AMENDMENT 2012-001
TO
PPSTA BENEFIT TRUST HEALTH AND DENTAL GROUP PLAN

BY THIS AGREEMENT, the PPSTA Benefit Trust Health and Dental Group Plan (herein called the "Plan") is hereby amended as follows, effective as of January 1, 2013.

NATURE OF AMENDMENT: To amend the Plan to comply with the federal Patient Protection and Affordable Care Act mandated coverage for well women care. To amend the Plan to replace Medco to Express Scripts and their web address to www.express-scripts.com throughout the document. To amend the Plan to clarify that Dependent Child coverage is terminated the last day of the month the Dependent Child turns 26. To amend the plan to clarify that in order to be eligible for the weight loss benefit a Covered Person must be enrolled in the plan for three months. To amend the plan to clarify the age limits for the infertility benefit. To amend the Plan to clarify that only inpatient Hospital copays do not apply to the Out-of-Pocket limit.

1. Section **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Eligibility, Eligible Classes of Dependents (3)** is amended to read as follows:

A covered Employee's Child(ren). An Employee's "Child" includes his natural Child, stepchild, Foster Child, adopted Child, Legal Guardianship, Domestic Partner's Child 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.

2. Section **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS, subsection Termination of Coverage, When Dependent Coverage Terminates (6-11)** are amended to read as follows **and (7)** are amended to read as follows:

(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.

3. Section **COST MANAGEMENT SERVICES, subsection Special Programs, Infertility Program (first paragraph only) and Weight Loss Program** will be amended to read as follows:

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.

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 by-pass-type surgery and must undergo counseling regarding the procedure's possible side effects.

4. Section **COST MANAGEMENT SERVICES, subsection Summary of Benefits** the following grid lines only will be amended to read as follows:

<table>
<tr><th>Plan Features</th><th>In-Network Benefits
(POMCO Allied/PHCS/MultiPlan Networks)</th><th>Out-of-Network Benefits</th></tr>
<tr><td rowspan="2">Out-of-Pocket (OOP) Limit Not Including Deductible, per Calendar Year</td><td>$1,250 per person
$2,500 per family
PPO outpatient copays and coinsurance combined</td><td>$2,500 per person
$5,000 per family
Inpatient and outpatient coinsurance.</td></tr>
<tr><td colspan="2">OOP limit does not apply to: Inpatient Hospital copayments, Infertility, ancillary benefit (vision exam, wellness benefits, and hearing aids), refractive surgery, "extended benefits", 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.</td></tr>
</table>

☎ = 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
Contraceptive Management	*See Preventive Care, Well Woman*	
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.*	
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.	
Preventive Care • ***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 Express Scripts 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.	
• ***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.	
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

☎ = 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**
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

PRESCRIPTION DRUG BENEFITS SCHEDULE

"Prescription Drug Benefits" are generally separate from "Medical Benefits" and do not apply to the deductibles, copayments, Out-of-Pocket limits for Medical Benefits. **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 *Express Scripts* Customer Service Department toll-free at 1.800.818.6632 for details. *Generic Prescription Drugs covered under ACA only will be reimbursed without a copay.***	
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 (*Express Scripts*)	**Note:** *You must pay applicable copayments. The Plan pays the balance of Allowable Fees.* 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 Out-of-Pocket Limit on copays: $1,820 per Covered Person. * see Diabetic Program for complete list
	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

5. Section **MEDICAL SERVICES AND SUPPLIES, subsection Contraceptive Management** remove as now described in Preventive Care, Well Woman**, subsections Infertility** will be amended to read as follows:

Infertility

Limited care, supplies and services for the treatment of Infertility of the Covered Person (Enrollee or opposite gender Spouse; no benefits available for Domestic Partners or 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.

6. Section **MEDICAL SERVICES AND SUPPLIES, subsection Contraceptive Management** remove as now described in Preventive Care, Well Woman**, subsections Prescription Drugs** will be amended to read as follows:

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*.

7. Section **MEDICAL SERVICES AND SUPPLIES, subsection Contraceptive Management** remove as now described in Preventive Care, Well Woman**, Preventive Care (3-9)** will be amended to read as follows:

Preventive Care Services

Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Summary of Benefits. 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.

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

(3) **Mammography**

- at any age for Covered Persons having prior history of breast cancer or whose mother or sister has a prior history of breast cancer;
- one per Calendar Year for Covered Persons prior to age 45;
- two per Calendar Year for Covered Persons age 45 or over.

(4) **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

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

(6) **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

(7) **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.

(8) ***Well Woman Preventive Services***

- ***Annual well-woman visit*** *for adults to obtain all recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care,* as recommended by the Physician*. The visit should include annual screening and counseling for interpersonal and domestic violence. Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women. Annual counseling for sexually transmitted infections for all sexually active women.*

Screening for gestational diabetes (between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

- ***Breastfeeding support, supplies, and counseling.*** *In conjunction with each birth the Plan includes coverage for comprehensive lactation support and counseling, by a trained Provider during Pregnancy and/or in the postpartum period; and the rental (up to the purchase price) of breastfeeding equipment. Coverage for related disposable supplies used with the breast feeding equipment is also covered.*

- ***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. Allowable Fees 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, implantable contraceptives, and emergency contraceptives (retail only) are covered **only** under the "Prescription Drug Benefits" section of the Plan.*

  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. ***Exception:*** *Over-the-counter emergency contraceptives will be covered at the retail pharmacy level as shown in the Prescription Drug Benefits section of this document.*

- ***Human papillomavirus (HPV) DNA testing.*** *High risk human papillomavirus DNA testing in women with normal cytology results.*

8. Section **PLAN EXCLUSIONS (42)** will be amended to read as follows:

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

9. Section **PRESCRIPTION DRUG BENEFITS, subsections Pharmacy Drug Charge, Co-payments and Covered Prescription Drugs (2, 8, and 9)** will be amended to read as follows:

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. *Express Scripts* 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 *Express Scripts* Customer Service Department toll-free at 1.800.818.6632 for details.

Co-payments

The co-payment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Summary of Benefits. The co-payment 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 Express Scripts' Customer Service Department toll-free at 1.800.818.6632 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.

Covered Prescription Drugs

(2) 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 are only covered at the retail Pharmacy. Benefits are not provided for abortifacient drugs*

(8) *Prescription smoking cessation*.

(9) *Prescription preventive medications are covered as required under the federal Patient Protection and Affordable Care Act. If these standards change, the Plan will automatically cover the new recommended standards.*

The Plan will comply within one year of the effective date of all <u>new</u> recommendations or guideline changes; the Plan will not cover any item or service that is no longer a recommended preventive service. No copayment is required for the following:

- *Aspirin when prescribed by a Physician, limited to males ages 45 years through 79 years to reduce risk of myocardial infarction and to females ages 45 years through 79 years to reduce risk of ischemic stroke.*

- *Vitamin supplements when prescribed by a Physician for over-the-counter and prescription forms of folic acid for females to age 50 years who are planning or capable of Pregnancy; iron (ferrous sulphate) supplements to age one year for children who are at increased risk of iron deficiency anemia; and fluoride for children to age five years.*

10. <u>Section **PRESCRIPTION DRUG BENEFITS, subsection Expenses Not Covered (3, 6, 19, and 21)** will be amended to read as follows:</u>

(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. *See the exceptions for aspirin, folic acid, and iron (ferrous sulphate) specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act.*

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

(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 (aspirin, folic acid, iron, and emergency contraceptives as specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act*.

(21) **Over-the-Counter Drugs,** except mega doses required due to serious medical conditions, such as diabetes *or drugs (aspirin, folic acid, iron, and emergency contraceptives as specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act*.

* * * * *

IN WITNESS WHEREOF, this agreement has been executed on behalf of PPSTA Benefit Trust.

By____

Title____

Date____