical Center

As defined, for outpatient surgery. Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

Anesthesia

Benefits are available for administration of general anesthesia found Medically Necessary for covered surgical procedures. Coverage is limited to anesthesia administration by anesthesiologists and/or Certified Registered Nurse Anesthetists. The Plan will not pay charges for administration of anesthesia given by the surgeon, the assistant surgeon, or by a Hospital employee. Exception: Administration of anesthesia by a Dentist who performed the surgery is covered when the anesthesia is rendered during a covered oral surgical procedure. The allowance for anesthesia includes the usual patient consultation before anesthesia and the usual care after surgery. Anesthesia administration expenses are not covered if the surgery is not covered by the Plan.

Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.

Acupuncture is covered when used as anesthesia or for palliative pain relief and when performed by a certified acupuncturist.

Autologous Conditioned Plasma (ACP) or Platelet-Rich Plasma (PRP)

ACP and PRP injections are used as an alternative to invasive surgical procedures. These procedures will be covered by the Plan according to the limits indicated in the Summary of Benefits.

Biofeedback

Type of alternative medicine that provides visual, auditory or other evidence of the status of certain body functions so that a person can voluntarily control the functions; thereby alleviating abnormal bodily condition(s).

Blood and Blood Product Services

Blood, including blood and blood derivatives that are not donated or replaced, blood transfusions, and blood processing when found Medically Necessary. Administration of these items is included.

Coverage also includes services related to blood donations, autologous (patient donates own blood) or directed (donation of blood by individual chosen by patient), when there is a scheduled surgery that customarily requires blood transfusions.

Cardiac Rehabilitation

For outpatient telemetric monitoring during exercise for cardiac rehabilitation rendered at a Hospital or free standing cardiac rehabilitation center. Services must be rendered by a Physician, or by a professional nurse trained in cardiac rehabilitation. Services must be ordered by the attending doctor and found Medically Necessary due to certain medical conditions, such as post valvular or congenital heart surgery; post heart transplants; dilated cardiomyopathy; post myocardial infarction; post bypass surgery or angioplasty; or stable angina. The plan of care must be approved for benefits by the Claims Administrator. The Claims Administrator may request medical records to evaluate the claim for Plan coverage.

This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are covered. Coverage is limited to frequency up to three times per week and up to a maximum 18 consecutive weeks for an approved plan of care. Related testing procedures such as stress tests will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits. Separate charges for use of exercise equipment are not covered.

Chemotherapy

This benefit applies when a chemotherapy charge is Incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A chemotherapy charge is the Allowed Charge of a Physician for chemotherapy.

The type of drug for which benefits are provided is limited to anticancer drugs that are not in an Investigational or Experimental stage to include antineoplastic agents (such as anticancer drugs) or agents used to destroy microorganisms (such as antibiotic drugs).

Coverage is available for home chemotherapy, supplies and equipment for an approved plan of care when ordered by the attending Physician. When purchased at a Pharmacy, the chemotherapy drugs are generally available under the section entitled “Prescription Drug Benefits” described later in this document

Chiropractic Care

Spinal manipulation/chiropractic services by a licensed doctor of chiropractic (D.C.) for the detection or correction of the structural imbalance or subluxation in the human body to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of or in the vertebral column. The therapeutic care must be directed at functional improvement (active treatment). Benefits will not be paid for any Maintenance Care or care to prevent worsening. See the Summary of Benefits for limitations.

Clinical Trials

The Plan will allow Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. **Exception:** Out-of-Network Providers will be allowed if an In-Network Provider will not accept the patient.

Cognitive Therapy

Cognitive therapy is short-term therapy based on the concept of the way things affect emotions. It focuses on present thinking, behavior and communication rather than on past experiences and is oriented toward problem solving.

Consultations, Specialist

A consultation is an examination requested by an attending Physician to obtain an opinion in the evaluation and management of an Illness or Injury. Benefits are not payable for consultation expenses when the consultant is part of the same medical or surgical group as the requesting Physician. If the consultant takes over the management (treatment) of the condition, subsequent management visits are not considered to be consultations.

(1) **Inpatient Consultations.** Coverage is limited to one inpatient consultation per specialty for each inpatient stay.

(2) **Outpatient/Office Consultations.** Coverage for outpatient or office consultations is provided for as many specialty opinions requested by the attending Physician as Medically Necessary.

(3) **Second Opinion Consultation.** Benefits are available for patient-requested second opinion consultations before proceeding with a covered surgical procedure or treatment. The second opinion consultation must be given by a board-certified Physician specialist whose specialty is appropriate to consider the need for the proposed procedure. If the consulting specialist renders the procedure, consultation benefits are not payable. If you or your Dependent seek a third opinion, benefits will be provided on the same basis as the second opinion. Whether or not the second (or third) opinion agrees that procedure is necessary, the Plan will cover the second opinion consultation. It is the patient's decision whether to undergo the procedure.

Contact Lens/Eyeglasses

Initial contact lenses or glasses required following intraocular surgery or cataract surgery, or required to treat corneal disease. No other eyeglasses, contact lens or visual aids, or related exams are covered under this benefit.

Dental Care, Limited Coverage

Injury to or care of mouth, teeth and gums. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to Sound Natural Teeth within 12 months of the Injury.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth within 12 months of the Injury

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of wisdom teeth.

Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diabetic Supplies, Equipment and Education

(1) The following supplies and equipment are covered for the treatment of a diabetic condition when such supplies are ordered or recommended by a Physician and when they are found to be Medically Necessary according to the Plan provisions:

(a) Blood glucose monitors (standard) and blood glucose monitors for the visually impaired;

(b) Test strips for glucose monitors, visual reading and urine testing;

(c) Injection aids;

(d) Cartridges for the legally blind;

(e) Syringes;

(f) Data management systems;

(g) Insulin pumps or insulin infusion pumps when Medically Necessary and when conventional injection therapy is found to be inadequate to treat the patient's condition.

Items such as alcohol, swabs, adhesive tape and gauze are not covered. Insulin, oral agents to control blood glucose, syringes, and test strips are covered under the separate Prescription Drug Benefits.

(2) Diabetic self-management education and education relating to diet may be covered for a covered Person with a diabetic condition. Self-management education or diet instruction will only be covered when the patient is initially diagnosed with diabetes or when a Physician diagnoses a significant change in the patient's symptoms or condition that requires changes in the patient's self-management. These educational services will be covered when provided by:

(a) A Physician or his/her staff during an office visit for diabetes diagnosis or treatment. When the self-management service education is provided during an office visit, the one benefit payment for the office visit will include payment for the self-management education;

(b) A certified diabetes nurse educator, certified nutritionist or certified and registered dietician when referred by a Physician. This education must be provided in a group setting. If it is decided that group education is not available in the patient’s area, the Plan may cover individual education;

(c) A professional Provider as described above may be covered for services rendered in the patient's home. However, it must be found to be Medically Necessary for the patient to receive services at home.

Diagnostic Testing, X-ray and Lab Charge Benefits

Diagnostic Testing, X-ray and Laboratory charges are the Allowed Charges for X-rays and laboratory tests. Benefits are provided for diagnostic services required in the diagnosis of a condition due to Injury or Sickness consisting of:

(1) Diagnostic radiology, ultrasound, nuclear medicine, and necessary supplies.

(2) Diagnostic medical services such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a Physician or covered facility.

(3) Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician or covered facility.

Coverage includes separate Physician's charges for interpretations of covered diagnostic services given by a Hospital, Skilled Nursing Facility or other covered facility.

Charges for the following will not be included in this section:

(1) premarital exams;

(2) routine physical exams;

(3) X-ray therapy or chemotherapy; or

(4) exams performed as part of dental work, eye tests or fitting of lenses for the eye.

Dialysis

The Enrollee's first 40 renal dialysis visits are allowed at the Allowed Charges minus any applicable Enrollee cost share (i.e., Deductible, Copay and/or Coinsurance). Additional visits are allowed up to 150% of the current Medicare allowed amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge. Renal dialysis visits will not be subject to Out-of-Network limitations.

Benefits are available for service or supplies related to outpatient dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Note: Persons of any age who are diagnosed with end stage renal disease (ESRD) should contact the Social Security Office for Medicare eligibility and enrollment details. If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period).See the definition of Allowed Charges shown later in this document for benefit payment details under the Plan. Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

Durable Medical Equipment

Rental of durable medical or surgical equipment when ordered by the attending Physician and found Medically Necessary according to Plan provisions. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase.

The necessary repairs and maintenance of purchased equipment may be allowed, unless covered by a warranty or purchase agreement. Charges for delivery and service are not covered.

DME purchases must be returned to the plan when it is no longer needed.

Fitness/Wellness Benefit

Benefits is limited to $100 per Employee; $50 per Spouse for membership. Claims must be submitted within one year after 12 months of membership is completed.

Food Products

Allowed Charges for covered food products are limited to $2,500 per Covered Person, per Calendar Year.

(1) **Enteral Formulas.** Limited coverage is available for certain food supplements, nutrients or food products when ordered, in writing, by a Physician, or other licensed healthcare Provider legally authorized to prescribe drugs. Benefits will not be paid for normal products used in the dietary management of any disorders.

The prescribing healthcare Provider must state in writing that the enteral formula is clearly Medically Necessary and has been proven effective as the disease-specific regimen for those individuals who are or will become malnourished or who suffer from disorders, which left untreated, cause chronic disability, mental retardation or death. These specific diseases include, but are not limited to, aminoacidopathies, gastric motility disorders such as chronic intestinal pseudo-obstruction and multiple severe food allergies that if left untreated will cause malnourishment, chronic physical disability, mental retardation, or death.

(2) **Modified Solid Food Products**. Coverage is available for modified solid food products that are low protein, or which contain modified proteins that are Medically Necessary for certain inherited diseases of amino acid and organic acid metabolism.

(3) **Nutritional Supplements for Phenylketonuria and Related Disorders.** Limited coverage is available for certain food supplements, nutrients or food products when ordered, in writing, by a Physician, or other licensed healthcare Provider legally authorized to prescribe drugs. Benefits will not be paid for normal products used in the dietary management of any disorders.

Certain nutritional supplements (formulas) are covered when found Medically Necessary for the therapeutic treatment of the following aminoacidopathies (disorders that prevent the body from properly digesting amino acids): phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Foot Care and Podiatry Services

Benefits are available for treatment related to care of the feet. Coverage includes services or supplies rendered and billed by licensed Physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet. Charges for routine foot care are covered for patients with severe systemic disorders, such as diabetes. Services or supplies for foot Orthotics and Orthotic shoes are limited to one during any 18-month period. Shoe inserts are not covered (please refer to Plan Exclusions).

Hearing Aid

Benefits are available for hearing aid expenses when ordered by a Physician. Coverage includes the expenses for the hearing aid, the related exam, and the fitting. Coverage is limited as indicated in the Summary of Benefits.

Hearing Exam

Comprehensive hearing exams are covered as diagnostic testing and limited to per the Summary of Benefits.

Holistic Prescriptions

Coverage is limited as indicated in the Summary of Benefits.

Home Health Care Services and Supplies

Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Summary of Benefits.

A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Hospice Care Services and Supplies

Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months, and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Summary of Benefits.

(1) Bed patient either in a designated Hospice Unit or in a regular Hospital bed or in a Skilled Nursing Facility;

(2) Day care service provided by the Hospice Agency;

(3) Home care and Outpatient Services provided by the Hospice including intermittent nursing by a registered nurse or licensed practical nurse or by a home health aide;

(4) Physical, occupational, speech, and respiratory therapy;

(5) Medical social services and nutritional services;

(6) Laboratory, X-ray, chemotherapy, and radiation therapy when needed to control symptoms;

(7) Medical supplies and drugs and medications considered approved for the patient's condition. Benefits are not payable if the drugs or medications are of an Experimental nature;

(8) Durable Medical Equipment;

(9) Medical care provided by the Hospice Physician or other Physician designated to render services by the Hospice Agency; and

(10) Bereavement counseling for the family, limited to five visits per family provided within one year preceding or following the Covered Person’s death.

During this period of acceptance, all the patient’s medical services must be provided by or obtained through the Hospice Agency. All services must be billed by the Hospice Agency.

Hospital Charges

This benefit applies when a Hospital charge is Incurred for the care of a Covered Person's Injury or Sickness and during a Hospital confinement that starts while that person is covered for this benefit.

(1) **Inpatient Hospital Care.** The medical services and supplies furnished by a Hospital or a Birthing Center.

The Usual and Reasonable Charges for room and board are payable as described in the Summary of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

The Plan pays the average semi-private rate for room and board charges by a Hospital or other covered inpatient health facility. If the inpatient facility does not have a semi-private rate, the rate shall be 80% of the room and board charges made by the facility for its lowest priced private room accommodations. If the facility has several semi-private rates, the prevailing, or the most common rate, shall be used.

Charges for an Intensive Care Unit stay are payable as described in the Summary of Benefits.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for a private room will be covered if a private room is deemed to be Medically Necessary.

The Allowed Charges for Hospital-billed medical services and supplies (other than room and board) and diagnostic X-rays and lab tests are payable.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

(2) **Outpatient Emergency Room Services**.

(3) **Outpatient Surgical Care**.

(4) **Clinic Services or Supplies**.

(5) **Other Services and Supplies** such as prescription medication, vaccines, and biologicals, and supplies in conjunction with diagnostic and therapeutic services, and their administration.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

Infertility

Limited care, supplies and services for the treatment of Infertility of the Covered Person (Enrollee or opposite gender Spouse; no benefits available same gender Spouses) and must be enrolled in the Infertility Program for benefits to be available.

(1) Expenses related to the diagnosis and treatment to correct an underlying medical condition that results in Infertility are covered separately as any other Illness.

(2) Basic care for the diagnosis and treatment of Infertility are Covered as part of a Physician's overall plan of care to include:

(a) Surgical or medical procedures to correct malformation, disease, or dysfunction resulting in Infertility;

(b) Diagnostic tests and procedures necessary to determine Infertility and necessary in connection with any treatments (including, but not limited to, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sonohysterogram, post-coital tests, testis biopsy, semen analysis, blood tests, ultrasound, and artificial insemination); and

(c) Prescription Drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of Infertility.

Only individuals from age 21-40 years are covered.

The standards and guidelines of the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine will apply to the determination of Infertility.

Excluded under this paragraph **(2)** are charges related to:

(a) Gamete intrafallopian transfers (GIFT) or zygote interfallopian transfers (ZIFT);

(b) Reversal of elective sterilizations;

(c) Sex change procedures;

(d) Cloning; or

(e) Medical or surgical services or procedures that are deemed to be Experimental.

In-Hospital/Facility Physician's Care Benefits

This benefit applies when a medical charge is Incurred for the care of a Covered Person's Injury or Sickness during a covered Hospital/facility confinement.

However, a medical charge will not include:

(1) a charge for care not rendered in the presence of a Physician; or

(2) a charge for care received on the day of or during the time of recovery from a surgical procedure. However, this limit does not apply if the care is for a condition that is unrelated to the one that required surgery.

IV Therapy/Infusion Services

Ambulatory or home intravenous services ordered by a Physician to include intravenous medications, blood, hydration and electrolyte replacement, and total parenteral nutrition.

Massage Therapy

Coverage is available up to the benefit limits described in the Summary of Benefits for massage therapy when performed by an individual licensed by New York State to perform massage therapy.

Maternity

The Allowed Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

> Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are available for services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care rendered for you, your Spouse, and your unmarried Dependent daughter (unless otherwise required by federal law). Expenses related to Pregnancy Incurred by your married Dependent daughter is excluded, except as required by federal law. Coverage is not provided for expenses connected with elective abortion. The Plan excludes service or supplies related to surrogate maternity care. The payment for childbirth, cesarean section or other termination of a Pregnancy will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care).

Medical Marijuana

Limited to serious/chronic Illnesses (cancer, AIDS, MS, Muscular Dystrophy, etc.) based on Medical Necessity in states where it is legal and subject to the dispensing rules of that state. Subject to step therapy. Benefits limited as indicated in the Summary of Benefits.

Medical Supplies (Home Use)

Benefits are available for certain medical and surgical supplies used in the home when ordered by the attending Physician and found Medically Necessary according to Plan provisions. Items such as gauze pads, swabs, alcohol, deodorizers, and adhesive tape are not covered. Coverage is limited to the following items:

(1) Ostomy bags and supplies required for their use.

(2) Catheters and supplies required for their use.

(3) Syringes and needles necessary for conditions such as diabetes.

(4) Extensive surgical dressings necessary for conditions such as cancer, diabetic ulcers and burns.

(5) Support hose limited to six pairs per Covered Person, per Calendar Year.

Mental Disorder Treatment

Covered Charges will include care, supplies and treatment of an approved treatment plan of Mental Disorders. Regardless of any limitations on benefits for Mental Disorders and Substance Use Disorders Treatment otherwise specified in the Plan, any aggregate Lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable. Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

(1) **Inpatient Treatment.** Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature. Coverage includes Partial Hospitalization treatment.

(2) **Outpatient Treatment.** Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

- Physician's visits are limited to one treatment per day.
- Services must be rendered and billed by a New York State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of New York State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician’s corporation, or clinic for the services of a similarly licensed Provider will also be covered.
- Intensive Outpatient Therapy included.

Covered Charges for care, supplies and treatment of Mental Health Disorders will be subject to the benefit payment maximums shown in the Summary of Benefits.

Newborn Care

The benefit is limited to the Allowed Charges made by a Physician for routine pediatric care while the newborn Child is Hospital-confined.

Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn Child is an eligible Dependent and is neither injured nor ill.

The benefit also is limited to the Allowed Charges made by a Hospital or Physician for routine pediatric care while the newborn Child is Hospital-confined.

The benefit is limited to Usual and Reasonable Charges for nursery care while the newborn Child is Hospital confined as a result of the Child's birth.

Nursing Care, Private Duty

The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(1) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and care must be so intense that the Hospital or Skilled Nursing Facility staff could not be expected to render such care. Shortage of general nursing staff does not establish Medical Necessity for private duty nurses.

(2) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The charges covered for outpatient nursing care are those shown under Home Health Care Services and Supplies or billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional nurse services.

Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

A licensed practical nurse will be allowed if the doctor certifies that a registered nurse is unavailable for an approved plan of skilled nursing care.

Skilled nursing must be needed to manage the care of acutely ill patients and must not be ordered primarily at the request of a family or household member.

Nutritional Counseling for Diagnosis Other Than Diabetes

The Plan will cover wellness (no underlying chronic condition required) nutritional counseling up to the benefit limits shown in the Summary of Benefits. Services must be rendered by certified nutritionist or certified and registered dietician.

Additionally, the Plan will cover nutritional counseling for serious medical conditions up to the benefit limits shown in the Summary of Benefits when medically appropriate to treat the condition. Services must be rendered by certified nutritionist or certified and registered dietician when referred by a Physician.

Serious medical conditions covered under this benefit are limited to the following diseases or conditions:

(1) Certain inborn errors of metabolism (branch-chain ketonuria, galactosemia, hereditary fructose intolerance, homocystinuria, phenylketonuria [PKU] and porphyries).

(2) Chronic renal insufficiency or failure.

(3) Eating disorders (anorexia nervosa or bulimia).

(4) Hypertension.

(5) Malabsorption or storage disorders (amyloidosis, Crohn's disease, gastrointestinal reflux (GERD), chronic intestinal pseudo-obstruction (Ogilvie's syndrome), glycol storage disorders, colitis, and lipid storage disorders).

(6) Malnourishment of patients with swallowing impairment or dysfunction who require nutritional guidance.

(7) Metabolic disorders (excluding diabetes, which is covered under a separate benefit).

(8) Morbid Obesity.

(9) Multiple or severe food allergies (if the allergy was left untreated it would cause malnourishment, mental retardation, physical disability, or death).

Obesity Treatment of Morbid Obesity

Benefits are available for treatment of Morbid Obesity. See the Summary of Benefits for limitations. Surgical intervention must be approved prior to the services being rendered. Morbid Obesity is defined by the National Heart Lung Blood Institute. A written treatment plan must be submitted to the Claims Administrator before services are rendered. Any services not pre-approved will not be covered.

Occupational Therapy

Services rendered by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

Orthotics

The initial purchase, fitting and repair of Orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Foot Orthotics are limited to one during any 18-month period.

Oxygen

Oxygen and supplies for its administration when found Medically Necessary and appropriate for self-care home use.

Physical Rehabilitation Facility, Inpatient

The room and board and nursing care furnished by a Physical Rehabilitation Facility will be payable if and when:

(1) the patient is confined as a bed patient in the facility;

(2) the attending Physician certifies that the confinement is needed for further care;

(3) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Facility;

Physical Therapy

Services rendered by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved function, or if care is found by the Claims Administrator to be Maintenance in nature, benefits will no longer be payable.

Physician Care

The professional services of a Physician for evaluation and management or therapeutic medical visits in an office, outpatient Hospital, clinic, home, or elsewhere. Services must be given and billed by covered healthcare Providers and found Medically Necessary according to Plan provisions. Consultations, surgical and obstetrical procedures, Mental Disorder care, Substance Use Disorder care, podiatrist care or foot care, rehabilitation therapies, are covered separately.

Preadmission Testing

The Medical Benefits percentage payable will be for diagnostic lab tests and X-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

Prescription Drugs (as defined)

When this Plan is secondary, all covered drugs and medicines are covered under Medical Benefits. Then, Plan benefits are coordinated with the primary plan payments. Please refer to the section entitled Summary of Benefits for benefit limits and Prescription Drug Benefits shown later in this document for details on covered expenses, limitations and exclusions. Copays of $10 or less for Prescription Drugs when this Plan is secondary will not be reimbursed.

Vitamins are not covered except: prenatal vitamins or mega vitamins due to serious medical condition such as diabetes or as indicated by federal law.

Preventive Care Services

Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Summary of Benefits. The Plan will comply with all mandated coverage provisions of the Patient Protection and Affordable Care Act. The following is a list of the most common services. This list is subject to change based on evidence-based items or services with an "A" or "B" rating from the United States Preventive Services Task Force; evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Heath Resources and Services Administration; and immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP). The Plan will comply within the first Plan Year after one year of the effective date of all new recommendations or guideline changes. The Plan will not cover any item or service that is no longer a recommended preventive service. Ancillary charges associated with any preventive care service will be available at no cost share. Please see www.HealthCare.gov/center/regulations/prevention.html for a complete listing and frequencies, unless listed in the Summary of Benefits.

Preventive care services/routine well care is care by a Physician that is not for an Injury or Sickness.

(1) **Contraceptive Management.** The Plan will cover FDA-approved contraceptive methods including injectable drugs, implantable drugs, patches, emergency contraceptives, and contraceptive devices prescribed by a professional Provider. Allowed Charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion of covered devices and the purchase of covered devices, are allowed.

FDA-approved contraceptive patches, injectable contraceptives and contraceptive devices are covered **only** under the "Medical Benefits" section of the Plan. Allowable charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion of covered devices and the purchase of covered devices, are covered. This is covered as a service of the professional Provider who administers them.

FDA-approved Oral contraceptives and implantable contraceptives are covered **only** under the "Prescription Drug Benefits" section of the Plan. Emergency contraceptives and other FDA-approved, Physician-prescribed over-the-counter methods are covered **only** under the "Prescription Drug Benefits" section of the Plan at retail only

Elective (female only) sterilization is covered under this benefit.

Benefits are not provided for abortifacient drugs or any drug or device obtainable without a prescription. Male contraceptive medicines or devices are not covered, regardless of intended use.

(2) **Nutritional Counseling.** The Plan will cover wellness (no underlying chronic condition required) nutritional counseling up to the benefit maximums shown in the "Schedule of Benefits". Services must be rendered by certified nutritionist or certified and registered dietician.

(3) **Prostate Exam.** Benefits are available for routine screening of the prostate gland, including digital rectal examination and PSA (prostate-specific antigen) testing.

- Coverage is limited to two per Calendar Year for men from age 50.
- Coverage is available for men at any age who have a prior medical history of prostate cancer and for men age 40 and older if determined to be at high risk for prostate cancer. Such high risk factors include a family history of prostate cancer and/or African-American ancestry

(4) **Routine Adult Physical Exams**, to include screening tests and age-appropriate immunizations.

(5) **Routine Eye Exam.** Limited to one exam per Covered Person, per Calendar Year, combined In- and Out-of-Network. This Plan will be secondary to any stand-alone vision plan

(6) **Routine Well Child Care** is routine care by a Physician that is not for an Injury or Sickness, to include health care visits and immunizations.

Coverage is intended to be consistent with the clinical standards set forth by the ACIP (Advisory Committee on Immunization Practices) of the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians recommendations. If these standards change, the Plan will automatically cover the new recommended standards. Coverage is intended to be consistent with the clinical and frequency standards set forth by the American Academy of Pediatrics. If these standards change, the Plan will automatically cover the new recommended standards.

(7) **Smoking Cessation Counseling.** Two individual tobacco cessation counseling attempts per Calendar Year will be covered. Each attempt may include a maximum of four intermediate or intensive sessions. The annual benefit will cover up to eight sessions for Covered Persons who use tobacco.

Prosthetics

The initial purchase, fitting and repair of fitted Prosthetic devices which replace body parts. Replacement may be covered if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

Special bras for women who have had a mastectomy will be allowed as any other benefit. A maximum of two bras every six months will be allowed.

Pulmonary Rehabilitation

Is covered when found Medically Necessary and the services are performed by a Pulmonary Rehabilitation program. Patients must meet the Medical Necessity criteria for Pulmonary Rehabilitation of the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) for patients with chronic pulmonary disease. The Claims Administrator may request medical records to evaluate the claim for Plan coverage.

Coverage is limited to a maximum of 36 visits per Covered Person per Lifetime for an approved plan of care. Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.

PUVA

Psoralen and Ultraviolet A is a therapy that the patient is exposed first to psoralens (drugs containing chemicals that react with ultraviolet light) and then to UVA light, when proven to be Medically Necessary.

Radiation Therapy

This benefit applies when a radiation charge is Incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit. A radiation charge is the Allowed Charge of a Physician for X-ray, radium or radiotherapy treatment. Radiation charges will not include charges for diagnostic or cosmetic procedures.

Refractive Surgery

Surgical procedure(s) to correct nearsightedness (myopia)/refraction disorders limited per the Schedule of Benefits.

Respiratory/Inhalation Therapy

For short-term outpatient respiratory/inhalation therapy when ordered by the attending Physician for therapy services given by certified licensed respiratory therapists or other qualified Provider. Custodial Care or Maintenance Care is not covered.

Skilled Nursing Facility (SNF) Care

(1) **Inpatient SNF Services.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;

(b) the attending Physician certifies that the confinement is needed for further care;

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility;

(2) **Outpatient SNF Services**

(a) **Rehabilitative Therapy**. Benefits are available for outpatient physical therapy, cardiac rehabilitation, occupational, speech therapy and inhalation/respiration therapy rendered to improve function lost due to an Illness or Injury under the Home Health Care Benefit. Such care must be ordered by the attending Physician and rendered by Professional Healthcare Providers licensed to render such care. Refer to the Summary of Benefits for benefit limits.

(b) **Other Outpatient Services and Supplies.** Benefits are available for other outpatient facility service or supplies when found Medically Necessary according to Plan provisions under the Home Health Care Benefit. Coverage includes all necessary supplies used during the covered treatment.

Speech Therapy

Services rendered by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. If the patient reaches maximum potential for improved, or age appropriate, function, benefits will no longer be payable.

Substance Use Disorder Treatment

Covered Charges will include care, supplies and treatment of Substance Use Disorder for services by a certified Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) for an approved plan of inpatient or Outpatient Care. Regardless of any limitations on benefits for Mental Disorders and Substance Use Disorder Treatment otherwise specified in the Plan, any aggregate Lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Use Disorder benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

(1) **Inpatient Treatment.** Inpatient detoxification is considered a medical condition eligible for acute care Hospital benefits. Expenses for inpatient Substance Use Disorders (alcohol or drug abuse) rehabilitation are covered separately from detoxification. Coverage is included for Partial Hospitalization.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

(2) **Outpatient Treatment.** Covered Charges for care, supplies and treatment of Substance Use Disorders will be subject to the benefit payment maximums shown in the Summary of Benefits for services by a certified alcohol or Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) for an approved plan of Outpatient Care.

All treatment is subject to the benefit payment maximums shown in the Summary of Benefits.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

Surgical Charge Benefits

(1) **Assistant Surgeon.** Charges for assistant surgeon services are covered when found Medically Necessary for performance of the covered procedure. The maximum payment for all assistant surgeons for each surgical procedure is 25% of the value listed for surgery.

(2) **Surgeon.** This benefit applies when a surgical charge is Incurred for a surgical procedure that is performed as the result of a Covered Person's Injury or Sickness and while that person is covered for this benefit.

It may be the fee of the surgeon or the assistant surgeon.

Care and treatment for voluntary surgical sterilizations are covered.

Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowed Charge for the primary procedures; 50% of the Allowed Charge for the second procedure; then 25% of the Allowed Charge for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowed Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowed Charge for that procedure.

(3) **Reconstructive Surgery**

The Plan covers care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a Dependent Child that has resulted in a functional defect.

Reconstructive mammoplasties will also be considered Covered Charges. The federally mandated mammoplasty coverage will include reimbursement for:

(a) reconstruction of the breast on which a mastectomy has been performed,

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(c) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

TMJ Syndrome

Medically Necessary surgical services for care and treatment of Temporomandibular Joint syndrome are covered for conditions that are consistent with the diagnosis of specific organic pathology of the joint that can be demonstrated by X-ray (such as arthritis, ankylosis, tumors, infections or traumatic injuries).

Only surgical correction and Orthotic splints are covered.

Transplants - Organ/Autologous Bone Marrow/Stem Cell Transplants

Benefits are available for expenses related to non-Investigational organ or tissue transplants the same as any other Illness. Unless otherwise specifically included, transplants are considered Investigational unless specifically included for Medicare coverage by the Centers for Medicare & Medicaid Services (CMS). Transplants must meet the Medicare criteria for coverage to be considered for coverage under this Plan. Benefits are not available for expenses related to transplants that have not been approved by CMS or that fail to meet CMS criteria for coverage. Plan coverage for Hospitals will be based on the same criteria set forth by CMS criteria. If CMS restricts coverage for a transplant to approved Hospitals only, then this Plan will only cover those transplants when rendered in the approved Hospital.

Benefits will be available for the following in connection with a covered transplant.

(1) **Recipient Expenses**. Coverage includes all Plan benefits available for Medically Necessary care and treatment related to covered organ transplants including, but not limited to; pre-transplant care including evaluation, diagnostic tests and X-rays by the transplant Hospital; procurement/tissue harvest and preparation; recipient's transplant surgery and recovery; and post discharge care.

(2) **Donor Expenses**.

(a) Coverage includes expenses Incurred by the live donor(s) for expenses related to procurement of an organ and for transportation of the organ(s) *to the extent such charges are not reimbursed by the donor's plan.*

(b) If you or your Dependent act as a donor, the donor expenses ***will not*** be covered by this Plan unless the recipient is a Covered Person under the Plan. Then, donor expenses will be considered as part of the organ recipient's claim.

Donor charges and donor search charges will be deemed to be Incurred on the date of the transplant even if the services were rendered before such date. Benefits will be paid for pre-transplant testing in connection with a search for a donor who is not a family member based on the limits indicated in the Summary of Benefits.

(3) **Autologous Bone Marrow/Stem Cell.** Courses of treatment involving high dose chemotherapy or radiotherapy and autologous bone marrow, stem cell rescue, or other hematopoietic support procedures are not covered as organ and tissue transplants, except for the following (and only then for candidates who meet established national health and age standards): acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, and neuroblastoma as allowed under CMS guidelines. If CMS guidelines change, adding or deleting coverage under Medicare, this Plan will include or exclude those procedures. Recipient and donor expenses for covered procedures will be considered on the same basis as organ transplants shown above.

(4) **Travel Expenses.** Travel expenses related to transplants are limited as indicated in the Summary of Benefits.

Urgent Care Facility

As defined. The Plan covers covered services and supplies provided by a legally operated emergency clinic or center for minor outpatient emergency medical care or emergency minor surgery. An outpatient Hospital emergency room does not qualify as an Urgent Care Facility.

Voluntary or Elective Abortion

Voluntary or elective abortions are not covered. Abortions will only be covered if Medically Necessary due to documented rape, incest, or when necessary due to mother's health, to preserve the life of the mother, or when the life, health, or "viability" of the fetus is in question. The abortion may be performed with impunity within the first 24 weeks on the advice of the MD and preapproved.

Voluntary or Elective Sterilization

Facility and other Provider charges for care and treatment related to voluntary surgical sterilizations are covered.

Wigs

Charges associated with the initial purchase of a wig for hair loss due to medical treatment. Coverage is limited to $250 per spell of Illness.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer per the collective bargaining agreement(s).

Advanced Physician Care Extender or Physician Extender includes Physician assistants (PAs), nurse midwives, nurse practitioners (NPs) and advanced practice nurses (APNs). These Providers are generally overseen by Physicians and must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

Allowed Charge - The Usual and Reasonable Charges as determined by the Claims Administrator for covered medical services rendered and billed by a covered Out-of-Network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. **Exception:** When Medicare is the secondary payer under the Medicare Secondary Payer rules for ESRD (based on the Covered Persons eligibility, not their enrollment in Medicare), the Allowed Charges for covered outpatient renal dialysis services are payable up to 150% of the current Medicare allowable amount for the Medicare region in which services were performed or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

Alternative Providers are Christian Science Practitioners and holistic medical Providers who operate within the scope of the licensure in the state where they practice.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays. It must be operated according to the applicable laws of the jurisdiction in which it is located, or accredited by the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Care or a national accreditation organization recognized by the Claims Administrator, or approved by Medicare to render outpatient surgery services. If the center is part of a Hospital, it will not be considered an Ambulatory Surgical Center.

Approved Clinical Trial - a Phase I-IV trial conducted for the prevention, detection, or treatment of cancer or other life-threatening conditions as follows:

- Federally funded or approved by NIH, CDC, AHCRQ, CMS, cooperative group or center of DOD, VA or DOE, or qualified non-governmental entity identified by NIH grant guidelines;
- Study or trial conducted under FDA approved Investigational new drug application;
- Drug trial exempt from FDA approved Investigational new drug application;
- Or as amended by the federal Patient Protection and Affordable Care Act.

Biomechanical Prosthetic Device is a Prosthetic device that utilizes a computer microchip, myoelectric technology or other similar technology to control movement or use.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is any person eligible and enrolled for benefits or coverage under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Deluxe equipment is not allowable when standard equipment is available and medically adequate for the reported condition.

Disposable Supplies may be allowed if required to operate the medical equipment.

Emergency Condition - a serious medical condition or behavioral condition after the onset of acute symptoms that were sudden and of such severity and/or pain that a prudent person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result placing the person in serious jeopardy to the health of an individual (including the health of a pregnant woman or her unborn child) or others, if severe behavioral condition; impairment to bodily function; dysfunction of any organ; or serious disfigurement.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services to evaluate an Emergency Condition and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Poughkeepsie Public Teachers' Association (PPSTA) Benefit Trust.

Enrollee or Covered Enrollee is an eligible Employee, Retiree, Divorced/Widowed Spouses of Retirees, or COBRA participant under whose Member ID number enrollment is made.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan

provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the US. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Foster Child means a Child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee or Retiree has assumed a legal obligation. All of the following conditions must be met: the Child is being raised as the covered Employee's or Retiree's; and the Child meets the definition of "Foster Child" under Internal Revenue Code 152 (f) (1).

A covered Foster Child is not a child temporarily living in the covered Employee's or Retiree's home; one placed in the covered Employee's or Retiree's home by a social service agency which retains control of the child; or whose biological parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement (or convalescent nursing home/extended care facility/Skilled Nursing Facility); and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical social services; medical supplies; and laboratory services by or on behalf of the Home Health Care Agency.

Hospice Agency is an organization whose main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association Healthcare Facilities Accreditation Program, or a national accreditation organization recognized by the Claims Administrator; or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

Hospitalist is a Physician that assumes the care of a Hospitalized patient and acts as a primary doctor while a patient is in a Hospital.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Immediate Relative of patient or Enrollee - Any of the following:

(1) Spouse of the patient or Enrollee;

(2) Natural or adoptive parent, Child or sibling;

(3) Stepparent, stepchild, stepbrother or stepsister;

(4) Father-in-law, mother-in-law, brother-in-law, or sister-in-law;

(5) Grandparent or grandchild; or

(6) Spouse of grandparent or grandchild.

Infertility is the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a Pregnancy to delivery. The duration of unprotected intercourse with failure to conceive should be about 12 months before an Infertility evaluation is undertaken, unless medical history, age, or physical findings dictate earlier evaluation and treatment.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular

rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Intensive Outpatient Program (IOP) is a licensed free-standing or Hospital-based program that includes half-day (i.e., fewer than four hours/day) Partial Hospitalization programs. IOPs provide services for at least three hours per day for two or more days per week and can be used to treat Mental Health Disorders or can specialize in the treatment of co-occurring Mental Health Disorders and Substance Use Disorders.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

Licensed Clinical Social Worker is a licensed social worker who has been certified by the New York State Board for Psychiatric Social Work or similar qualifications outside New York.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations for Covered Charges. Lifetime is understood to mean while covered under this Plan (and the prior policy or plan). Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Maintenance Care - Care rendered and directed at relieving discomfort or preserving function secondary to conditions where further enhancement of function cannot be demonstrated or expected. Care that cannot be reasonably expected to lessen the patient's disability enabling him or her to leave an institution. Maintenance Care does not imply the absence of symptoms nor does it imply such services are not necessary. It implies care rendered to maintain a function and prevent the condition from worsening.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical and dental services; is not conducted for research purposes; is not Experimental or Investigational or not of an educational nature; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Claim Administrator reserves the right to decide, in its discretion, if a service or supply is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Health Disorder in the current edition of International Classification of Diseases, published by the US. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person. Alternatively, a BMI (body mass index) value greater than 39 may be used to diagnose Morbid Obesity.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with accidents in an automobile or other vehicle, as mandated under the applicable law.

Orthotics - An external appliance or device intended to correct any defect in form or function of the human body. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, corsets, apparel, orthopedic shoes or shoe inserts, or supportive devices for the feet.

Out-of-Pocket means the patient liability portion of the percentage copayment, Deductible and Copayments.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization (PHP) program or day/night program is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Health Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator, and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts at least 20 hours per week no charge is made for room and board. Partial Hospitalization also encompasses Partial Hospitalization programs that provide overnight boarding.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Certified Nurse Anesthetist, certified psychiatric nurse, licensed professional counselor, Licensed Professional Physical Therapist, certified registered or Licensed Clinical Social Worker (for care of Mental Disorders), Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the Poughkeepsie Public Teachers' Association (PPSTA) Benefit Trust Group Health & Dental Plan, which is a benefits plan for certain Active Employees and Retired Employees of Poughkeepsie Public Teachers' Association (PPSTA) Benefit Trust and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetics - The making and application of any artificial part that replaces all or part of a body part, organ or function lost or impaired as the result of disease or Injury. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, orthopedic shoes or supportive devices for the feet.

Provider - Any legally licensed Physician or any physical therapist, speech therapist, certified or Licensed Clinical Social Worker (for Mental Disorder care), or other health care Providers giving a covered service ordered by a Physician. Any licensed independent laboratory, Hospital, Skilled Nursing Facility, Substance Use Disorder Facility, Hospice Agency, Home Health Care Agency; or other facility/agency included for Plan coverage. Coverage includes charges billed by Urgent Care Facilities, and other health centers or clinics for Covered Services given by Covered Physicians or other healthcare Providers that would otherwise be covered by the Plan. Also, see definitions for certain Providers. To be covered, a Provider must meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

Psychiatric Facility means a private facility that has been approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator as an inpatient facility for the treatment of Mental Disorder and is licensed by appropriate state agencies. A public (government-owned) mental health facility for the treatment of Mental Disorders.

Pulmonary Rehabilitation is an individualized therapeutic multidisciplinary program of care for patients with chronic respiratory disease who remain symptomatic or continue to have decreased function despite standard medical treatment. Pulmonary Rehabilitations' goals are to reduce symptoms, optimize functional status, increase participation, and to train patients to successfully manage their disease process, and improve the overall quality of life for patients with chronic respiratory disease.

Qualified Individual is a Covered Person who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either (i) the referring Provider is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Rehabilitation Facility means a facility established, equipped and operated, according to the applicable laws of the jurisdiction in which it is located to provide restorative therapy to disabled persons on an inpatient or outpatient basis. The facility must be approved by the Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a national accreditation organization recognized by the Claims Administrator, or be a Medicare approved facility for Medicare Part A Skilled Nursing Facility benefits. See also Skilled Nursing Facility.

Retired Employee or Retiree is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written Plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Routine Patient Costs include all items and services consistent with the coverage provided in this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include the Investigational item/device/service itself; items/services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

(8) It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a national accreditation organization recognized by the Claims Administrator.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

Sound Natural Teeth are natural teeth that are fully restored to function; or do not have any decay; or that are not more susceptible to Injury than virgin teeth; or do not have significant periodontal disease.

Substance Use Disorder is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Substance Use Disorder Facility - An agency or freestanding facility or a Hospital center that is certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for the treatment of Substance Use Disorders (drugs and alcohol). For services given outside New York, the facility must be certified by a state agency similar to the New York State OASAS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator for the treatment of Substance Use Disorders.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint. Care and treatment is limited to surgery.

Total Disability (Totally Disabled) means:

In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. The Employer will determine Total Disability.

In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health. For a disabled Dependent Child, disability will be defined by state law or the Social Security Administration and is a Physician's certification of permanent and Total Disability making a Dependent incapable of self-support is required prior to the Child's 19th birthday.

Tricare is the Department of Defense's health care program for members of the uniformed services, their families and survivors.

Urgent Care Facility means a medical facility that is open on an extended basis, is staffed by Physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a Physician's office.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the Provider of the care or supply and does not exceed the usual charge made by most Providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

To calculate reimbursements, the Plan will use the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Waiting Period means the time between the first day of employment and the first day of coverage under the Plan.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan and all exclusions related to Dental are shown in the Dental Plan.

This list is not an all-inclusive list. Certain service may not be covered based on Plan policy and procedures, as may be established from time-to-time, that are in keeping with the general benefit structure and intent of the Plan. New FDA-approved treatment and procedures will generally be covered within the benefits provided.

For all Medical Benefits shown in the Summary of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the Pregnancy is the result of rape or incest, or when necessary due to mother's health, to preserve the life of the mother, or when the life, health, or "viability" of the fetus is in question.

(2) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(3) **Anesthesia.** Services or supplies for the administration of anesthesia for any surgery or treatment that is not covered by the Plan.

(4) **Automobile Insurance, No-Fault Auto Insurance** for which the Covered Person is eligible to receive benefits through mandatory No Fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for services or supplies not paid by the No-Fault coverage due to its deductible or maximum payment limits will be covered under this Plan to the extent allowable fees would have otherwise been payable by this Plan. **Note:** No-Fault and motor vehicle liability coverage is considered another plan under the Coordination of Benefits provision of this Plan.

(6) **Blood.** Costs associated with the drawing/preserving of blood prior to surgery to be used in the event that a transfusion is required during surgery. This is not Medically Necessary unless it is know in advance of the surgery that a transfusion will be required. Blood that is drawn for this purpose, in advance, at eh patient's expense, and becomes necessary to use this blood during surgery, the Plan will reimburse the Covered Person the cost of the actual transfusion at the cost per pint of blood.

(7) **Charges Outside the USA**, are limited to emergency care and as provided under Foreign Travel for Covered Persons permanently residing outside the USA, unless approved by the Plan.

(7) **Clinical Services** for reasons other than Medical Necessity, e.g., to comply with court order, obtain shelter, deter anti-social behavior, deter truancy or runaway behavior, or achieve family respite.

(7) **Complications of Non-Covered Treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered

(5) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for

beautification, or treatment relating to the consequences of a, or as a result of, cosmetic surgery (including re-implantation). Services or supplies connected with elective cosmetic surgery or treatment. Reversal of elective, cosmetic surgery will not be covered unless found to be Medically Necessary according to Plan provisions. Exception: Care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a Dependent Child that has resulted in a functional defect.

(6) **Counseling/Analysis/Support Groups**. Services or supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling; gender identity counseling, sex therapy, or support groups. Therapy charges in connection with meeting a Covered Person's motivational needs and not related to a specific, diagnosed, psychiatric Illness.

(7) **Court Ordered/Police Custody Services**. Services or supplies Incurred while the Covered Person is in police custody, jail or in prison, or services or supplies related to court ordered evaluations for Mental Disorders or substance (drug and alcohol) abuse. This includes voluntary treatment in order to reduce potential legal penalties or actions; and court ordered treatment when the treatment is agreed to by the individual in lieu of other legal/court action including fees, jail time and public service.

(7) **Custodial Care.** Services or supplies provided mainly as a rest cure, Maintenance or Custodial Care or domiciliary care consisting chiefly of room and board. This includes nursing home, long-term care, or assisted living care when care is not in lieu of Hospitalization or skilled nursing care, due to Medical Necessity. This also includes half-way houses, any shelter or facility that is not appropriately licensed by the state as a medical or Psychiatric Facility with appropriate medical staffing and management by a Physician or psychiatrist.

(8) **Dental Care.** Services or supplies related to care or treatment of the teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other services considered to be dental, rather than medical, in nature. Adjustments, services or supplies related to appliances for treatment of Temporomandibular Joint disorders (TMJ) or similar disorders, other than surgery or Orthotic splints. Dental implants, no matter the reason.

Exceptions: Charges by a Dentist or Physician for care otherwise considered medical such as reduction of fractures of the jaw or facial bones, surgical correction of cleft lip, cleft palate, removal of stones from salivary ducts, bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues, treatment and surgery for joint disorders, freeing of muscle attachments; removal of impacted teeth and removal of wisdom teeth. Limited dental care given for Accidental Injury to Sound Natural Teeth within 12 months following the accident; in no event will the Plan pay for the repair or replacement of dentures, crowns or other dental devices.

Dental implants to replace broken teeth have been removed, due to a medical condition or accident, are not covered under the Plan.

Benefits are also available for Hospital or other facility charges for dental-related services that require a Hospital inpatient or outpatient admission due to an underlying medical condition.

(9) **DNA Testing, Stem Cell Research, Storage of Stem Cells, or Related Charges.** This includes charges for harvesting or storage of tissue or cells for storage, unless as specifically included in the Plan.

(9) **Durable Medical Equipment/Braces/Prosthetics/Devices.** Services or supplies related to duplicate medical equipment, braces, Prosthetics or other devices or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices due to loss, theft or destruction, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. The purchase of Durable Medical Equipment that can be rented unless the length of time that the equipment will be needed makes the purchase less costly than the rental. The

purchase or replacement of any Biomechanical Prosthetic Device. Specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, Orthotics, or splints that are primarily for athletic use.

(10) **Educational/Cognitive/Therapy for Developmental/Birth Defects.** Services or supplies related to special education or cognitive therapy for any reason, or for occupational, physical, psychological or other therapy that is primarily directed at educational or mental or physical development for learning deficiencies, mental retardation, developmental disorders, birth defects, spinal bifida, educational or occupational deficits or perceptual and conceptual dysfunctions. This applies whether or not associated with manifest mental Illness or other disturbances. Services or supplies considered remedial or educational. Services and supplies that any school system is required to provide under any law. This applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system.

(11) **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(12) **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, approved Pulmonary Rehabilitation programs, occupational or physical therapy covered by this Plan or as specifically included in this Plan.

(13) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/ Investigational or not Medically Necessary, unless as otherwise stated as being covered under the Plan, unless as required by federal law.

(14) **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. Services and supplies related to vision therapy. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(15) **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). Orthopedic and corrective shoes not attached to a covered brace; foot Orthotics; support, heel pads, heel cups or other supportive foot devices, unless otherwise covered by the Plan.

(16) **Foreign Travel.** Care, treatment or supplies out of the U.S., if travel is for the sole purpose of obtaining medical services. Services provided outside the US are limited to emergency care and as provided per the Summary of Benefits as foreign coverage for Enrollees permanently living outside the US as approved by the Plan. Transportation back to the US due to a medical condition is not covered unless due to an acute condition and Medically Necessary to return the Covered Person to the US as soon as possible. Students studying abroad are not covered except for emergency care. Treatment is not covered (except for emergency treatment) while traveling “temporarily” for a period not exceeding six weeks in any one country or three months in total.

(17) **Genetic Counseling.** Genetic counseling or DNA testing is not covered, unless otherwise covered by the Plan. Genetic testing for preventive purposes is not covered.

(17) **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(18) **Government Facilities/Institutions.** Services or supplies received in an institution owned or operated by federal, state or local governments. However, benefits will be available for covered expenses for the following exceptions:

(a) Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces.

(b) State or local government owned acute care Hospital or Skilled Nursing Facility that

customarily bills for its services.

(c) State or local government owned mental health facility.

(d) Government owned facility that otherwise meets Plan limitations for coverage as an outpatient alcohol or Substance Use Disorder treatment facility.

(e) USA military acute care Hospital or Skilled Nursing Facility for treatment of retired or inactive military personnel or their dependents or for the dependents of active military personnel.

(f) Any government facility, if the patient with a sudden and serious Illness or Injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary or it is impossible to transfer the patient to another facility.

(18) **Growth Hormone Therapy.** Not covered unless preapproved and Medically Necessary.

(18) **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs for hair loss due to medical treatment.

(19) **Hearing.** Services or supplies related to hearing aids, tinnitus masking devices (or similar devices), communication devices, and examinations to determine the need for, adjustments or repair of them. Exceptions: The initial hearing aid for hearing loss caused by a covered surgical procedure rendered to a patient while he is covered under the Plan; services covered under the well adult or well child sections of this Plan and F.D.A. approved cochlear implant will be covered under the Plan's Prosthetic benefit

(20) **Home Births.** Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

(21) **Hospital Confinement.** Charges primarily for physiotherapy, hydrotherapy, convalescent, rest care, or other routine physical examination that are not connected with an Illness or Injury are not covered. Charges for any period of time when the Covered Person is not physically present.

(22) **Hospital/Facility Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital, Skilled Nursing Facility, or any inpatient facility where care is received and paid by the Hospital or facility for the service. **Exception:** Hospitalists and Physician Extenders who have contracts for payment with the Claims Administrator.

(23) **Illegal Acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a riot or public disturbance or an illegal act, felony, or attempting to commit a criminal or illegal act. For the purpose of this exclusion, it is not necessary that criminal charges be filed and the crime could be punishable by any term of imprisonment. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(24) **Illegal Care.** Services or supplies considered illegal according to the laws of the state of jurisdiction or according to federal law. Benefits will not be provided if these excluded services are obtained outside the USA even if these services are legal in the foreign country.

(25) **Illegal Drugs or Medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(26) **Immediate Relative or Self Giving Professional Services.** Professional services performed by a person who ordinarily resides in the Covered Person's home, or self, or is related to the Covered Person as a Spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

(27) **Implants.** Claims for implants billed by a facility may be denied unless they are submitted with the invoice.

(28) **Infertility**. Care, supplies, services and treatment for Infertility, unless specifically included in the Plan. Costs associated with withdrawal/preservation of sperm or eggs for purposes of future impregnation and/or fertility treatments unless preapproved by the Claims Administrator. Services rendered in anticipation of potential future Infertility services are not covered, as such services are not Medically Necessary at the time of the service.

(29) **Military Service.** Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.

(30) **Missed Appointments/Phone Consultations/Forms/No Care Given.** Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, charges for standby services. Services or supplies not actually received by the patient or Incurred by someone other than the patient unless specifically included in this Plan such as coverage limits for organ donors.

(31) **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(32) **No Obligation to Pay.** Charges Incurred for which the Plan has no legal obligation to pay.

(33) **No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(34) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(35) **Non-emergency Hospital Admissions.** Care and treatment billed by a Hospital for non-Emergency Condition admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(36) **Not Specified as Covered.** Medical services, treatments and supplies which are not specified as covered under this Plan.

(37) **Nuclear Accident.** Expenses Incurred due to a nuclear accident or terrorist act are not covered.

(38) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary non-surgical charges for Morbid Obesity will be covered. Medically Necessary surgical charges for Morbid Obesity will be covered, if preauthorized.

(39) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Payment will not be made even if you or your Dependents do not claim the entitled benefits.

(40) **Other Plan/Benefit Penalties/Primary Care Network/HMO Network**. Services or supplies to the extent such expenses were disallowed by a primary health plan due to failure by their enrollee or participant to follow the requirements of its benefit management or managed care program, preadmission reviews, second surgical opinion, or any other reason, including failure to abide by

the primary care Physician network established by a health maintenance organization that is a primary plan payer.

(41) **Over-the-Counter Medications.** This includes non-prescription medications, even if prescribed by a Physician, unless as specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act.

(42) **Plan Design Excludes.** Charges excluded by the Plan design as specified in this document.

(43) **Prohibited Referral**. Any Pharmacy services, clinical laboratory, radiation therapy, X-ray or imaging services which were provided pursuant to a referral prohibited by the New York State Public Health Law or similar laws in other states, if service is rendered out of New York.

(44) **Room and Board** when the Covered Person is not physically present for any period of time.

(45) **Routine Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Summary of Benefits or as required by applicable law.

(46) **Scope of Licensure.** Medical services/ supplies that are provided by a Provider not operating within their scope of licensure.

(47) **Services Before or After Coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(48) **Sex Changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(49) **Storage Costs.** Costs to retrieve or store blood, plasma, eggs, sperm, body organs, stem cells or tissue is not covered. Costs for harvesting or storage of tissue or cells for storage.

(50) **Subrogation/Third Party Claim.** Services or supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or actions). Exception: Conditional payments shown in the section entitled “Third Party Recovery Provision”.

(51) **Surgical Assistance**. Expenses billed for surgical assistance in a Hospital if the Hospital has qualified staff Physicians to provide such assistance. Expenses billed for surgical assistance by Providers other than qualified surgeons (M.D., D.O., or a D.P.M for foot surgery, or a D.D.S., D.M.D. for covered oral surgery).

(52) **Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

(53) **Surrogate Pregnancy.** Services or supplies related to surrogate maternity care, including but not limited to, those needed to initiate a Pregnancy, prenatal care, delivery or other procedures, and postnatal care or any other related care of the Pregnancy. Benefits are available for Newborns who meet the Child eligibility requirements and who are enrolled under family coverage.

(54) **TMJ Appliances.**

(55) **Transplants.** The acquisition, donation and transportation of any covered organ, when a transplant is performed, is not covered, except as provided in the Plan.

(56) **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge or transportation services specifically listed in this Plan.

(57) **Treatment Outside the US, Canada, or Mexico.** Only treatment for Emergency Conditions are covered while the Enrollee is temporarily traveling (periods not to exceed six weeks in any one country or three months in total).

Retirees living permanently outside the US are generally covered, as long as proof of residency is provided and non-residence status is approved by the Plan in advance. The approval will be at the sole discretion of the Plan, based on all relevant facts and circumstances, including the country in which the Retiree lives. Coverage in countries considered “high risk” areas will not be approved, subject to the sole discretion of the Plan. Students on exchange-type programs are not covered.

(58) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. ProAct is the administrator of the Pharmacy drug Plan.

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. Covered Persons may contact ProAct Customer Service Department toll-free at 1.877.635.9545 for details.

Copayments

The Copayment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Summary of Benefits. The Copayment amount is not a Covered Charge under the medical Plan. Any one Pharmacy prescription is limited to a 31-day supply. Any one mail order prescription is limited to a 93-day supply.

Exceptions: Some Prescription Drugs have a quantity/dosage limit other than the 31-day and 93-day limit shown above. Copayment is waived for Prescription Drugs that are mandated as covered under the “Preventive Care” provisions as per the federal Patient Protection and Affordable Care Act. Contact ProAct’s Customer Service Department toll-free at 1.877.635.9545 for details on quantity limits and “Preventive Care” provisions under the Plan. If a Generic Drug version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by ProAct. Contact the ProAct Customer Service Department toll-free at 1.877.635.9545 for details on quantity limits and “Preventive Care” provisions under the Plan.

If a drug is purchased from a non-participating Pharmacy or a participating Pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the Summary of Benefits will be the ingredient cost and dispensing fee.

Prescription Drug Out-of-Pocket Limit

Covered expenses are payable at the percentage shown each Calendar Year until the Prescription Drug Out-of-Pocket shown in the Schedule of Benefits is reached. Then, covered Prescription Drug expenses Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the remainder of the Calendar Year.

Mandatory Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Medco, the mail order Pharmacy, is able to offer Covered Persons significant savings on their prescriptions. If Covered Enrollees do not use mail order on any maintenance drugs not filled after the third refill, Copays will be TRIPLED.

> **Exception:** For preventive care drugs mandated as covered under the preventive care provisions of the federal Patient Protection and Affordable Care Act, if a Generic drug would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by ProAct. No penalty will apply.

Pre-authorization Requirements

Some drugs require pre-authorization before benefits become available. All drugs over $1,000 must be precertified. The participating Pharmacy or mail order Pharmacy will not provide coverage unless drugs have been approved for benefit payment. If a Pharmacy advises you that you need pre-authorization, you should call Customer Service Department at 1.877.635.9545 for assistance. Failure to obtain prior authorization will result in denial of benefits. The drugs that require pre-authorization include: anti-obesity agents, Synagis/ Respigam, growth hormones, Infertility drugs, Retin-A, OTC vitamins (except ferrous sulfate) and folic acid.

Specialty Pharmacy Services

ProAct has a special program for specialty drugs developed for chronic and or complex Illnesses including but not limited to Crohn's disease, hepatitis C, osteoarthritis, rheumatoid arthritis, Infertility, and pulmonary disease. These drugs may have special handling storage, shipping requirements, or require disease specific treatment programs. They may be injections, infusions, or oral products. Specialty drugs provided during outpatient treatment are subject to precertification. Chemotherapy, radiation therapy and infusion therapy specialty drugs for approved treatment will be allowed at 100% of Allowed Charges.

All drugs deemed specialty drugs by ProAct and received by ProAct mail order will be sent to the ProAct Specialty Pharmacy to be filled. A complete list of drugs available under the specialty Pharmacy is available by calling ProAct Customer Service Department's toll-free number: 1.877.635.9545, or you may access the list on their website at www.ProActrx.com.

Mandatory Generic Drug Substitution Program

As part of a continuing effort to control costs and preserve the quality of the Plan, you are encouraged to use Generic Drugs whenever appropriate for your condition. A Generic Drug is chemically equivalent to the original Brand Name Drug. The only difference is that the Brand Name manufacturer's patent has expired, allowing other manufacturers to sell the drug. As a result, the Generic manufacturer does not incur research costs and can charge significantly less for the drug. Since Generic Drugs cost less than Brand Name Drugs, cost savings result for you (a lower percentage payable liability amount) and the Plan when you substitute the lower priced drug. If you have any questions about Generic Drugs, ask for advice from your Physician or your pharmacist.

Noncompliance Benefit Reduction. If you or your eligible Dependent receives a Brand Name Drug when a Generic Drug (AB-rated only) substitution is available, you are responsible for paying the difference between what the Plan would pay for the Generic Drug and the charges for the Brand Name Drug, up to a maximum of two times the normal Brand Name Copay. The Brand Name Copay will be doubled, if a Covered Person refuses the Generic, unless a Medical Necessity override is in place based on a Physician's documentation of adverse reaction of ineffectiveness of the Generic. This penalty will also apply to DAW (dispense as written) drugs with no approved override for Medical Necessity. This can result in substantial payment by you as there is a significant difference in costs between the Brand Name Drugs and Generic Drugs.

Exceptions to Drug Policy/Vacation Overrides

Any request for an exception must be submitted in writing by your Physician with all relevant considerations and the Medical Necessity for such medication. Requests will be treated the same as any other appeal. Exceptions will be at the sole judgment of the Plan based on Medical Necessity and the relevant facts. A written letter of Medical Necessity is required if you are unable to take certain Generic drugs. Contact *ProAct* for vacation overrides for prescriptions.

Step Therapy

This program requires Covered Persons to try other drugs in the same therapeutic classification prior to approving a drug covered by the step therapy program. It is important for Providers to respond immediately to requests for medical information to avoid delays in filling prescriptions.

Prescriptions While in a Nursing Home

Requests must be made to the Claims Administrator to have all prescriptions dispensed from a local Pharmacy in blister packs. Mail order requirement will be waived. If the nursing home has an in-house Pharmacy, benefits are not available.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law, excluding any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Impotency drugs will be limited to a maximum benefit of $1,000 per Calendar Year.

(4) Prenatal vitamins and mega vitamins, if approved by the Plan, due to a serious or chronic on-going medical condition when over-the-counter vitamins are not appropriate; prenatal vitamins for Pregnant women are coved at the normal Copay.

(5) Weight loss or anti-obesity drugs are subject to the Plan rules for weight loss and prior approval.

(6) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered unless preauthorized.

(7) The Plan will comply within one year of the effective date of all new recommendations or guideline changes as required under the federal Patient Protection and Affordable Care Act; the Plan will not cover any item or service that is no longer a recommended preventive service. No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval. Please see www.HealthCare.gov/center/regulations/prevention.html for a complete listing and frequencies, unless listed in the Summary of Benefits.

- Smoking/tobacco use cessation agents when prescribed by a Physician for Covered Persons over age 18 for over the counter and prescription forms to include gum, lozenge, patch, inhaler, nasal spray, and oral agents. Limit: Two individual tobacco cessation attempts (180 days) per Calendar Year will be covered.

- Birth control, including oral contraceptives, systemic, non-oral (NuvaRing, Ortho Evra patch), and contraceptive injections. Injectable contraceptives, Nor-Plant, and other contraceptive devices are allowed under Medical Services and Supplies of this Plan. FDA-approved contraceptives when prescribed by a Physician for females with reproductive capacity to include Generic Drug oral contraceptives, implants, and emergency contraceptives. Over-the-counter emergency contraceptives or other over-the-counter Physician-prescribed FDA-approved methods of female contraceptives are only covered at the retail Pharmacy. Benefits are not provided for abortifacient drugs.

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

(3) Quantity limits that could apply to controlled substances based on state regulations.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Allergy Serums.**

(3) **Appetite Suppressants/Dietary/Vitamin Supplements.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride, except as specifically included in the Plan or as specifically mandated for coverage by federal law.

(4) **Blood or Blood Plasma Products.**

(5) **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(6) **Contraceptive Jellies, Creams, Foams, Implants, Mifeprex**, except as mandated by federal law**.**

(7) **Devices.** Devices of any type, even though such devices may require a prescription, including contraceptive devices. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(8) **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes (i.e., Renova, Vaniqa, Tri-Luma, Botox-Cosmetic, Solage, Avage), such as anabolic steroids, Retin-A or medications for hair growth or removal (i.e., Rogaine, Propecia), except as specifically included in the Plan.

(9) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person, except as mandated by federal law.

(10) **FDA.** Any drug not approved by the Food and Drug Administration.

(11) **Growth Hormones,** if determined not to be Medically Necessary by the Plan.

(12) **Immunization.** Immunization agents or biological sera.

(13) **Injectable Supplies.** A charge for hypodermic syringes and/or needles (other than for insulin). Certain injectable medications may be allowed as a Medical Services and Supplies benefit.

(14) **Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(15) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

(16) **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.

(17) **Methadone and Methadone Maintenance Drugs.**

(18) **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(19) **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or drugs as mandated by federal law.

(20) **Non-legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(21) **Over-the-Counter Drugs,** except mega does required due to serious medical conditions, such as diabetes*,* except as mandated by federal law.

(22) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

DENTAL BENEFITS

This benefit applies when covered dental charges are Incurred by a person while covered under this Plan.

ELIGIBILITY FOR ENROLLMENT

The collective bargaining agreement determines eligibility for enrollment in the dental Plan. Open Enrollment is not applicable to dental; eligibility is determined by the collective bargaining agreement.

BENEFIT PAYMENT

Each Benefit Year benefits will be paid to a Covered Person for the dental charges. Payment will be made at the rate shown under Dental Percentage Payable in the Summary of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount. This Plan will utilize DenteMax's fee schedule and participating Providers.

BENEFIT YEAR

The benefit year for dental benefits is July 1 to June 30

MAXIMUM BENEFIT AMOUNT

The maximum dental benefit amount is shown in the Summary of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is Incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be Incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Items listed below are examples of covered services for each class. Appendix A will list the specific services allowed and the class those services will be allowed.

Class 1 Services:
Preventive and Diagnostic Dental Procedures

The limits on Class 1 services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) **Routine oral exams** are limited to two per Covered Person each Benefit Year.

(2) **Prophylaxes** (cleaning and scaling) of teeth. Limit of two per Covered Person each Benefit Year.

(2) **Bitewing X-rays**, limit of two series every Benefit Year – one preventive and one additional bitewing series will be covered if Dentally Necessary.

(3) One **full mouth X-ray** every three Benefit Years. Occlusal and extra oral X-rays will not be paid for more than two films within any two Benefit Years.

(4) **Fluoride treatments** for covered Dependent Children under age 18 each Benefit Year. Limit of two per Benefit Year.

(5) **Space maintainers** for missing primary teeth.

(6) **Emergency exams** will be limited to two per Benefit Year or emergency palliative treatment for the purpose of removing or alleviating pain and sedative fillings. If additional dental services are provided on the same day as an emergency exam, no payment will be made for the exam.

(7) **Sealants** will be covered to age 18 every three years or as Dentally Necessary.

(8) **Periodontal prophylaxes** (limited to two) will be allowed for Covered Persons over age 18 for those previously treated for periodontal disease. Periodontal maintenance is limited to two in any Benefit Year period or in conjunction with regular cleanings with no more than four visits/cleanings per Benefit Year in total.

(9) Benefits for a filling include **local anesthesia and conscious sedation** (including nitrous oxide) or direct pulp capping the same date as the filling.

(10) **Guards**. Occlusal guard is limited to one every 12 months for Covered Persons 13 and older. Fabrication of an athletic mouth guard is limited to one per 12 months.

Class 2 Services:
Basic Dental Procedures

(1) **Restoration**. Amalgam and composite fillings, pulp caps and nitrous oxide. Fillings may consist of silver amalgam and/or tooth color restorations using synthetic materials.

(2) **Periodontal Scaling and Root Planing**: benefit includes teeth quad and maintenance. Other periodontal services are considered Class 3 services.

(3) **Dentures**. Includes denture adjustments, realignment and repair of broken denture base.

(4) **Consultations**. Only one consultation will be covered in any Benefit Year.

(5) **Surgical services**. Extractions and alveoplasty. Impacted tooth extraction and wisdom tooth extraction will be allowed under the medical portion of the Plan.

Class 3 Services:
Major Dental Procedures

(1) **Endodontics**. Charges for root canal therapy includes necessary X-rays. The fillings may consist of silver amalgam and/or tooth color restoration using synthetic materials. (See also crowns.) Tooth canal therapy includes anesthesia, X-rays, pulpotomy, temporary fillings and post-operative care.

(2) **Restorations**. Restorative cast restorations, crowns, inlays and onlays are covered if Dentally Necessary due to decay or traumatic Injury and the tooth cannot be restored with a routine filling material. Restorations include fillings to molars.

(3) **Bridges and Dentures**. Charges for initial installations of dentures or fixed bridgework to replace at lease one natural tooth extracted while covered under this dental Plan or where credited service is given for participation per HIPAA rules under any prior dental plan if there was no break in service of more than 63 days. Removable dentures are limited to one every 60 months.

(4) **Replacement and Repairs**. Charges for replacement of existing crowns, inlays/onlays, dentures (full or partial), or fixed bridgework if the existing was installed at least five years prior to its replacement and the exiting crown, denture, or bridgework cannot be repaired and made serviceable.

(5) **Inlay/Onlay Services**. Covered when the teeth cannot be restored by filling, local anesthesia, direct pulp capping on the same day as cementation, indirect pulp capping, lap charges, base, pins, gum preparation and temporary restoration. Replacement of inlays is limited to once every five years.

(6) **Crowns**. Covered when the teeth cannot be restored by other means and when the crown is not part of a bridge. Crowns for periodontal splinting are not covered, but services for local anesthesia,

direct pulp capping done on the same date as cementation, indirect pulp capping, lab charges, base, pings, gum preparation and temporary restorations are covered. Crowns can be replaced once every five years if Dentally Necessary. For child crowns (up to age 14), covered services include pulpotomy, including local anesthesia, X-rays, pulp capping, temporary fillings and post-operative care.

(7) **Implants**. Reimbursement on any singe implant (single tooth) and all related services for such implant is limited to and applied to the Benefit Year maximum. Implant services include any attachments, implant crowns and any procedures related to the implant (not separately covered, e.g. removal of a tooth or crown), subject to the Benefit Year maximum.

(8) **Periodontal services**. Surgical and non-surgical periodontal services such as gingivectomy, osseous surgery, soft tissue graft procedures, provisional splinting, full mouth debridement (limited to one every five years). Scaling and maintenance are considered Class 2 services.

The following are only allowed if the Covered Person has been covered under this Plan or another dental plan covering such major services for 12 months prior to the date of service (HIPAA certificate or proof of coverage is required):

(9) **New bridges**.

(10) **New dentures**.

(11) **Implants or any prosthetic device** – includes any attachments, implant crowns and any procedures related to the implant (not separately covered, e.g. removal of a tooth), subject to the Benefit Year maximum. Removal of a tooth for purposes of later installing an implant will be covered as oral surgery for the removal of a tooth.

Class 4 Services:
Orthodontic Treatment and Appliances

Payments will be made per the Summary of Benefits for charges Incurred while eligible, up to the maximum Lifetime limit. Total Covered Charges will be divided into quarterly payments. The first quarterly payment becomes due upon insertion of the appliance. The remaining quarterly payments will continue over the next 12 months. If you terminate coverage prior to the payment due date, no payment will be made unless the Covered Person has elected to continue dental coverage under COBRA.

Orthodontic expenses will include the following:

(1) radiographs, cephalometic film and casts.

(2) minor or interceptive treatment for tooth guidance including removable appliance therapy and fixed or cemented appliance therapy.

(3) treatment of primary transitional dentition including Class I, II and III malocclusion.

Class 5 Services:
TMJ Treatment

Limited X-rays, appliances and TMJ therapy will be allowed.

EXTENDED BENEFITS

Benefits will be extended for a dental procedure that began before the date an Enrollee's coverage terminated and which was completed within 30 days after the termination date, if the coverage charge is for any of the following:

(1) a removable appliance or modification of an appliance for which an impression is made.

(2) a fixed bridge, crown, gold or cast restoration when the tooth or teeth are fully prepped.

(3) root canal therapy when the pulp chamber is opened and explored to the apex, provided the Enrollee does not become covered under any other group dental plan for that dental procedure.

DENTAL COVERAGE AFTER RETIREMENT

Retirees may elect to continue their dental coverage after retirement. However, dental coverage is voluntary and subject to payment of the current dental premiums and rules set up by the Trust.

If a Retiree discontinues their dental coverage for any reason, including lack of payment of premium, they may not re-enroll.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $250 or more, it is recommended a predetermination of benefits form be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting X-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

POMCO
2425 James Street
Syracuse, New York 13206
1.866.227.9936

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, X-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

SERVICES BY MORE THAN ONE PROVIDER

The covered services or supplies will be used to decide the Plan benefits, not the number of Providers doing the services. If dental care is transferred from one Dentist or Physician to another Provider during treatment, total Plan payment will not be more than the Plan would have been paid had one Provider given the covered service.

TREATMENT STARTED BEFORE COVERAGE BEGAN

Charges for the following services are not covered if the services began prior to the Covered Person becoming eligible under the Plan, unless the Covered Person provides proof of continuous creditable dental coverage with no break in coverage according to HIPAA rules. The Covered Person must supply the Plan with a copy of the HIPAA Certificate for any prior dental coverage (or other proof of coverage) before any consideration will be given to allowing any treatment which began prior to the date of coverage under this Plan. If a new benefit is added, only treatment that begins on or after the effective date of such coverage will be allowed, e.g. orthodontia treatment.

(1) Dentures, if the impression for the dentures was taken prior to coverage;

(2) Crowns, bridges, or gold restorations if preparation of the teeth was begun prior to coverage;

(3) Root canal therapy;

(4) Orthodontic charges or treatment which began prior to January 1, 2008 for current Covered Persons is not allowed. For current Covered Persons only, that portion of the charges Incurred on or July 1, 2008 with an eligible Provider will be allowed under the Plan.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative Costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Appliances or Restorations** except full dentures, to change vertical dimension, or restore occlusion or correct TMJ. Diagnostic procedures and any treatment for each are excluded.

(3) **Athletic Mouth Guards**; night guards; analgesia; implants, except as specifically covered; occlusal analysis; replacement of lost or stolen appliances; myofunctional therapy; precision or semi-precision attachments; or denture duplication; unless as otherwise specified as covered by the Plan.

(4) **Before Coverage.** Dental procedures performed before coverage was effective. This will include procedures that began before a Covered Person's effective date although partially performed after that date.

(5) **Bleaching. Except:** Internal bleaching will be allowed for endodontically treated anterior teeth once per tooth every 3 year period.

(6) **Broken Appointments.** Charges for broken or missed dental appointments.

(7) **Consultations** with another Dentist on the same day your Dentist provides another covered service.

(8) **Cosmetic.** Dental procedures solely performed for cosmetic reasons are not covered. Examples include: porcelain overlays, veneers and teeth whitening.

(9) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(10) **Dental Injuries** Incurred as a result of “biting” or “chewing” will only be allowed under the dental Plan and not considered as an accident benefit under the health Plan.

(11) **Drugs.** Prescription and non-Prescription Drugs supplied by the Dentist.

(12) **Excluded Under Medical.** Services that are excluded under Medical Plan Exclusions.

(13) **Gold Foil Restorations.**

(14) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions; bacteriological studies; caries susceptibility tests; pulp vitality tests; diagnostic photographs; or diet planning.

(15) **Medical Services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(16) **No Listing.** Services which are not included in the list of covered dental services, unless the Plan Administrator determines care is necessary.

(17) **Not Within Standards.** Services or procedures not within the scope of normal, acceptable dental practice nor consistent with the highest ethical dental standards of the dental profession as Dentally Necessary for dental health.

(18) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Payment will not be made even if you or your Dependents do not claim the entitled benefits.

(19) **Orthognathic Surgery.** Surgery to correct malpositions in the bones of the jaw.

(20) **Personalization.** Personalization of dentures or bridges.

(21) **Prescriptions** and non-Prescription Drugs. Prescription Drugs prescribed by a Dentist will be covered under the Prescription Drug Benefit portion of this Plan.

(22) **Replacement.** Replacement of lost or stolen appliances.

(23) **Services Before or After Coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan

(24) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Network Provider benefits are always paid directly to the Network Provider. Benefits for Hospital or other facility are generally paid directly to the Hospital or facility, if charges have not been paid by you. All other Allowed Charges/benefits are generally paid directly to you unless you direct payment to the Provider with written authorization. You may not assign your right to take legal action under this Plan to any Provider of service. Direct payments to a Provider, Physician or Hospital does not constitute a waiver of this anti-assignment provision.

When the claim is processed, POMCO will send you an Explanation of Benefits Statement attached to your benefit payment (if applicable). This information should be carefully reviewed to make sure the charges were submitted to POMCO correctly and that the claim was processed accurately.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form by logging onto www.PPSTA.MyPOMCO.com or from the PPSTA office.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED. .

(3) Have the Physician or Dentist complete the Provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. Handwritten bills will not be accepted; even if the Provider is not billing the Claims Administrator directly. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Member ID number
- Name of patient
- Name, address, telephone number of the Provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

POMCO
2425 James Street
Syracuse, New York 13206
1.866.227.9936

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were Incurred or within 90 days of payment by the primary plan. Benefits are based on the Plan's provisions at the time the charges were Incurred. Claims filed later than that date may be declined or reduced unless:

(1) it's not reasonably possible to submit the claim in that time; and

(2) the claim is submitted within one year from the date Incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. A claim does not include a request for a determination of an individual's eligibility to participate in the Plan. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	15 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims

subject to Predetermination of Benefits, pre-certification or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal
Review of adverse benefit determination	60 days

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of

any Adverse Benefit Determination or Final Adverse Determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) The date of service, the health care Provider, and the claim amount, if applicable.

(2) The specific reason or reasons for the adverse determination.

(3) Reference to the specific Plan provisions on which the determination was based and the Plan's standard, if any, that was used in denying the claim.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal appeals and external review procedures, including information about how to initiate an appeal, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) The claimant will also be provided free of charge with any new or additional rationale or evidence considered, relied upon, or generated by the Plan, or at the direction of the Plan, in connection with the Claim with sufficient notice, assuming the Plan has received the information in a timely manner, so that the claimant has a reasonable opportunity to respond.

(8) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(9) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided upon request.

INTERNAL APPEALS

First Level Appeal

This provision shall be in accordance with the federal Patient Protection and Affordable Care Act and its regulations, as amended. When a claimant receives an Adverse Benefit Determination, the claimant or an authorized representative acting on behalf of the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. Submit all appeals to:

(1) **Medical Benefits:** POMCO, Appeals Department, P.O. Box 6329, Syracuse, NY 13217.

(2) **Prescription Drug Benefits:** ProAct Pharmacy Services, Inc., 29 East Main Street, Gouverneur, NY 13642.

The period of time within which an Adverse Benefit Determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by someone who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Plan or Claims Administrator shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

Second Level Appeal

If the Enrollee disagrees with the First Level Appeal, a Second Level Appeal is available through the Claims Administrator. The claimant or an authorized representative acting on behalf of the claimant has 45 days following receipt of the notification of the First Level Appeal in which to appeal the decision. The request for review must be in writing and include specific reasons for the decision and any additional information including documents, records, and other information relating to the Claim. The decision will be made in a reasonable time period, but no later than 60 days after receipt of the request. The determination will include the specific reason(s) for the decision with specific reference(s) to the pertinent policy provisions on which the determination was based.

In the event of an adverse determination, benefit or coverage based on the treatment plan, appropriateness of treatment, or Medical Necessity of treatment, the Enrollee may request that a peer review by an independent review organization (IRO). Peer reviews are limited to adverse benefit determinations and final internal adverse benefit determinations based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or care.

This will be considered the final determination and the internal appeals process shall be exhausted.

Important: External Appeals must be filed within four months from the date upon which you receive written notification from the Plan that the Internal Appeal has upheld the denial regardless of whether you choose to file a Second Level Appeal as shown below. By deciding to file a Second Level Appeal you are not waiving your option to file an External Appeal; however, in doing so you may miss the four month External Appeal filing deadline.

EXTERNAL APPEALS

(1) Your Right to an External Appeal

This provision shall be in accordance with the federal Patient Protection and Affordable Care Act and its regulations, as amended and applicable New York State Insurance Law, as amended (regardless of state of residence).

Under certain circumstances, you have a right to an external appeal of a denial of coverage.

Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's Medically Necessary requirements (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit), or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the state to conduct such appeals.

(2) Your Right to appeal a Determination that a Service is not Medically Necessary

If the Plan has denied coverage on the basis that the service does not meet the Plan's Medically Necessary requirements, you may appeal to an external appeal agent if you satisfy the following two criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Plan; and

- You must have received a Final Adverse Determination through the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

(3) Your Right to Appeal a Determination that a Service is Experimental or Investigational

If the Plan has denied coverage on the basis that the service is an Experimental or Investigational treatment, you must satisfy the following two criteria:

- The service must otherwise be a Covered Service under the Plan; and

- You must have received a Final Adverse Determination through the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

Your attending Physician must also certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending Physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered); or

- A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the

National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease. In addition, for a rare disease treatment, the attending Physician may not be your treating Physician.

(4) The External Appeal Process

If, through the Plan's internal appeal process, you have received a Final Adverse Determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an Experimental or Investigational treatment you have four months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. If the Plan fails to adhere to claim processing requirements, you have four months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the Final Adverse Determination issued through the Plan's internal appeal process or its written waiver of an internal appeal.

You must then submit the completed application to the Claims Administrator at the address indicated on the application. If you satisfy the criteria for an external appeal, the Claims Administrator will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your Physician, or the Plan. If the external appeal agent requests additional information, it will have five additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending Physician certifies that the standard external appeal time frame would seriously jeopardize your life, health, or ability to regain maximum function; or if you received Emergency Services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment the Plan will provide coverage subject to the other terms and conditions of the Plan. Please note that if the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-Experimental or non-Investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

The Plan will charge you a fee of $25 for an external appeal, not to exceed $75 in a single Plan Year. The external appeal application will instruct you on the manner in which you must submit the fee. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

(5) Your Responsibilities

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the Claims Administrator. You may appoint a representative to assist you with your external appeal request; however, the Claims Administrator may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law (regardless of state of residence), your completed request for appeal must be filed with the Plan within four months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.

Covered Services/Exclusions

In general, the Plan does not cover Experimental or Investigational treatments. However, the Plan shall cover an Experimental or Investigational treatment approved by an external appeal agent in accordance with the External Appeal Section of the Plan. If the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Plan for non-Experimental or non-Investigational treatments provided in such clinical trial.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. Exception: See also Medicare Integration described below.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to Medicare and Tricare.

(5) Other plans or programs required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowed Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

For Medicare integration, see section below.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits and vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow the National Association of Insurance Commissioners (NAIC) model regulations for coordination of benefits. Current regulations are shown below. If these regulations change, the Plan will automatically follow the amended regulations.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowed Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of either a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

- **(i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- **(ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

- **(i)** This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
- **(ii)** This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
- **(iii)** This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
- **(iv)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.
- **(v)** For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situation in which a person who is covered a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you

should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare or a state child health plan to the extent required by federal law.

Claims Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

MEDICARE

If Medicare is primary for you or your Dependent, the benefits of the Plan will be integrated as follows:

(1) **Medicare Payment Integration**. The plan determines the allowable fee first, and then pays the difference between the allowable fee and Medicare's payment up to the lesser of the balance of the bill or the Plan's normal benefit. If Medicare is primary, any Medicare Provider is considered an In-Network Provider when this Plan is secondary.

(2) **Not Enrolled in Medicare**. This integration will apply to persons eligible for Medicare whether or not they are actually enrolled in Medicare or incur Services in a Veterans Administration Hospital/federal facility.

If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B or in Part C, the Medicare benefit will be estimated and used to reduce allowable fees. This could result in significant reduction or denial of the Plan benefits. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

For services Incurred in a Veterans Administration Hospital/federal facility which are not billable to Medicare, benefit integration will be estimated. Part A services will be estimated according to Medicare payment rules. Part B will be estimated, based on 80% of Usual and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

(3) **Medicare Private Contract Options**. This integration will apply to persons eligible for Medicare primary benefits if Medicare benefits are not paid due to a Medicare Private Contract Option with Physicians and certain other practitioners. (When a Medicare beneficiary agrees to the terms of a Private Contract with certain Providers, Medicare will not pay. The patient is responsible for the entire charge. The Provider may bill more than the charges allowed by Medicare.) Under this Plan, if a private contract is used, Medicare benefits will be estimated. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated,

based on 80% of Usual and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Plan benefits.

(4) **Medicare Part C (Medicare Advantage).** This integration will not apply when Medicare and a Medicare-sponsored Advantage Plan denies coverage due to its enrolled beneficiary's failure to abide by the HMO or Participating Provider Program requirements. This Plan will not cover the expenses for those services or supplies and Plan benefits will not be paid.

Allowed Charges for Medicare integration only will be based on the following:

- If the Provider accepts Medicare assignment of benefits, the Allowed Charges will be the same fees allowed by Medicare. If Medicare is primary, any Medicare Provider is considered an In-Network Provider when this Plan is secondary.

- If the Provider does not accept Medicare assignment, the Allowed Charges will be based on the Usual and Reasonable Charges for Out-of-Network Providers, the Network allowance for Network Providers or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.

- If the Provider provides services under a Medicare Private Contract Option, Allowed Charges will be based on the Usual and Reasonable Charges or the Participating Provider Network allowance, if applicable for services Covered by this Plan. If Medicare is primary, any Medicare Provider is considered an In-Network Provider when this Plan is secondary.

According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amounts and the Provider's charges when that Provider accepts Medicare assignment. If a Provider does not accept assignment, a beneficiary cannot be billed for charges over the limiting charge established by Medicare for that service by that Provider. However, if services are provided under the Medicare Private Contract Option, the Provider's charges can exceed the Medicare allowable fees.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this Provision Applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. The Plan Administrator may, at its option, deny all charges or authorize conditional interim benefit payments for medical or dental expenses that would otherwise be covered by the Plan. However, any advance payments are subject to the Plan's subrogation rights. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer, including but not limited to the Covered Person's insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) cannot assign any rights against any Third Party or insurer without express written consent of the Plan; and

(3) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount Subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits Incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all

Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined Terms: "Covered Person" means anyone covered under the Plan, including minor Dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person and his/her designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from Another Plan Under Which the Covered Person is Covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to deny or make conditional payments, and to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the Poughkeepsie Public Teachers' Association (PPSTA) Benefit Trust Group Health & Dental Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is the PPSTA Benefit Trust. COBRA continuation coverage for the Plan is administered by POMCO. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There May be Other Options Available When You Lose Group Health Coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower Out-of-Pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage? COBRA continuation coverage is the temporary extension of group health Plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who Can Become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Domestic Partner is not a Qualified Beneficiary.

A same-sex Spouse is covered as a Qualified Beneficiary under federal law as of September 16, 2013.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA"), as amended, does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What Factors Should be Considered When Determining to Elect COBRA Continuation Coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law.

First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Please note: pre-existing condition exclusions will become prohibited for Plan Years beginning on or after January 1, 2014 under the Affordable Care Act.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Are There Other Coverage Options Besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the Procedure for Obtaining COBRA Continuation Coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the Election Period and How Long Must it Last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Poughkeepsie Public Teachers' Association (PPSTA) Benefit Trust
40 Garden Street, Ste. 207
Poughkeepsie, New York 12603-3404

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,

- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost (if under your plan the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month). If you or your Spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health Plan (including a successor plan) to any Employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary. Please note: pre-existing condition exclusions will become prohibited for Plan Years beginning on or after January 1, 2014 under the Affordable Care Act.

(5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) **(i)** 29 months after the date of the Qualifying Event, or **(ii)** the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the Maximum Coverage Periods for COBRA Continuation Coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under What Circumstances can the Maximum Coverage Period be Expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Sponsor.

How does a Qualified Beneficiary Become Entitled to a Disability Extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60

days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor.

Does the Plan Require Payment for COBRA Continuation Coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for Payment for COBRA Continuation Coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa or call their toll-free number at 1.866.444.3272.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Poughkeepsie Public School Teachers Association Benefit Trust Health & Dental Benefit Plan is the benefit plan of Poughkeepsie Public School Teachers Association Benefit Trust, the Plan Administrator, also called the Plan Sponsor.

An individual may be appointed by Poughkeepsie Public School Teachers Association Benefit Trust to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Poughkeepsie Public School Teachers Association Benefit Trust shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

(8) Ensure continuing compliance with the HIPAA Privacy and Security Regulation and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as amended.

Plan Administration Compensation. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

MISREPRESENTATION/FRAUD

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that you or your Dependents or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, such claim may be denied in total and the Plan Administrator and/or the Claims Administrator may recover any benefits paid to you and/or a Provider. The Plan Administrator may terminate Plan coverage for the submission of a fraudulent claim. This paragraph does not affect the right of the Plan Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

REFUND DUE TO OVERPAYMENT OF BENEFITS

If payment has been made for Covered services or supplies under the Plan that are more than the benefits that should have been paid, or for services or supplies that should not have been paid, according to Plan provisions, the Plan Administrator or the Claims Administrator shall have the right to demand a full refund, or may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such Covered Person or other present or future amounts payable to such person, or recover such amounts by any other appropriate method that the Plan Administrator, in its sole discretion, shall decide. Each Covered Person hereby authorized the deduction of such excess payment from such benefits, or other present or future benefit payments.

Payments made in error for services or supplies not covered by this Plan shall not be considered certification of coverage and will not limit the enforcement of any provision of this Plan for any and all claims submitted under the Plan.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination.

The Employer and the Board of Trustees intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

In the event the Plan terminates, the remaining assets of the Trust, if any, would be disbursed to the membership in accordance with the rules of the VEBA or 501(c)(9) Trust.

FEDERAL LAWS

This Plan shall be governed and construed according to Federal laws such as, but not limited to, the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Public Health Service Act, as applicable, and the Health Insurance Portability and Accountability Act, as amended. Federal laws will affect the provisions of this Plan only when directed at this type of self-funded health Plan for Plan Sponsors regulated by the laws. You may seek assistance or information about your rights under this plan by contacting the closest Employee Benefits Security Administration (EBSA), U.S. Department of Labor shown in your local phone directory or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

HIPAA COMPLIANCE

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality, integrity, security and privacy of individually identifiable health information. A description of a Covered Person's HIPAA Privacy rights are found in the Plan Administrator's Privacy Notice which is delivered separately to each Employee covered under the Plan. The Plan and those administering it will use and disclose health information only as allowed by federal law. The Plan and those administering it agree to implement physical and technical safeguards that protect the information that it creates, receives, maintains or transmits on behalf of the Covered Person. If a Covered Person has a complaint, questions, concerns, or requires a copy of the Privacy Notice, he or she should contact the Plan Administrator's Privacy Officer at the Employer.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees and Retired Employees. The Plan is not insured.

This Plan is a self-funded Plan that is considered exempt from state insurance laws and is administered under the terms of the Plan and Voluntary Employee Benefit Trust (VEBA) established under §501(c)(9) and §115 of the Internal Revenue Code (IRC). Payment of all benefits shall be made out of the Plan/Trust assets and as provided by any stop loss reinsurance coverage. This Plan is administered by POMCO as an independent third party administrator (TPA) appointed by the Board of Trustees. The Board of Trustees are ultimately responsible for the overall administration and operation of the Plan, including the delegation of specific duties.

PLAN NAME: Poughkeepsie Public School Teachers Association Benefit Trust Group Health and Dental Plan

TAX ID NUMBER: 14-1773337

PLAN EFFECTIVE DATE: September 1, 2015

PLAN YEAR ENDS: December 31 for the health plan
June 30 for the dental plan

EMPLOYER INFORMATION: Poughkeepsie Public School Teachers Association Benefit Trust
40 Garden Street, Ste. 207
Poughkeepsie, New York 12603-3404
845.471.3376 or 845.471.6792

PLAN ADMINISTRATOR: Poughkeepsie Public School Teachers Association Benefit Trust

CLAIMS ADMINISTRATOR: POMCO
2425 James Street
Syracuse, New York 13206
1.866.227.9936

APPENDIX A – DENTAL CODES

The following is a list of covered dental procedures and the dental class. New codes will be added at the discretion of the Plan Administrator and remove deleted codes. The classes for new codes will be determined by the Plan Administrator.

D0100-D0999 I. DIAGNOSTIC		***CLASS***
Clinical Oral Evaluations		
D0120	Periodic oral examination, established patient	1
D0140	Limited oral evaluation, problem focused	1
D0145	Oral evaluation patient under 3 years of age	1
D0150	Comprehensive oral evaluation, new or established patient	1
D0160	Detailed and extensive oral evaluation	1
D0170	Re-evaluation	1
D0180	Comprehensive periodontal evaluation	1
Radiographs / Diagnostic Imaging		
D0210	Intraoral-complete series, including bitewing	1
D0220	Intraoral-periapical-first film	1
D0230	Intraoral periapical-each add'l film	1
D0240	Intraoral-occlusal film	1
D0250	Extraoral-first film	Excluded
D0260	Extraoral-each add'l film	Excluded
D0270	Bitewings-single film	1
D0272	Bitewings-two films	1
D0273	Bitewings-three films	1
D0274	Bitewings -four films	1
D0277	Vertical bitewings – 7 to 8 films	1
D0290	Posterior-anterior or lateral skull and facial bone survey film	Excluded
D0310	Sialography	Excluded
D0320	TMJ joint arthrogram, including injection	5
D0321	Other Temporomandibular Joint films, by report	5
D0322	Tomographic survey	3
D0330	Panoramic film	1
D0340	Cephalometric film	4
D0350	Oral/facial photographic Images	4
D0360	Cone beam ct – craniofacial data capture	3
D0362	Cone beam ct – two-dimensional image reconstruction using existing data, includes multiple images	3
D0363	Cone beam – three-dimensional image reconstruction using existing data, includes multiple images	3
Tests and Laboratory Examinations		
D0415	Collection of microorganisms for culture and sensitivity	Excluded
D0416	Viral culture	Excluded
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Excluded
D0418	Analysis of saliva sample	Excluded
D0421	Genetic test for susceptibility to oral diseases	Excluded
D0425	Caries susceptibility test	Excluded
D0431	Adjunctive pre-diagnostic test to detect abnormalities	Excluded
D0460	Pulp vitality tests	Excluded
D0470	Diagnostic casts	4
Oral Pathology Laboratory (use Codes D0472-D0502)		
D0472	Accession of tissue, gross exam, prep and transmission of written report	Excluded

D0473	Accession of tissue, gross and microscopic exam, prep and transmission of written report	Excluded
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, prep and transmission of written report	Excluded
D0475	Decalcification procedure	Excluded
D0476	Special stains for microorganisms	Excluded
D0477	Special stains, not for microorganisms	Excluded
D0478	Immunohistochemical stains	Excluded
D0479	Tissue in-situ hybridization, including interpretation	Excluded
D0480	Accession of exfoliative cytologic smears, microscopic exam, prep and transmission of written report	Excluded
D0481	Electron microscopy – diagnostic	Excluded
D0482	Direct immunofluorescence	Excluded
D0483	Indirect immunofluorescence	Excluded
D0484	Consultation on slides prepared elsewhere	Excluded
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	Excluded
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	Excluded
D0502	Other oral pathology procedures, by report	
D0999	Unspecified diagnostic procedure, by report	
D1000-D1199 II. PREVENTATIVE		
Dental Prophylaxis		
D0110	Prophylaxis - adult	1
D0120	Prophylaxis - child (12 and under)	1
Topical Fluoride Treatment (Office Procedure)		
D1203	Topical application fluoride	1
D1204	Topical application fluoride-adult	1
D1206	Topical fluoride varnish for moderate to high caries risk patients	Excluded
		Excluded
Other Preventative Services		
D1310	Nutritional counseling for control of dental disease	Excluded
D1320	Tobacco counseling for the control and prevention of oral disease	Excluded
D1330	Oral hygiene instructions	Excluded
D1351	Sealant-per tooth	1
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	Excluded
Space Maintenance (Passive Appliances)		
D1510	Space maintainer-fixed-unilateral	1
D1515	Space maintainer-fixed-bilateral	1
D1520	Space maintainer-removable unilateral	1
D1525	Space maintainer-removable-bilateral	1
D1550	Re-cementation of space maintainer	1
D1555	Removal of fixed space maintainer	1
D2000-D2999 III. RESTORATIVE		
Amalgam Restorations (Including Polishing)		
D2140	Amalgam-1 surface, primary or permanent	2
D2150	Amalgam-2 surfaces, primary or permanent	2
D2160	Amalgam-3 surfaces, primary or permanent	2
D2161	Amalgam-4 or more surfaces, Primary or permanent	2
Resin-Based Composite Restoration – Direct		

D2330	Resin-1 surface, anterior	2
D2331	Resin-2 surfaces, anterior	2
D2332	Resin-3 surfaces, anterior	2
D2335	Resin-4 or more surfaces or involving incisal angle, anterior	2
D2390	Resin crown-anterior	Excluded
D2391	Resin crown-1 surface, posterior	2
D2392	Resin crown-2 surfaces, posterior	2
D2393	Resin crown-3 surfaces, posterior	2
D2394	Resin crown-4 or more surfaces, posterior	2
Gold Foil Restorations		
D2410	Gold foil-1 surface	Excluded
D2420	Gold foil-2 surfaces	Excluded
D2430	Gold foil-3 surfaces	Excluded
Inlay/Outlay Restorations		
D2510	Inlay-metallic-1 surface	3
D2520	Inlay-metallic-2 surfaces	3
D2530	Inlay-metallic-3 or more surfaces	3
D2542	Onlay-porcelain/ceramic 2 surfaces	3
D2543	Onlay-porcelain/ceramic 3 surfaces	3
D2544	Onlay-porcelain/ceramic 4 or more surfaces	3
Porcelain/Ceramic Restorations		
D2610	Inlay-1 surface	3
D2620	Inlay-2 surfaces	3
D2630	Inlay-3 or more surfaces	3
D2642	Onlay-2 surfaces	3
D2643	Onlay-3 surfaces	3
D2644	Onlay-4 or more surfaces	3
Resin-Based Restorations		
D2650	Inlay 1 surface	Excluded
D2651	Inlay 2 surfaces	Excluded
D2652	Inlay 3 or more surfaces	Excluded
D2662	Onlay 2 surfaces	3
D2663	Onlay 3 surfaces	3
D2664	Onlay 4 or more surfaces	3
Crowns – Single Restorations Only		
D2710	Crown-resin-based composite (indirect)	3
D2712	Crown-3/4 resin based composite (indirect)	3
D2720	Crown-resin with high noble metal	3
D2721	Crown-resin-predominantly base metal	3
D2722	Crown-resin with noble metal	3
D2740	Crown-porcelain/ceramic substrate	3
D2750	Crown-porcelain-fused to high noble metal	3
D2751	Crown-porcelain-fused to predominantly base metal	3
D2752	Crown-porcelain fused to noble metal	3
D2780	Crown-3/4 cast noble metal	3
D2781	Crown- 3/4 cast predominantly base metal	3
D2782	Crown-3/4 cast noble metal	3
D2783	Crown-3/4 porcelain/ceramic	3
D2790	Crown-full cast high noble metal	3
D2791	Crown-full cast predominantly base metal	3
D2792	Crown-full cast noble metal	3
D2794	Crown-titanium	3
D2799	Provisional crown	Excluded

Other Restorative Services		
D2910	Recement inlay, onlay, or partial coverage restoration	2
D2915	Recement cast or prefabricated post and core	Excluded
D2920	Recement crown	2
D2930	Prefabricated stainless steel crown-primary tooth	3
D2931	Prefab stainless steel crown-permanent tooth	2
D2932	Prefab resin crown	Excluded
D2933	Prefab stainless steel crown with resin window	Excluded
D2934	Prefab esthetic coated stainless steel crown – primary tooth	Excluded
D2940	Protective restoration	Excluded
D2950	Core buildup, including any pins	3
D2951	Pin retention, per tooth, in addition to restoration	2
D2952	Post and core in addition to crown, indirectly fabricated	3
D2953	Each additional indirectly fabricated post – same tooth	3
D2954	Prefab post and core in addition to crown	3
D2955	Post removal (not in conjunction with endodontic therapy)	Excluded
D2957	Each additional prefab post – same tooth	3
D2960	Labial veneer (resin laminate) chairside	Excluded
D2961	Labial veneer (resin laminate) laboratory	Excluded
D2962	Labial veneer (porcelain laminate) laboratory	Excluded
D2970	Temporary crown (fractured tooth)	Excluded
D2971	Additional procedures to construct new crown under existing partial denture framework	Excluded
D2975	Coping	Excluded
D2980	Crown repair, by report	3
D2999	Unspecified restorative procedure, by report	
D300-D3999 IV. ENDODONTICS		
Pulp Capping		
D3110	Pulp cap-direct (excluding final restoration)	2
D3120	Pulp cap-indirect (excluding final restoration)	2
Pulpotomy		
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament	2
D3221	Pulpal debridement, primary and permanent teeth	2
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	2
Endodontic Therapy on Primary Teeth		
D3230	Pulpal therapy (resorbable filling) -anterior or primary tooth (excluding final restoration)	2
D3240	Pulpal therapy (resorbable filling) -posterior or primary tooth (excluding final restoration)	2
Endodontic Therapy (Including treatment plan, clinical procedures and follow up care)		
D3310	Endodontic therapy-anterior tooth (excluding final restoration)	3
D3320	Endodontic therapy-bicuspid tooth (excluding final restoration)	3
D3330	Endodontic therapy-molar (excluding final restoration)	3
D3331	Treatment of root canal obstruction- non surgical access	Excluded
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Excluded
D3333	Internal root repair of perforation defects	Excluded
Endodontic Retreatment		

D3346	Retreatment of previous root canal therapy- anterior	3
D3347	Retreatment of previous root canal therapy- bicuspid	3
D3348	Retreatment of previous root canal therapy- molar	3
Apexification/Recalcification Procedures		
D3351	Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	3
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforation, root resorption, pulp space disinfection, etc.)	3
D3353	Apexification/recalcification- final visit, includes completed root canal	3
D3354	Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	3
Apicoectomy/Periradicular Services		
D3410	Apicoectomy/periradicular surgery-anterior	3
D3421	Apicoectomy/periradicular surgery-bicuspid (first root)	3
D3425	Apicoectomy/periradicular surgery-molar (first root)	3
D3426	Apicoectomy/periradicular surgery- each additional root	3
D3430	Retrograde filling - per root	3
D3450	Root amputation-per root	3
D3460	Endodontic endosseous implant	Excluded
D3470	Intentional reimplantation (including necessary splinting)	Excluded
Other Endodontic Procedures		
D3910	Surgical procedure for isolation of tooth with rubber dam	Excluded
D3920	Hemisection (including any root removal) not including root canal therapy	3
D3950	Canal prep and fitting of preformed dowel or post	Excluded
D3999	Unspecified endodontic procedure, by report	
D4000-D4999 V. PERIODONTICS		
Surgical Services (Including usual postoperative care)		
D4210	Gingivectomy or gingivoplasty-4 or more contiguous teeth or tooth bounded spaces per quadrant	3
D4211	Gingivectomy or gingivoplasty-1 to 3 contiguous teeth or tooth bounded spaces per quadrant	3
D4230	Anatomical crown exposure- 4 or more contiguous teeth per quadrant	Excluded
D4231	Anatomical crown exposure – 1 to 3 teeth per quadrant	Excluded
D4240	Gingival flap procedure, including root planning – 4 or more contiguous teeth or tooth bounded spaces per quadrant	3
D4241	Gingival flap procedure, including root planning – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	3
D4245	Apically positioned flap	Excluded
D4249	Clinical crown lengthening-hard tissue	3
D4260	Osseous surgery (including flap entry and closure) – 4 or more contiguous teeth or tooth bounded spaces per quadrant	3
D4261	Osseous surgery (including flap entry and closure) – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	3
D4263	Bone replacement graft- first site in quadrant	Excluded
D4264	Bone replacement graft- each additional site in quadrant	Excluded
D4265	Biologic materials to aid in soft and osseous tissue regeneration	
D4266	Guided tissue regeneration- resorbable barrier, per site	Excluded

D4267	Guided tissue regeneration- non-resorbable barrier, per site (includes membrane removal)	Excluded
D4268	Surgical revision procedure, per tooth	Excluded
D4270	Pedicle soft tissue graft procedure	3
D4271	Free soft tissue graft procedure (including donor site surgery)	3
D4273	Subepithelial connective tissue graft procedures, per tooth	3
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Excluded
D4275	Soft tissue allograft	Excluded
D4276	Combined connective tissue and double pedicle graft, per tooth	Excluded
Non-Surgical Periodontal Service		
D4320	Provisional splinting – intracoronal	3
D4321	Provisional splinting - extracoronal	Excluded
D4341	Periodontal scaling and root planing-4 or more teeth per quadrant	2
D4342	Periodontal scaling and root planing-1 to 3 teeth, per quadrant	2
D4355	Full mouth debridement to enable comprehensive eval and diagnosis	3
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth, by report	Excluded
Other Periodontal Services		
D4910	Periodontal maintenance	2
D4920	Unscheduled dressing change (by someone other than treating Dentist)	Excluded
D4999	Unspecified periodontal procedure, by report	
D5000-D5899 VI. PROSTHODONTICS, REMOVABLE		
Complete Dentures – Including 6 months of post-delivery care		
D5110	Complete denture-maxillary	3
D5120	Complete denture-mandibular	3
D5130	Immediate denture-maxillary	3
D5140	Immediate denture-mandibular	3
Partial Dentures – Including Routine Post-delivery Care		
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	3
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)	3
D5213	Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	3
D5214	Mandibular partial denture-metal framework with resin denture bases (including any conventional clasps, rests and teeth)	3
D5225	Maxillary partial denture- flexible base (including any clasps, rests and teeth)	3
D5226	Mandibular partial denture-flexible base (including any clasps, rests and teeth)	3
D5281	Removable unilateral partial denture- 1 piece cast metal (including clasps and teeth)	3
Adjustment to Dentures		
D5410	Adjust complete denture-maxillary	2
D5411	Adjust complete denture-mandibular	2
D5421	Adjust partial denture-maxillary	2
D5422	Adjust partial denture-mandibular	2

Repairs to Complete Dentures		
D5510	Repair broken complete denture base	2
D5520	Replace missing or broken teeth-complete denture (each tooth)	2
Repairs to Partial Dentures		
D5610	Repair resin denture base	2
D5620	Repair cast framework	2
D5630	Repair or replace broken clasp	2
D5640	Replace broken teeth/tooth, per tooth	2
D5650	Add tooth to existing partial denture	2
D5660	Add clasp to existing partial denture	2
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	2
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	2
Denture Duplication		
D5710	Rebase complete maxillary denture	2
D5711	Rebase complete mandibular denture	2
D5720	Rebase maxillary partial denture	2
D5721	Rebase mandibular partial denture	2
Denture Reline Procedures		
D5730	Reline complete maxillary denture (chairside)	2
D5731	Reline complete mandibular denture (chairside)	2
D5740	Reline maxillary partial denture (chairside)	2
D5741	Reline mandibular partial denture(chairside)	2
D5750	Reline complete maxillary denture (lab)	2
D5751	Reline complete mandibular denture (lab)	2
D5760	Reline maxillary partial denture (lab)	2
D5761	Reline mandibular partial denture (lab)	2
Interim Prosthesis		
D5810	Interim complete denture (maxillary)	Excluded
D5811	Interim complete denture (mandibular)	Excluded
D5820	Interim partial denture (maxillary)	Excluded
D5821	Interim partial denture (mandibular)	Excluded
Other Removable Prosthetic Services		
D5850	Tissue conditioning maxillary	2
D5851	Tissue conditioning mandibular	2
D5860	Overdenture – complete, by report	Excluded
D5861	Overdenture – partial, by report	Excluded
D5862	Precision attachment, by report	Excluded
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	Excluded
D5875	Modification of removable prosthesis following implant surgery	Excluded
D5899	Unspecified removable prosthodontic procedure, by report	
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS		
D5911	Facial moulage (sectional)	Excluded
D5912	Facial moulage (complete)	Excluded
D5913	Nasal prosthesis	Excluded
D5914	Auricular prosthesis	Excluded
D5915	Orbital prosthesis	Excluded
D5916	Ocular prosthesis	Excluded
D5919	Facial prosthesis	Excluded

D5922	Nasal septal prosthesis	Excluded
D5923	Ocular prosthesis, interim	Excluded
D5924	Cranial prosthesis	Excluded
D5925	Facial augmentation implant prosthesis	Excluded
D5926	Nasal prosthesis, replacement	Excluded
D5927	Auricular prosthesis, replacement	Excluded
D5928	Orbital prosthesis, replacement	Excluded
D5929	Facial prosthesis, replacement	Excluded
D5931	Obturator prosthesis, surgical	Excluded
D5932	Obturator prosthesis, definitive	Excluded
D5933	Obturator prosthesis, modification	Excluded
D5934	Mandibular resection prosthesis with guide flange	Excluded
D5935	Mandibular resection prosthesis without guide flange	Excluded
D5936	Obturator prosthesis, interim	Excluded
D5937	Trismus appliance (not for TMD treatment)	Excluded
D5951	Feeding aid	Excluded
D5952	Speech aid prosthesis, pediatric	Excluded
D5953	Speech aid prosthesis, adult	Excluded
D5954	Palatal augmentation prosthesis	Excluded
D5955	Palatal lift prosthesis, definitive	Excluded
D5958	Palatal lift prosthesis, interim	Excluded
D5959	Palatal lift prosthesis, modification	Excluded
D5860	Speech aid prosthesis, modification	Excluded
D5982	Surgical stent	Excluded
D5983	Radiation carrier	Excluded
D5984	Radiation shield	Excluded
D5985	Radiation cone locator	Excluded
D5986	Fluoride gel carrier	Excluded
D5987	Commissure splint	Excluded
D5988	Surgical splint	Excluded
D5991	Topical medicament carrier	Excluded
D5992	Adjust maxillofacial prosthetic appliance, by report	Excluded
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report	Excluded
D5999	Unspecified maxillofacial prosthesis, by report	
D6000-D6199 VIII. IMPLANT SERVICES		
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	3
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	3
D6040	Surgical placement - endosteal implant	3
D6050	Surgical placement- transosteal implant	3
D6100	Implant removal, by report	3
Implant/Abutment Supported Removable Dentures		
D6053	Implant/abutment supported removable denture for completely edentulous arch	3
D6054	Implant/abutment supported removable denture for partially edentulous arch	3
Supporting Structures		
D6055	Dental implant supported connecting bar	3
D6056	Prefab abutment- includes placement	3
D6057	Custom abutment-includes placement	Excluded
Single Crowns, Abutment Supported		
D6058	Abutment supported porcelain/ceramic crown	3

D6059	Abutment supported porcelain fused to metal crown (high noble metal)	3
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	3
D6061	Abutment supported porcelain fused to metal crown (noble metal)	3
D6062	Abutment supported cast metal crown (high noble metal)	3
D6063	Abutment supported cast metal crown (predominantly base metal)	3
D6064	Abutment supported cast metal crown (noble metal)	3
D6094	Abutment supported crown (titanium)	3
Single Crowns, Implant Supported		
D6065	Implant supported porcelain/ceramic crown	3
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	3
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	3
Fixed Partial Denture, Abutment Supported		
D6068	Abutment supported retainer for fixed porcelain/ceramic FPD	3
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	3
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	3
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	3
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	3
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	3
D6074	Abutment supported retainer for cast metal FPD (noble metal)	3
D6194	Abutment supported retainer crown for FPD (titanium)	3
Fixed Partial Denture, Implant Supported		
D6075	Implant supported retainer for ceramic FPD	3
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	3
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	3
Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)		
D6078	Implant/abutment supported fixed denture for completely edentulous arch	3
D6079	Implant/abutment supported fixed denture for partially edentulous arch	3
Other Implant Services		
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	3
D6090	Repair implant supported prosthesis, by report	3
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	3
D6092	Recement implant/abutment supported crown	3
D6093	Recement implant/abutment supported fixed partial denture	3
D6095	Repair implant abutment, by report	3

D6100	Implant removal, by report	
D6190	Radiograph/surgical implant index, by report	3
D6199	Unspecified implant procedure, by report	
D6200-D6999 IX. PROSTHODONTICS, FIXED		
Fixed Partial Denture Pontics		
D6205	Pontic-indirect resin based composite	3
D6210	Pontic-cast high noble metal	3
D6211	Pontic-cast predominantly base metal	3
D6212	Pontic-cast noble metal	3
D6214	Pontic-titanium	3
D6240	Pontic-porcelain fused to high noble metal	3
D6241	Pontic-porcelain fused to predominantly base metal	3
D6242	Pontic-porcelain fused to noble metal	3
D6245	Pontic-porcelain/ceramic	3
D6250	Pontic-resin with high noble metal	Excluded
D6251	Pontic-resin with predominantly base metal	Excluded
D6252	Pontic-resin with noble metal	Excluded
D6253	Provisional pontic	Excluded
D6254	Interim pontic	Excluded
Fixed Partial Denture Retainers – Inlays/Outlays		
D6545	Retainer-cast metal for resin bonded fixed prosthesis	3
D6548	Retainer-porcelain/ceramic for resin bonded fixed prosthesis	3
D6600	Inlay-porcelain/ceramic -2 surfaces	Excluded
D6601	Inlay-porcelain/ceramic – 3 or more surfaces	3
D6602	Inlay-cast high noble metal – 2 surfaces	Excluded
D6603	Inlay-cast high noble metal – 3 or more surfaces	Excluded
D6604	Inlay-cast predominately base metal-2 surfaces	3
D6605	Inlay-cast predominately base metal-3 or more surfaces	3
D6606	Inlay-cast noble metal-2 surfaces	3
D6607	Inlay-cast noble metal-3 or more surfaces	3
D6608	Onlay-porcelain/ceramic-2 surfaces	3
D6609	Onlay-porcelain/ceramic-3 or more surfaces	Excluded
D6610	Onlay-cast high noble metal-2 surfaces	Excluded
D6611	Onlay-cast high noble metal-3 or more surfaces	3
D6612	Onlay-cast predominately base metal-2 surfaces	Excluded
D6613	Onlay-cast predominately base metal-3 or more surfaces	3
D6614	Onlay-cast noble metal-2 surfaces	Excluded
D6615	Onlay-cast noble metal-3 or more surfaces	3
D6624	Inlay – titanium	Excluded
D6634	Onlay - titanium	Excluded
Fixed Partial Denture Retainers - Crowns		
D6710	Crown – indirect resin based composite	Excluded
D6720	Crown- resin with high noble metal	Excluded
D6721	Crown- resin with predominantly base metal	Excluded
D6722	Crown- resin with noble metal	Excluded
D6740	Crown –porcelain/ceramic	3
D6750	Crown-porcelain fused to high noble metal	3
D6751	Crown-porcelain fused to predominantly base metal	3
D6752	Crown-porcelain fused/noble metal	3
D6780	Crown-Ret-3/4 cast high noble metal	3
D6781	Crown-3/4 cast predominantly base	3
D6782	Crown – 3/4 cast noble metal	3
D6783	Crown – 3/4 porcelain/ceramic	3
D6790	Crown-full cast high noble metal	3
D6791	Crown-full cast predominantly base metal	3

D6792	Crown-full cast noble metal	3
D6793	Crown – titanium	Excluded
D6794	Provisional retainer crown	3
D6795	Interim retainer crown	Excluded
Other Prosthetic Services		
D6920	Connector bar	Excluded
D6930	Recement fixed partial denture	2
D6940	Stress breaker	Excluded
D6950	Precision attachment	Excluded
D6970	Post and core in addition to fixed partial denture retainer, indirect fabricated	Excluded
D6972	Prefab. post and core in addition to fixed partial denture retainer	3
D6973	Core build up for retainer, including any pins	3
D6975	Coping - metal	Excluded
D6976	Each additional indirectly fabricated post- same tooth	Excluded
D6977	Each additional prefab. post- same tooth	Excluded
D6980	Fixed partial denture repair, by report	2
D6985	Pediatric partial denture, fixed	3
D6999	Unspecified fixed prosthodontic procedure, by report	
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY		
Extractions – Includes Local Anesthesia, Suturing, if needed and Routine Postoperative Care		
D7111	Extraction, coronal remnants-deciduous tooth	2
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	2
Surgical Extractions (includes local anesthesia, suturing, if needed and routing postoperative care)		
D7210	Surgical removal erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	2
D7220	Removal of impacted tooth-soft tissue	Excluded
D7230	Removal of impacted tooth-partially bony	Excluded
D7240	Removal of impacted tooth-completely bony	Excluded
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	Excluded
D7250	Surgical removal of residual tooth roots (cutting procedure)	2
D7251	Coronectomy – intentional partial tooth removal	Excluded
Other Surgical Procedures		
D7260	Oroantral fistula closure	Excluded
D7261	Primary closure of a sinus perforation	3
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth or displaced tooth	2
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	3
D7280	Surgical access of An unerupted tooth	2
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Excluded
D7283	Placement of device to facilitate eruption of impacted tooth	Excluded
D7285	Biopsy of oral tissue-hard (bone, tooth)	Excluded
D7286	Biopsy of oral tissue-soft	Excluded
D7287	Exfoliative cytological sample collection	Excluded
D7288	Brush biopsy – transepithelial sample collection	Excluded
D7290	Surgical repositioning of teeth	Excluded
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	Excluded

D7292	Surgical replacement: temporary anchorage (screw retained plate) requiring surgical flap	3
D7293	Surgical replacement: temporary anchorage device requiring surgical flap	3
D7294	Surgical placement: temporary anchorage device without surgical flap	3
D7295	Harvest of bone for use in autogenous grafting procedure	Excluded
Alveoloplasty - Surgical Preparation of Ridge		
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces, per quadrant	2
D7311	Alveoloplasty in conjunction with extractions-1 to 3 teeth or tooth spaces, per quadrant	2
D7320	Alveoloplasty not In conjunction with extractions-4 or more teeth or tooth spaces, per quadrant	2
D7321	Alveoloplasty not in conjunction with extractions- 1 to 3 teeth or tooth spaces, per quadrant	2
Vestibuloplasty		
D7340	Vestbuloplasty- ridge extension (secondary epithelialization)	Excluded
D7350	Vestbuloplasty- ridge extension (includes soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Excluded
Surgical Excision of Soft Tissue Lesions		
D7410	Excision or benign lesion up to 1.25 cm	Excluded
D7411	Excision of benign lesion greater 1.25 cm	Excluded
D7412	Excision of benign lesion -complicated	Excluded
D7413	Excision of malignant lesion up to 1.25 cm	Excluded
D7414	Excision of malignant lesion greater than 1.25 cm	Excluded
D7415	Excision of malignant lesion- complicated	Excluded
D7465	Destruction of lesion(s) by physical or chemical method, by report	Excluded
Surgical Excision of Intra-Osseous Lesions		
D7440	Excision of malignant tumor- diameter up to 1.25	Excluded
D7441	Excision of malignant tumor- diameter greater than1.25	Excluded
D7450	Removal- of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	Excluded
D7451	Removal- of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	Excluded
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25cm	Excluded
D7461	Removal- of benign odontogenic cyst or tumor – lesion diameter greater than 1.25cm	Excluded
Excision of Bone Tissue		
D7471	Removal of lateral exostosis (maxilla or mandible)	2
D7472	Removal of torsu palatinus	Excluded
D7473	Removal of torus mandibularis	Excluded
D7485	Surgical reduction of osseous tuberosity	Excluded
D7490	Radical resection of maxilla or mandible	Excluded
Surgical Incision		
D7510	Incision and drainage abscess intraoral-soft tissue	2
D7511	Incision and drainage abscess intraoral-soft tissue- complicated (includes drainage of multiple fascial spaces)	Excluded
D7520	Incision and drainage abscess extraoral soft tissue	Excluded

D7521	Incision and drainage abscess extraoral soft tissue-complicated (includes drainage of multiple fascial spaces)	Excluded
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Excluded
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	Excluded
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	Excluded
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Excluded
Treatment of Fractures - Simple		
D7610	Maxilla fracture-open reduction (teeth immobilized, if present)	Excluded
D7620	Maxilla fracture-closed reduction (teeth immobilized, if present)	Excluded
D7630	Mandible fracture-open reduction (teeth immobilized, if present)	Excluded
D7640	Mandible fracture-closed reduction (teeth immobilized, if present)	Excluded
D7650	Malar and/or zygomatic arch-open reduction	Excluded
D7660	Malar and/or zygomatic arch-closed reduction	Excluded
D7670	Alveolus-closed reduction, may include stabilization of teeth	Excluded
D7671	Alveolus-open reduction, may include stabilization of teeth	Excluded
D7680	Facial bones-complicated reduction with fixation and multiple surgical approaches	Excluded
Treatment of Fracture - Compound		
D7710	Maxilla – open reduction	Excluded
D7720	Maxilla – closed reduction	Excluded
D7730	Mandible – open reduction	Excluded
D7740	Mandible – closed reduction	Excluded
D7750	Malar and/or zygomatic arch – open reduction	Excluded
D7760	Malar and/or zygomatic arch – closed reduction	Excluded
D7770	Alveolus - open reduction stabilization of teeth	Excluded
D7771	Alveolus – closed reduction stabilization of teeth	Excluded
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	Excluded
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions		
D7810	Open reduction of dislocation	
D7820	Closed reduction of dislocation	Excluded
D7830	Manipulation under anesthesia	Excluded
D7840	Condylectomy	Excluded
D7850	Surgical discectomy, with/without implant	Excluded
D7852	Disc repair	Excluded
D7854	Synovectomy	Excluded
D7856	Myotomy	Excluded
D7858	Joint reconstruction	Excluded
D7860	Arthrotomy	Excluded
D7865	Arthroplasty	Excluded
D7870	Arthrocentesis	Excluded
D7871	Non-arthroscopic lysis and lavage	Excluded
D7872	Arthroscopy – diagnosis, with or without biopsy	Excluded
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	Excluded
D7874	Arthroscopy – surgical: disc repositioning and stabilization	Excluded
D7875	Arthroscopy – surgical: synovectomy	Excluded
D7876	Arthroscopy – surgical: discectomy	Excluded
D7877	Arthroscopy – surgical: debridement	Excluded
D7880	Occlusal orthotic device, by report	3
D7889	TMJ therapy	5

D7899	Unspecified TMD therapy, by report	3
Repair of Traumatic Wounds		
D7910	Suture of recent small wounds up to 5 cm.	2
Complicated Suturing (reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)		
D7911	Complicated suture – up to 5 cm.	3
D7912	Complicated suture – greater than 5 cm.	3
Other Repair Procedures		
D7920	Skin graft (identify defect covered, location and type of graft)	Excluded
D7940	Osteoplasty – for orthognathic deformities	
D7941	Osteotomy – mandibular rami	Excluded
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	Excluded
D7944	Osteotomy – segmented or subapical	Excluded
D7945	Osteotomy – body of mandible	Excluded
D7946	LeFort I (maxilla – total)	Excluded
D7947	LeFort I (maxilla – segmented)	Excluded
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Excluded
D7949	LeFort II or LeFort III – with bone graft	Excluded
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	Excluded
D7951	Sinus augmentation with bone or bone substitutes	Excluded
D7953	Bone replacement graft for ridge preservation- per site	Excluded
D7955	Repair of maxillofacial soft and/or hard tissue defect	
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure not incidental to another	Excluded
D7963	Frenuloplasty	Excluded
D7970	Excision of hyperplastic tissue – per arch	Excluded
D7971	Excision of percoronal gingival	2
D7972	Surgical reduction of fibrous tuberosity	Excluded
D7980	Sialolithotomy	Excluded
D7981	Excision of salivary gland, by report	Excluded
D7982	Sialodochoplasty	Excluded
D7983	Closure of salivary fistula	Excluded
D7990	Emergency tracheotomy	Excluded
D7991	Coronoidectomy	Excluded
D7995	Synthetic graft – mandible or facial bones, by report	Excluded
D7996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report	Excluded
D7997	Appliance removal (not by Dentist who placed appliance), includes removal of archer	Excluded
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	Excluded
D7999	Unspecified oral surgery procedure, by report	
D8000-D899 XI. Orthodontics		
Limited Orthodontic Treatment		
D8010	Limited orthodontic treatment of the primary dentition	4
D8020	Limited orthodontic treatment of the transitional dentition	4
D8030	Limited orthodontic treatment of the adolescent dentition	4
D8040	Limited orthodontic treatment of the adult dentition	Excluded
Interceptive Orthodontic Treatment		
D8050	Interceptive orthodontic treatment of the primary dentition	4

D8060	Interceptive orthodontic treatment of the transitional dentition	4
Comprehensive Orthodontic		
D8070	Comprehensive orthodontic treatment of the transitional dentition	4
D8080	Comprehensive orthodontic treatment of the adolescent dentition	4
D8090	Comprehensive orthodontic treatment of the adult dentition	4
Minor Treatment to Control Harmful Habits		
D8210	Removable appliance therapy	4
D8220	Fixed appliance therapy	4
Other Orthodontic Services		
D8660	Pre-orthodontic treatment visit	4
D8670	Periodic orthodontic treatment visit (as part of contract)	4
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	4
D8690	Orthodontic treatment (alternate billing to a contract fee)	4
D8691	Repair of orthodontic appliance	Excluded
D8692	Replacement of lost or broken retainer	Excluded
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	Excluded
D8999	Unspecified orthodontic procedure, by report	
D9000-D999 XII. ADJUNCTIVE GENERAL SERVICES		
Unspecified Treatment		
D9110	Palliative (emergency) treatment of dental pain-minor procedure	1
D9120	Fixed partial denture sectioning	Excluded
Anesthesia		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Excluded
D9211	Regional block anesthesia	Excluded
D9212	Trigeminal division block anesthesia	Excluded
D9215	Local anesthesia in conjunction with operative or surgical procedure	Excluded
D9220	Deep sedation/general anesthesia – first 30 minutes	1
D9221	Deep sedation/general anesthesia - each additional 15 mins	1
D9230	Inhalation of Nitrous Oxide/analgesia, anxiolysis	1
D9241	IV conscious sedation/analgesia - first 30 mins	1
D9242	IV conscious sedation/analgesia - each additional 15 mins	1
D9248	Non-intravenous conscious sedation	1
Professional Consultation		
D9310	Consultation – diagnostic service provided by Dentist or Physician other than requesting Dentist or Physician	1
Professional Visits		
D9410	House/extended care facility call	Excluded
D9420	Hospital or ambulatory surgical call	Excluded
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	1
D9440	Office visit - after regularly scheduled hours	1
D9450	Case presentation, detailed and extensive treatment planning	Excluded
Drugs		

D9610	Therapeutic parenteral drug- single administration	1
D9612	Therapeutic parenteral drug- two or more administrations, different medications	1
D9630	Other drugs and/or medicaments, by report	
Miscellaneous Services		
D9910	Application of desensitizing medicament	Excluded
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Excluded
D9920	Behavior management, by report	Excluded
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	
D9940	Occlusal guard, by report	1
D9941	Fabrication of athletic mouthguard	1
D9942	Repair and/or reline of occlusal guard	3
D9950	Occlusion analysis- mounted case	3
D9951	Occlusal adjustment- limited	3
D9952	Occlusal adjustment- complete	
D9970	Enamel microabrasion	Excluded
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	Excluded
D9972	External bleaching- per arch	Excluded
D9973	External bleaching- per tooth	Excluded
D9974	Internal bleaching- per tooth	1
D9999	Unspecified adjunctive procedure, by report	