BUFFALO BOARD OF EDUCATION

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2015

AS RESTATED EFFECTIVE MARCH 1, 2017

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Applicable to all plans except Schedule of Medical Benefits – N:

GRANDFATHERED HEALTH PLAN DISCLOSURE STATEMENT

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SCHEDULE OF MEDICAL BENEFITS - A Traditional Blue 901/Class 00418019 and 00418058 00A4, 00418020 and 00418068 AT19			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$150	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$300	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	100%	90%	100%	N/A	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required..
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS – B Traditional Blue 901/Class 00418019 and 00418058 00A5, 00418020 and 00418068 A027			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$150	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$300	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	100%	90%	100%	N/A	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS – C Traditional Blue 901/Class 00418020 AT01, 00418068 AT01			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$50	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$100	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	N/A	N/A	N/A	Not covered	
Ambulance – Ground	N/A	N/A	N/A	80%*	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	80%*	Basic benefit applies to administration only, major medical benefit applies to drugs only.
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	80%*	Basic benefits limited to $100 per calendar year. Major medical benefits apply when basic benefits are exhausted.
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital- Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	N/A	N/A	N/A	80%*	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - D Traditional Blue 901/Class 00418020 and 00418068 AT05			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$250	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - E Traditional Blue 901/Class 00418020 and 004180680, AT07			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$250	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required. .
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - F Traditional Blue 901/Class 00418020 AT08, 00418023 LT03, 00418061 LT03, 00418068 AT08			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$100	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$200	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	80%*	Basic benefit applies to administration only, major medical benefit applies to drugs only.
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	80%*	Basic benefits limited to $100 per calendar year. Major medical benefits apply when basic benefits are exhausted.
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - G Traditional Blue 901/Class 00418020 AT06 AT10 AT15, 00418023 0T05, 00418061 0T05, 00418068 AT06 AT10 AT15 0T03			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$50	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$100	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - H Traditional Blue 901/Class 00418020 AT13 AT16, 00418068 AT13 AT16			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$50	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$100	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	Not covered	Not covered	Not covered	Not covered	
Ambulance – Ground	N/A	N/A	N/A	80%*	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	80%*	Basic benefit applies to administration only, major medical benefit applies to drugs only.
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	80%*	Basic benefits limited to $100 per calendar year. Major medical benefits apply when basic benefits are exhausted.
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	N/A	N/A	N/A	80%*	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - I Traditional Blue 901/Class 00418020 AT12 0T18, 00418023 0T18, 00418061 0T18, 00418068 AT12 0T18			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$50	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$100	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	Not covered	Not covered	Not covered	Not covered	
Ambulance – Ground	N/A	N/A	N/A	80%*	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Substance Abuse	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Mental Health	100%	Not covered	80%	100%	Prior authorization is required. Benefit includes residential treatment.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - J Traditional Blue 901/Class 00418020 ATA9 AT09, 00414068 ATA9 AT09			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$100	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$200	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - K Traditional Blue 901/Class 00418020 00418068 AT11			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$50	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$100	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	Not covered	Not covered	Not covered	Not covered	
Ambulance – Ground	N/A	N/A	N/A	80%*	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	80%*	Basic benefit applies to administration only, major medical benefit applies to drugs only.
Chiropractic Care – Chiropractor	100%	90%	100%	N/A	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	80%*	Basic benefits limited to $100 per calendar year. Major medical benefits apply when basic benefits are exhausted.
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse	100%	Not covered	80%	100%	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital - Inpatient Mental Health Residential Care	100%	Not covered	80%	100%	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - L Traditional Blue 901/Class 00418020 AA17 AT14 AT17, 00418068 AA17 AT14 AT17			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$50	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$100	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	Not covered	Not covered	Not covered	Not covered	
Ambulance – Ground	N/A	N/A	N/A	80%*	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	80%*	Basic benefit applies to administration only, major medical benefit applies to drugs only.
Chiropractic Care – Chiropractor	N/A	N/A	N/A	80%*	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	80%*	Basic benefits limited to $100 per calendar year. Major medical benefits apply when basic benefits are exhausted.
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
Hospital - Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	N/A	
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required. Benefit includes residential treatment.
Hospital - Inpatient Mental Health Residential Treatment	100%	Not covered	80%	100%	
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - M Traditional Blue 901/Class 00418019 00A1 00A3, 00418020 AT02 AT03 AT04 ATA2 ATA3, 00418021 0T01 0T02, 00418022 ATA2, 00418023 0T03 0T06 0T07, 00418058 00A1 00A3, 00418059 0T01 0T02, 00418060 0T03, 00418061 0T03 0T06 0T90, 00418068 ATA2 AT02 ATA3 AT03 AT04			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$150	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$300	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	100%	90%	100%	N/A	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital - Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital - Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required. Benefit includes residential treatment.
Hospital - Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital - Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital - Urgent Care Center	100%	Not covered	100%	N/A	
Hospital - All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Outpatient Therapy - Mental Health/Substance Abuse	N/A	N/A	N/A	80%*	
Outpatient Therapy - Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician - Inpatient Surgeon	100%	90%	100%	N/A	
Physician - Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician - Office Surgeon	100%	90%	100%	N/A	
Physician - Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
Post-Mastectomy External Prosthetic	100%	90%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	90%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	90%	100%	N/A	Limited to 4 per calendar year.
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	80%*	Prior authorization is required.
Radiation Therapy	100%	90%	100%	N/A	Prior authorization is required for certain services.
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS - N Healthy Balance Traditional Blue POS 8200/Class 00418019 00418058 BRNZ			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
Single Deductible	$5,000	$5,000	If you are enrolled as a Single, the Single Deductible applies. If you are enrolled as a Family, the Family Deductible applies—any individual within the family may be responsible for the entire amount. Deductible is combined for in- and out-of-network services.
Family Deductible	$10,000	$10,000	
Coinsurance	80%	60%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Single Maximum Out-Of-Pocket Amount	$6,350	$10,000	Includes deductible, co-pays and coinsurance amounts. If you are enrolled as a Single, the Single Maximum Out-of-Pocket applies. If you are enrolled as a Family, the Family Maximum Out-of-Pocket Amount applies—any individual within the family may be responsible for the entire amount. Maximum Out-of-Pocket Amount is combined for in- and out-of-network services. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	$12,700	$20,000	

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	80%*	60%*	
Ambulance - Air	80%*	60%*	Medically necessary only. In-network deductible and maximum out-of-pocket amount apply for out-of-network services.
Ambulance - Ground	80%*	60%*	In-network deductible and maximum out-of-pocket amount apply for out-of-network services.
Anesthesia	80%*	60%*	
Applied Behavioral Analysis (ABA) for Autism	80%*	60%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	80%*	60%*	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Assistive Communication Devices for Autism	80%*	60%*	Precertification is required.
Cardiac Rehabilitation	80%*	60%*	Limited to 24 visits per calendar year in a 12-week period per episode.
Chemotherapy	80%*	60%*	
Chiropractic Care - Chiropractor	80%*	60%*	
Chiropractic Care - Physician	80%*	60%*	
Diabetic Education	80%*	60%*	
Diabetic Equipment and Supplies	80%*	60%*	
Diagnostic Laboratory Testing	80%*	60%*	
Diagnostic Radiology	80%*	60%*	
Diagnostic Radiology - MRI/MRA/PET	80%*	60%*	Precertification is required.
Dialysis	80%*	60%*	
Durable Medical Equipment	80%*	60%*	Precertification is required for select equipment.
Fetal Non-Stress Test	80%*	60%*	
Flu Vaccination	100%	100%	
Home Health Care	80%*	60%*	Limited to 40 visits per calendar year.
Hospice Care	80%*	60%*	
Hospital – Emergency Room	80%*	Paid as in-network	In-network deductible and maximum out-of-pocket amount apply for out-of-network services.
Hospital – Inpatient Acute Physical Rehabilitation Facility	80%*	60%*	Precertification is required. Limited to 60 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse	80%*	60%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	80%*	60%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	80%*	60%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	80%*	60%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	80%*	60%*	
Hospital – Urgent Care Center	80%*	60%*	In-network deductible and maximum out-of-pocket amount apply for out-of-network services.
Hospital – All Other Outpatient Services	80%*	60%*	
Infusion Therapy	80%*	60%*	
Injectable Medications	80%*	60%*	
Maternity Care	80%*	60%*	
Medical Supplies	80%*	60%*	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	80%*	60%*	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	80%*	60%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	80%*	60%*	
Physician Visit – Emergency Room	80%*	Paid as in-network	In-network deductible and maximum out-of-pocket amount apply for out-of-network services.
Physician Visit – Office/ Clinic	80%*	60%*	
Physician Visit – Inpatient Consultation	80%*	60%*	
Physician Visit – Inpatient Visit	80%*	60%*	
Physician – Inpatient Surgeon	80%*	60%*	Precertification is required for certain services.
Physician – Hospital or Free-Standing Surgical Center Surgeon	80%*	60%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Office Surgeon	80%*	60%*	
Physician – Assistant Surgeon	80%*	60%*	
Post-Mastectomy External Prosthetic	80%*	60%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	80%*	60%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	80%*	60%*	Limited to 4 per calendar year.
Preventive Care	100%	60%*	Includes all mandated care under the Patient Protection and Affordable Care Act (PPACA). Not all preventive services are covered out-of-network.
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	80%*	60%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	80%*	60%*	Limited to an aggregate of 30 visits per calendar year.
Rehabilitative Therapy – Pulmonary	80%*	60%*	
Rehabilitative Therapy – Respiratory	80%*	60%*	
Second Surgical Opinions	80%*	60%*	
Skilled Nursing Facility	80%*	60%*	Precertification is required. Limited to 60 visits per calendar year.
Sleep Studies	80%*	60%*	
Transfusion	80%*	60%*	
All Other Covered Expenses	80%*	60%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS - O Traditional Blue POS 202/Class 00418019 00418058 00B3, 00418020 00418068 B021			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$8	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $8 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance - Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $8 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $8 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $8 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $8 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $8 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $8 co-pay	80%*	
Chiropractic Care - Physician	100% after $8 co-pay	80%*	
Diabetic Education	100% after $8 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $8 co-pay	80%*	
Diagnostic Laboratory Testing	100%	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $8 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $8 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $8 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $8 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $8 co-pay	80%*	
Maternity Care	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100%	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $8 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $8 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $8 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $8 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $8 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $8 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $8 co-pay	80%*	
Transfusion	100% after $8 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – P Traditional Blue POS 201 POS 201 Plus/Class 00418019 00D1 00D2 00D3, 00418020 D025 D026 DA25 DA26 DB26 DC26, 00418021 0001, 00418058 00D1 00D2 00D3, 00418059 0001, 00418068 D025 D026 DA25 DA26 DC26			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP Co-Pay	$5	N/A	
Specialist Co-Pay	$10	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Co-pay is waived for pediatric visits to primary care providers.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $5 or $10 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance - Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $10 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Artificial Insemination - Physician	100% after $5 or $10 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $10 co-pay	80%*	Precertification is required.
Cardiac Rehabilitation	100% after $10 co-pay	80%*	Limited to 24 visits in a 12-week period per calendar year.
Chemotherapy	100% after $10 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $5 co-pay	80%*	
Chiropractic Care - Physician	100% after $5 or $10 co-pay	80%*	
Diabetic Education	100% after $5 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $5 co-pay	80%*	
Diagnostic Laboratory Testing	100%	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	80%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $5 co-pay	80%*	
Flu Vaccination	100%	100%	
Home Health Care	100% after $10 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $10 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $5 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $10 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $5 or $10 co-pay	80%*	
Maternity Care	100% after $5 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	Not covered	Not covered	
Outpatient Therapy – Mental Health/ Substance Abuse	100%	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit – Office/ Clinic	100% after $5 or $10 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $5 or $10 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $5 or $10 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $5 or $10 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $10 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100% after $5 or $10 co-pay	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100% after $5 or $10 co-pay	80%*	Precertification is required.
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $10 co-pay	80%*	Limited to 20 visits per calendar year.
Rehabilitative Therapy – Pulmonary	100% after $10 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $10 co-pay	80%*	
Second Surgical Opinions	100% after $10 co-pay	80%*	
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $10 co-pay	80%*	
Transfusion	100% after $5 or $10 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – Q Traditional Blue POS 202/Class 00418022 00418060 0001			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$8	N/A	
Inpatient Hospital Co-pay	$240 per admission	N/A	In-network co-pay limited to a maximum of $480 per year.
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $8 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance - Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $8 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $8 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $8 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $8 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $8 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $8 co-pay	80%*	
Chiropractic Care - Physician	100% after $8 co-pay	80%*	
Diabetic Education	100% after $8 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $8 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $8 co-pay	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $8 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100% after $240 co-pay	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100% after $240 co-pay	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100% after $240 co-pay	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100% after $240 co-pay	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $8 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $8 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $8 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $8 co-pay	80%*	
Maternity Care	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $8 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $8 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $8 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $8 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $8 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $8 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $8 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100% after $240 co-pay	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $8 co-pay	80%*	
Transfusion	100% after $8 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – R Traditional Blue POS 202/Class 00418021 0005, 00418059 0005			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$8	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $8 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance - Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $8 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $8 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $8 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $8 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $8 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $8 co-pay	80%*	
Chiropractic Care - Physician	100% after $8 co-pay	80%*	
Diabetic Education	100% after $8 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $8 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $8 co-pay	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $8 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $8 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $8 co-pay	80%*	.
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $8 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $8 co-pay	80%*	
Maternity Care	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $8 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $8 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $8 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $8 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $8 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $8 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $8 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $8 co-pay	80%*	
Transfusion	100% after $8 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – S Traditional Blue POS 202/Class 00418021 0003, 00418059 0003			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$8	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $8 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance – Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $8 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $8 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $8 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $8 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $8 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $8 co-pay	80%*	
Chiropractic Care - Physician	100% after $8 co-pay	80%*	
Diabetic Education	100% after $8 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $8 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $8 co-pay	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $8 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $8 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $8 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $8 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $8 co-pay	80%*	
Maternity Care	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $8 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $8 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $8 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $8 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $8 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $8 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $8 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $8 co-pay	80%*	
Transfusion	100% after $8 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – T Traditional Blue POS 202/Class 00418019 00B2, 00418020 B022, 00418023 0001 00R6, 00418058 00B2, 00418061 0001 00R6, 00418068 B022			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$8	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $8 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance – Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $8 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $8 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $8 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $8 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $8 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $8 co-pay	80%*	
Chiropractic Care - Physician	100% after $8 co-pay	80%*	
Diabetic Education	100% after $8 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $8 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $8 co-pay	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $8 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $8 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $8 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $8 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $8 co-pay	80%*	
Maternity Care	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $8 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $8 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $8 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $8 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $8 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $8 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $8 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $8 co-pay	80%*	
Transfusion	100% after $8 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – U Traditional Blue POS 202/Class 00418019 00B4, 00418020 B020, 00418058 00B4, 00418068 B020			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$8	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $8 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance – Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $8 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $8 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $8 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $8 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $8 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $8 co-pay	80%*	
Chiropractic Care - Physician	100% after $8 co-pay	80%*	
Diabetic Education	100% after $8 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $8 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $8 co-pay	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $8 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $8 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $8 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $8 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $8 co-pay	80%*	
Maternity Care	100% after $8 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $8 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $8 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $8 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $8 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $8 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $8 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $8 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $8 co-pay	80%*	
Transfusion	100% after $8 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – V Traditional Blue POS 203/Class 00418019 00B5, 00418058 00B5			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$10	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $10 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100% after $25 co-pay	100% after $25 co-pay	Medically necessary only.
Ambulance – Ground	100% after $25 co-pay	100% after $25 co-pay	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $10 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $10 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $10 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $10 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $10 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $10 co-pay	80%*	
Chiropractic Care - Physician	100% after $10 co-pay	80%*	
Diabetic Education	100% after $10 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $10 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $10 co-pay	80%*	
Diagnostic Radiology	100% after $15 co-pay	80%*	
Diagnostic Radiology - MRI/MRA/PET	100% after $15 co-pay	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $10 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $10 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $50 co-pay	100% after $50 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $10 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $10 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $10 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $10 co-pay	80%*	
Maternity Care	100% after $10 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $10 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100% after $10 co-pay	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $10 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $10 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $10 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $10 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, and routine mammograms.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $10 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	Certain screenings (abdominal aortic aneurysm, osteoporosis) are paid at 100% after $15 co-pay in-network.
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $10 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $10 co-pay	80%*	
Transfusion	100% after $10 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – W Traditional Blue POS 204/204 Plus/Class 00418019 00B6, 00418020 B028, 00418058 00B6, 00418068 B028			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$15	N/A	
Inpatient Hospital Co-pay	$250 per admission	N/A	In-network co-pay limited to a maximum of $500 per year.
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Co-pay is waived for pediatric visits to primary care providers.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $15 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100% after $50 co-pay	100% after $50 co-pay	Medically necessary only.
Ambulance – Ground	100% after $50 co-pay	100% after $50 co-pay	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $15 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $15 co-pay	80%*	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Assistive Communication Devices for Autism	100% after $15 co-pay	80%*	Precertification is required.
Cardiac Rehabilitation	100% after $15 co-pay	80%*	Limited to 24 visits in a 12-week period per calendar year.
Chemotherapy	100% after $15 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $15 co-pay	80%*	
Chiropractic Care - Physician	100% after $15 co-pay	80%*	
Diabetic Education	100% after $15 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $15 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $15 co-pay	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	80%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $15 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $50 co-pay	100% after $50 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100% after $250 co-pay	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100% after $250 co-pay	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Mental Health	100% after $250 co-pay	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $15 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $15 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $15 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $15 co-pay	80%*	
Maternity Care	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	80%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $15 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $15 co-pay	80%*	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $15 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $15 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $15 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, and routine mammograms.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $15 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 60 visits per calendar year.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $15 co-pay	80%*	
Skilled Nursing Facility	100% after $250 co-pay	80%*	Precertification is required.
Sleep Studies	100% after $15 co-pay	80%*	
Transfusion	100% after $15 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – X Traditional Blue POS 229/Class 00418019 00C2, 00418020 C024, 00418058 00C2, 00418068 C024			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$5	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$3,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$6,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Co-pay is waived for pediatric care, except for the following benefits: Hospital – Emergency Room and Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $5 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance – Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $5 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $5 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $5 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $5 co-pay	80%*	Limited to 36 visits every 12 weeks.
Chemotherapy	100% after $5 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $5 co-pay	80%*	
Chiropractic Care - Physician	100% after $5 co-pay	80%*	
Diabetic Education	100% after $5 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $5 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $5 co-pay	80%*	
Diagnostic Radiology	100% after $5 co-pay	80%*	
Diagnostic Radiology - MRI/MRA/PET	100% after $5 co-pay	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	Not covered	Not covered	
Fetal Non-Stress Test	100% after $5 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $5 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $25 co-pay	100% after $25 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 60 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $5 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $5 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $5 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $5 co-pay	80%*	
Maternity Care	100% after $5 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	Not covered	Not covered	
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $5 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100% after $5 co-pay	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $5 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $5 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $5 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $5 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $5 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	Abdominal aortic aneurysm screening is paid at 100% after $5 co-pay in-network.
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100% after $5 co-pay	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $5 co-pay	80%*	Limited to 30 visits per calendar year.
Rehabilitative Therapy – Pulmonary	100% after $5 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $5 co-pay	80%*	
Second Surgical Opinions	100% after $5 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $5 co-pay	80%*	
Transfusion	100% after $5 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – Y Traditional Blue POS 229/Class 00418019 00C1, 00418020 C023, 00418021 0004, 00418058 00C1, 00418059 0004, 00418068 C023			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$5	N/A	
Individual Deductible	$0	$200	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$400	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$3,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$6,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Co-pay is waived for pediatric care, except for the following benefits: Hospital – Emergency Room and Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $5 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance – Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $5 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $5 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $5 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $5 co-pay	80%*	Limited to 36 visits every 12 weeks.
Chemotherapy	100% after $5 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $5 co-pay	80%*	
Chiropractic Care - Physician	100% after $5 co-pay	80%*	
Diabetic Education	100% after $5 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $5 co-pay	80%*	
Diagnostic Laboratory Testing	100%	80%*	
Diagnostic Radiology	100% after $5 co-pay	80%*	
Diagnostic Radiology - MRI/MRA/PET	100% after $5 co-pay	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	Not covered	Not covered	
Fetal Non-Stress Test	100% after $5 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $5 co-pay	80%*	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $25 co-pay	100% after $25 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 60 days per calendar year. Long term acute care facility services are not covered.
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $5 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $5 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $5 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $5 co-pay	80%*	
Maternity Care	100% after $5 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	Not covered	Not covered	
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $5 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100% after $5 co-pay	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $5 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $5 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $5 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $5 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $5 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100% after $5 co-pay	80%*	Abdominal aortic aneurysm screening is paid at 100% after $5 co-pay in-network.
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100% after $5 co-pay	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $5 co-pay	80%*	Limited to 30 visits per calendar year.
Rehabilitative Therapy – Pulmonary	100% after $5 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $5 co-pay	80%*	
Second Surgical Opinions	100% after $5 co-pay	80%*	
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $5 co-pay	80%*	
Transfusion	100% after $5 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – Z Traditional Blue PPO 812/Class 00418022 0T01			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$10	N/A	
Inpatient Hospital Co-pay	$250	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$1,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$2,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $10 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance – Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $10 co-pay	80%*	Precertification is required. Limited to a maximum of 680 hours per calendar year.
Artificial Insemination - Physician	100% after $10 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $10 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $10 co-pay	80%*	Limited to 24 visits in a 12-week period per calendar year.
Chemotherapy	100% after $10 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $10 co-pay	80%*	
Chiropractic Care - Physician	100% after $10 co-pay	80%*	
Diabetic Education	100% after $10 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $10 co-pay	80%*	
Diagnostic Laboratory Testing	100% after $10 co-pay	80%*	
Diagnostic Radiology	100% after $10 co-pay	80%*	
Diagnostic Radiology - MRI/MRA/PET	100% after $10 co-pay	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	Not covered	
Fetal Non-Stress Test	100% after $10 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $10 co-pay	80%*	Limited to a maximum of 100 visits per year, including home infusion therapy.
Hospice Care	100% after $10 co-pay	80%*	
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100% after $250 co-pay per admission	80%*	Precertification is required. Limited to 60 days per calendar year. Long term acute care facility services are not covered.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Substance Abuse	100% after $250 co-pay per admission	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Mental Health	100% after $250 co-pay per admission	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100% after $250 co-pay per admission	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $10 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $10 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $10 co-pay	80%*	Home infusion is limited to a maximum of 100 visits per year, combined with home health care.
Injectable Medications	100% after $10 co-pay	80%*	
Maternity Care	100% after $10 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	80%*	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	100%	80%*	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $10 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100% after $10 co-pay	80%*	
Physician Visit – Emergency Room	100%	100%	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit – Office/ Clinic	100% after $10 co-pay	80%*	
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations by 2 different physicians per admission.
Physician Visit – Inpatient Visit	100%	80%*	
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $10 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	50%	50%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $10 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $10 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $10 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100% after $10 co-pay	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100% after $10 co-pay	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $10 co-pay	80%*	Limited to 60 visits per calendar year.
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Pulmonary	100% after $10 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $10 co-pay	80%*	
Second Surgical Opinions	100% after $10 co-pay	80%*	
Skilled Nursing Facility	100% after $250 co-pay per admission	80%*	Precertification is required. Limited to 120 days per calendar year.
Sleep Studies	100% after $10 co-pay	80%*	
Transfusion	100% after $10 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS - AA Traditional Blue 901 00418019 00418020, 00418058 (DBC) and 00418068 (DBC) 00A6			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Annual Maximum Benefit	Unlimited		
Individual Deductible	$0	$150	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	$300	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$500	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$1,000	

	Basic Benefit				
	Par	**In-Area Non-Par**	**Out-of-Area Non-Par**	**Major Medical Benefit**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	80%*	
Ambulance – Air	100%	90%	100%	N/A	
Ambulance – Ground	100%	90%	100%	N/A	
Anesthesia	100%	90%	100%	N/A	
Applied Behavioral Analysis (ABA) for Autism	100%	90%	100%	Not covered	
Artificial Insemination - Physician	100%	90%	100%	N/A	
Assistive Communication Devices for Autism	100%	90%	100%	Not covered	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Cardiac Rehabilitation	N/A	N/A	N/A	80%*	Limited to 24 visits per calendar year following an acute heart condition.
Chemotherapy	100%	90%	100%	N/A	
Chiropractic Care – Chiropractor	100%	90%	100%	N/A	
Chiropractic Care – Physician	N/A	N/A	N/A	80%*	
Diabetic Education	N/A	N/A	N/A	80%*	Services obtained from a participating certified diabetic educator are covered in full.
Diabetic Equipment and Supplies	N/A	N/A	N/A	80%*	
Diagnostic Laboratory Testing	100%	90%	100%	N/A	
Diagnostic Radiology	100%	90%	100%	N/A	
Diagnostic Radiology – MRI/MRA/PET	100%	Not Covered	100%	N/A	Prior authorization is required.
Dialysis	100%	90%	100%	N/A	
Durable Medical Equipment	N/A	N/A	N/A	80%*	Prior authorization is required for some equipment.
Fetal Non-Stress Test	N/A	N/A	N/A	80%*	
Flu Vaccination	100%	100%	100%	N/A	
Home Health Care	100%	Not covered	100%	N/A	Prior authorization is required. Limited to 365 visits per calendar year (4 hours = 1 visit).
Hospice Care	100%	Not covered	100%	N/A	Limited to 210 days per calendar year.
Hospital – Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	100%	Not covered	80%	N/A	Prior authorization is required. Limited to 45 days per calendar year. Further limited to 2 admissions per lifetime. Long term acute care facility services are not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detox and Rehab	100%	Not covered	80%	N/A	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Substance Abuse Residential Treatment	100%	Not covered	80%	N/A	
Hospital – Inpatient Mental Health	100%	Not covered	80%	N/A	Prior authorization is required..
Hospital – Inpatient Mental Health Residential Treatment	100%	Not covered	80%	N/A	Prior authorization is required.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	Not covered	80%	100%	Prior authorization is required. Limited to 365 days per confinement.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100%	Not covered	100%	N/A	
Hospital – Pre-Admission Testing	100%	Not covered	100%	N/A	
Hospital – Urgent Care Center	100%	Not covered	100%	N/A	
Hospital – All Other Outpatient Services	100%	Not covered	100%	N/A	
Infusion Therapy – Physician's Office	N/A	N/A	N/A	80%*	
Infusion Therapy	100%	Not covered	100%	N/A	Home infusion therapy is limited to 365 visits per calendar year.
Injectable Medications	N/A	N/A	N/A	80%*	
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Maternity Care	100%	90%	100%	N/A	
Medical Supplies	N/A	N/A	N/A	80%*	
Orthoptic Therapy	N/A	N/A	N/A	80%*	Prior authorization is required.
Orthotics and External Prosthetics	N/A	N/A	N/A	80%*	
Outpatient Therapy – Mental Health/Substance Abuse	100%	90%	100%	N/A	
Outpatient- Mental Health Crisis Intervention	N/A	N/A	N/A	100%	
Outpatient Therapy – Mental Health/Crisis Intervention	N/A	N/A	N/A	100%	
Physician Visit-Emergency Room	100%	90%	100%	N/A	
Physician Visit-Office / Clinic	N/A	N/A	N/A	80%*	
Physician Visit-Inpatient Consultation	100%	90%	100%	80%*	Basic benefits are limited to 2 consultations by no more than 2 consulting physicians per admission. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Inpatient Visit	100%	90%	100%	80%*	Basic benefits are limited to 1 visit per provider per day. Major medical benefits apply when basic benefits are exhausted.
Physician Visit-Skilled Nursing Facility Visit	N/A	N/A	N/A	80%*	
Physician – Inpatient Surgeon	100%	90%	100%	N/A	
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	90%	100%	N/A	
Physician – Office Surgeon	100%	90%	100%	N/A	
Physician – Assistant Surgeon	100%	90%	100%	N/A	Assistant surgeon in a physician's office is not covered.
*Deductible applies					

	Basic Benefit				
	Par	In-Area Non-Par	Out-of-Area Non-Par	Major Medical Benefit	Limitations and Explanations
Post-Mastectomy External Prosthetic	100%	100%	100%	N/A	Limited to 1 per affected breast in any calendar year.
Post-Mastectomy Sleeve	100%	100%	100%	N/A	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	100%	100%	N/A	Limited to 4 per calendar year.
Preventive Care – Routine Well Woman Care	100%	90%	100%	N/A	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	90%	100%	N/A	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100%	Not covered	100%	N/A	
Preventive Care – Other Covered Services	N/A	N/A	N/A	80%*	
Private Duty Nursing	Not covered	Not covered	Not covered	80%*	
Radiation Therapy	100%	90%	100%	N/A	
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	80%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	80%*	
Second Surgical Opinions	100%	90%	100%	N/A	
Skilled Nursing Facility	N/A	N/A	N/A	80%*	Prior authorization is required.
Sleep Studies	N/A	N/A	N/A	80%*	
Transfusion	100%	Not covered	100%	N/A	
All Other Covered Expenses	100%	90%	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS – AB Traditional Blue POS 202 00418019 00418020 00418058 (DBC) 00418068 (DBC) 00B7			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$15	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $15 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance - Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $15 co-pay	80%*	Precertification is required.
Artificial Insemination - Physician	100% after $15 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $15 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $15 co-pay	80%*	Limited to 36 visits per episode.
Chemotherapy	100% after $15 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $15 co-pay	80%*	
Chiropractic Care - Physician	100% after $15 co-pay	80%*	
Diabetic Education	100% after $8 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $8 co-pay	80%*	
Diagnostic Laboratory Testing	100%	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	50%	50%*	Precertification is required for select equipment. Limited to $1,000 per year.
Fetal Non-Stress Test	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $15 co-pay	80%*	The co-pay is waived for early maternity discharge. Out-of-Network benefits are limited to 365 visits, reduced by In-Network visits.
Home Care-Respiratory Therapy	100% after $15 co-pay	Not covered	
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $15 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $15 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $15 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $15 co-pay	80%*	Co-pay only applies when injectable medication is the only service billed.
Maternity Care	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	50%	Not covered	Precertification is required for select items.
Outpatient Therapy – Mental Health/ Substance Abuse	100%	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
Physician Visit – Office/ Clinic	100% after $15 co-pay	80%*	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission. Out-of-network benefits will be paid at the in-network benefit level when related services are in-network.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day. Out-of-network benefits will be paid at the in-network benefit level when related services are in-network.
Physician – Inpatient Surgeon	100%	80%*	
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	
Physician – Office Surgeon	100% after $15 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	Out-of-Network will be paid at In-Network when related services are In-Network.
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $15 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $15 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $15 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100%	80%*	Precertification is required.
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 2 consecutive months of treatment per condition.
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $15 co-pay	80%*	
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $15 co-pay	80%*	
Transfusion	100% after $15 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – AC Traditional Blue POS 229/ 00418019, 00418020, 00418058 (DBC), 00418068 (DBC) 00C3			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP/Specialist Co-Pay	$15	N/A	
Individual Deductible	$0	$200	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$400	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$3,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$6,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Co-pay is waived for pediatric care, except for the following benefits: Hospital – Emergency Room and Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $15 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance – Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $15 co-pay	80%*	Precertification is required.
Artificial Insemination - Physician	100% after $15 co-pay	80%*	
Assistive Communication Devices for Autism	100% after $15 co-pay	80%*	Precertification is required.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Cardiac Rehabilitation	100% after $15 co-pay	80%*	Limited to 36 visits every 12 weeks. The co-pay is waived for dependents under age 19.
Chemotherapy	100% after $15 co-pay	80%*	The co-pay is waived for dependents under age 19.
Chiropractic Care - Chiropractor	100% after $15 co-pay	80%*	
Chiropractic Care - Physician	100% after $15 co-pay	80%*	The co-pay is waived for dependents under age 19.
Diabetic Education	100% after $5 co-pay	80%*	The co-pay is waived for dependents under age 19.
Diabetic Equipment and Supplies	100% after $5 co-pay	80%*	The co-pay is waived for dependents under age 19.
Diagnostic Laboratory Testing	100%	80%*	
Diagnostic Radiology	100% after $5 co-pay	80%*	The co-pay is waived for dependents under age 19.
Diagnostic Radiology - MRI/MRA/PET	100% after $5 co-pay	80%*	Precertification is required. The co-pay is waived for dependents under age 19.
Dialysis	100%	80%*	
Durable Medical Equipment	Not covered	Not covered	
Fetal Non-Stress Test	100% after $15 co-pay	80%*	Primary care physician co-pay on initial maternity visit only. Co-pay is waived for dependents under age 19.
Flu Vaccination	100%	100%	
Home Health Care	100% after $15 co-pay	80%*	Co-pay is waived for early maternity discharge and dependents under age 19. Out-of-network benefits are limited to 365, reduced by the number of in-network visits.
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $25 co-pay	100% after $25 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 60 days per calendar year. Long term acute care facility services are not covered.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $5 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $15 co-pay	80%*	The co-pay is waived for dependents under age 19.
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $15 co-pay	80%*	Co-pay only applies when infusion is the only service billed. Co-pay is waived for dependents under age 19.
Injectable Medications	100% after $15 co-pay	80%*	Co-pay only applies when injectable medication is the only service billed. Co-pay is waived for dependents under age 19.
Maternity Care	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only. The co-pay is waived for dependents under age 19.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	Not covered	Not covered	
Outpatient Therapy – Mental Health/ Substance Abuse	100% after $15 co-pay	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100% after $15 co-pay	80%*	
Physician Visit – Emergency Room	100%	100%	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit – Office/ Clinic	100% after $15 co-pay	80%*	The co-pay is waived for dependents under age 19.
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission. Out-of-network will be paid at the in-network benefit level when related services are in-network.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day. Out-of-network will be paid at the in-network benefit level when related services are in-network.
Physician – Inpatient Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	
Physician – Office Surgeon	100% after $15 co-pay	80%*	The co-pay is waived for dependents under age 19.
Physician – Assistant Surgeon	100%	80%*	Out-of-network will be paid at the in-network benefit level when related services are in-network.
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $15 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $15 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $15 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50. The co-pay is waived for adults over age 50.
Preventive Care – Other Covered Services	100% after $15 co-pay	80%*	Abdominal aortic aneurysm screening is paid at 100% after $5 co-pay in-network. The co-pay is waived for some services.
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100% after $15 co-pay	80%*	Precertification is required. The co-pay is waived for dependents under age 19.
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 30 visits per calendar year. The co-pay is waived for dependents under age 19.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $15 co-pay	80%*	The co-pay is waived for dependents under age 19.
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year.
Sleep Studies	100% after $15 co-pay	80%*	The co-pay is waived for dependents under age 19.
Transfusion	100% after $15 co-pay	80%*	The co-pay is waived for dependents under age 19.
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF MEDICAL BENEFITS – AD Traditional Blue POS 201 00418019, 00418020, 00418058 (DBC), 00418068 (DBC) 00D4			
Medical Plan	**In-Network**	**Out-of-Network**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
PCP Co-Pay	$15	N/A	
Specialist Co-Pay	$15	N/A	
Individual Deductible	$0	$250	Once an individual meets their individual deductible amount, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied.
Family Deductible	$0	$500	
Coinsurance	100%	80%	Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible.
Individual Maximum Out-Of-Pocket Amount	N/A	$2,000	Includes deductible and coinsurance amounts. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	N/A	$4,000	
√ A visit co-pay applies to any physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Co-pay is waived for pediatric visits to primary care providers.			

	In-Network	**Out-Of-Network**	**Limitations and Explanations**
Allergy Testing and Injections	100% after $15 co-pay	80%*	Co-pay does not apply for in-network allergy serum.
Ambulance - Air	100%	100%	Medically necessary only.
Ambulance - Ground	100%	100%	Medically necessary only.
Anesthesia	100%	100%	
Applied Behavioral Analysis (ABA) for Autism	100% after $15 co-pay	80%*	Precertification is required.
Artificial Insemination - Physician	100% after $15 co-pay	80%*	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Assistive Communication Devices for Autism	100% after $15 co-pay	80%*	Precertification is required.
Cardiac Rehabilitation	100% after $15 co-pay	80%*	Limited to 24 visits in a 12-week period per calendar year.
Chemotherapy	100% after $15 co-pay	80%*	
Chiropractic Care - Chiropractor	100% after $15 co-pay	80%*	
Chiropractic Care - Physician	100% after $15 co-pay	80%*	
Diabetic Education	100% after $5 co-pay	80%*	
Diabetic Equipment and Supplies	100% after $5 co-pay	80%*	
Diagnostic Laboratory Testing	100%	80%*	
Diagnostic Radiology	100%	80%*	
Diagnostic Radiology - MRI/MRA/PET	100%	80%*	Precertification is required.
Dialysis	100%	80%*	
Durable Medical Equipment	80%	50%*	Precertification is required for select equipment.
Fetal Non-Stress Test	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only.
Flu Vaccination	100%	100%	
Home Health Care	100% after $15 co-pay	80%*	The co-pay is waived for early maternity discharge. Out-of-network benefits are limited to 365, reduced by the number of in-network visits.
Hospice Care	100%	80%*	Limited to a maximum of 210 days.
Hospital – Emergency Room	100% after $35 co-pay	100% after $35 co-pay	Co-pay waived if admitted.
Hospital – Inpatient Acute Physical Rehabilitation Facility	100%	80%*	Precertification is required. Limited to 45 days per calendar year. Long term acute care facility services are not covered.
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detox, Rehab and Residential Treatment	100%	80%*	No prior authorization is required for an initial 14 days of inpatient detox, inpatient rehab or inpatient residential treatment rehab in facilities that are in NYS, OASAS-certified and in our network, without concurrent authorization, as long as the provider notifies the plan and provides an initial treatment plan within 48 hours of the admission; otherwise, prior authorization is required.
Hospital – Inpatient Mental Health	100%	80%*	Prior authorization is required. Benefit includes residential treatment.
Hospital – Inpatient Treatment Of Other Covered Conditions	100%	80%*	Precertification is required.
Hospital – Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	100% after $15 co-pay	80%*	Precertification is required for select procedures.
Hospital – Pre-Admission Testing	100%	80%*	
Hospital – Urgent Care Center	100% after $15 co-pay	80%*	
Hospital – All Other Outpatient Services	100%	80%*	
Infusion Therapy	100% after $15 co-pay	80%*	Co-pay only applies when infusion is the only service billed.
Injectable Medications	100% after $15 co-pay	80%*	Co-pay only applies when injectable medication is the only service billed.
Maternity Care	100% after $15 co-pay	80%*	Co-pay on initial maternity visit only.
Medical Supplies	100%	Not covered	
Orthoptic Therapy	Not covered	Not covered	
Orthotics and External Prosthetics	Not covered	Not covered	
Outpatient Therapy – Mental Health/ Substance Abuse	100%	80%*	
Outpatient Therapy – Mental Health/ Crisis Intervention	100%	80%*	
Physician Visit – Emergency Room	100%	100%	
*Deductible applies			

	In-Network	Out-Of-Network	Limitations and Explanations
Physician Visit – Office/ Clinic	100% after $15 co-pay	80%*	The PCP co-pay is waived for dependents under age 19.
Physician Visit – Inpatient Consultation	100%	80%*	Out-of-network benefits are limited to 2 consultations per admission. Out-of-network benefits will be paid as in-network when related services are in-network.
Physician Visit – Inpatient Visit	100%	80%*	Out-of-network benefits are limited to 1 visit per condition per day. Out-of-network benefits will be paid as in-network when related services are in-network.
Physician – Inpatient Surgeon	100%	80%*	
Physician – Hospital or Free-Standing Surgical Center Surgeon	100%	80%*	Precertification is required for certain services.
Physician – Office Surgeon	100% after $15 co-pay	80%*	
Physician – Assistant Surgeon	100%	80%*	Out-of-network services will be paid at the in-network benefit if related services are in-network.
Post-Mastectomy External Prosthetic	100%	80%*	Limited to 1 per breast per calendar year.
Post-Mastectomy Sleeve	100%	80%*	Limited to 2 per calendar year.
Post-Mastectomy Surgical Bra	100%	80%*	Limited to 4 per calendar year.
Preventive Care – Routine Exam	100% after $15 co-pay	Not covered	Limited to 1 routine exam per calendar year for adults. Includes adult immunizations.
Preventive Care – Routine Well Woman Care	100% after $15 co-pay	80%*	Includes 2 routine OB/GYN exams each year, 1 routine Pap test per year, 1 HPV test every 3 years, routine mammograms, and osteoporosis screening.
Preventive Care – Well Child Care	100%	80%*	Includes well child care exams and immunizations.
Preventive Care – Colorectal Cancer Screening	100% after $15 co-pay	80%*	Includes routine colonoscopy, sigmoidoscopy, and fecal occult screening for individuals over age 50. The co-pay is waived for individuals over age 50.
Preventive Care – Other Covered Services	100%	80%*	
Private Duty Nursing	Not covered	Not covered	
Radiation Therapy	100% after $15 co-pay	80%*	Precertification is required.
* Deductible applies.			

	In-Network	Out-Of-Network	Limitations and Explanations
Rehabilitative Therapy – Physical / Occupational/ Speech	100% after $15 co-pay	80%*	Limited to 20 visits per calendar year.
Rehabilitative Therapy – Pulmonary	100% after $15 co-pay	80%*	
Rehabilitative Therapy – Respiratory	100% after $15 co-pay	80%*	
Second Surgical Opinions	100% after $15 co-pay	80%*	
Skilled Nursing Facility	100%	80%*	Precertification is required. Limited to 50 days per calendar year.
Sleep Studies	100% after $15 co-pay	80%*	
Transfusion	100% after $15 co-pay	80%*	
All Other Covered Expenses	100%	80%*	Limited to covered expenses as described in the Summary Plan Description.
*Deductible applies			

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – A Class 00418020 AT03 ATA3 Co-Pay Option: $5/$10/$15			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$5	$5	
Tier 2 Drug Co-pay	$10	$10	
Tier 3 Drug Co-pay	$15	$15	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – B Class 00418019 00A3 00A4, 00418020 AT04 AT19, 00418021 0T02, 00418058 00A3, 00418059 0T02 Co-Pay Option: $7/$15/$25			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$7	$7	
Tier 2 Drug Co-pay	$15	$15	
Tier 3 Drug Co-pay	$25	$25	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – C Class 00418019 00C1 00D1, 00418020 D026 DA26 DB26 DC26 C023, 00418021 0001 0004, 00418058 0D1, 00418059 0001 0004, 00418068 0004 C023 Co-Pay Option: $5/$10/$25			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$5	$15	
Tier 2 Drug Co-pay	$10	$30	
Tier 3 Drug Co-pay	$25	$75	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – D Class 00418019 00D2 00D3 00C2, 00418020 D025 DA25 C024, 00418058 00C2, 00418068 C024 Co-Pay Option: $7/$15/$35			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$7	$21	
Tier 2 Drug Co-pay	$15	$45	
Tier 3 Drug Co-pay	$35	$105	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – E Class 00418022 0T01 Co-Pay Option: $3/$15/$30			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$3	$7.50	
Tier 2 Drug Co-pay	$15	$37.50	
Tier 3 Drug Co-pay	$30	$75	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – F Class 00418019 00B2, 00418020 B022, 00418021 0005, 00418022 0001, 00418023 0001 00R6, 00418058 00B2, 00418059 0005, 00418061 0001 00R6, 00418068 00R6 Co-Pay Option: $3/$15/$30			
	Pharmacy/	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$3	$9	
Tier 2 Drug Co-pay	$15	$45	
Tier 3 Drug Co-pay	$30	$90	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – G Class 00418019 00B3, 00418020 B021, 00418021 0003, 00418059 0003, 00418068 B021 Co-Pay Option: $5/$15/$30			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$5	$15	
Tier 2 Drug Co-pay	$15	$45	
Tier 3 Drug Co-pay	$30	$90	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – H Class 00418019 00B4 00B5, 00418020 B020, 00418058 00B5, 00418068 B020 Co-Pay Option: $7/$15/$30			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$7	$21	
Tier 2 Drug Co-pay	$15	$45	
Tier 3 Drug Co-pay	$30	$90	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – I Class 00418019 00A5 00B6, 00418020 A027 B028 Co-Pay Option: $1/$15/$30			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$1	$3	
Tier 2 Drug Co-pay	$15	$45	
Tier 3 Drug Co-pay	$30	$90	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – J Class 00418019 00A1, 00418020 AT02 ATA2, 00418021 0T01, 00418022 ATA2, 00418023 0T03, 0T06, 0T07, 00418058 0A1, 00418059 0T01, 00418060 0T03, 00418061 0T03 0T06 0T90, 00418068 AT02 ATA2 Co-Pay Option: $5/$10			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$5	$5	
Tier 2 Drug Co-pay	$10	$10	
Maximum Supply	34 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – K Class 00418020 AT09 AT10 ATA9, 00418068 AT09 AT10 Co-Pay Option: $1/$5			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$1	$1	
Tier 2 Drug Co-pay	$5	$5	
Maximum Supply	34 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – L Class 00418020 AA17 AT14 AT15 AT16 AT17 AT18, 00418023 0T04, 00418061 0T04, 00418068 AT16 AT17 Co-Pay Option: $.50			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$.50	$1.50	
Tier 2 Drug Co-pay	$.50	$1.50	
Maximum Supply	34 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – M Class 00418020 AT06 AT11 AT12 AT13, 00418023 0T05, 00418061 0T05, 00418068 AT12 Co-Pay Option: $1			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$1	$3	
Tier 2 Drug Co-pay	$1	$3	
Maximum Supply	34 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – N Class 00418020 AT08, 00418023 LT03, 00418061 LT03, 00418068 AT08 Co-Pay Option: $5			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$5	$15	
Tier 2 Drug Co-pay	$5	$15	
Maximum Supply	34 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – O Class 00418020 AT05 AT07 Co-Pay Option: $3/$7			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$3	$9	
Tier 2 Drug Co-pay	$7	$21	
Maximum Supply	34 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – P Class 00418019 BRNZ Co-Pay Option: $15/50%/50%			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$15	$45	
Tier 2 Drug Co-pay	50%	50%	
Tier 3 Drug Co-pay	50%	50%	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – AA Class 00418019, 00418020, 00418058 (DBC), 00418068 (DBC) 00A6 Co-Pay Option: $$10/$25/$25			
	Pharmacy	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$10	$10	
Tier 2 Drug Co-pay	$25	$25	
Tier 3 Drug Co-pay	$25	$25	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – AB Class 00418019, 00418020, 00418058 (DBC), 00418068 (DBC) 00B7 Co-Pay Option: $$10/$25/$25			
	Pharmacy Or Mail Order	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$10	$30	
Tier 2 Drug Co-pay	$25	$75	
Tier 3 Drug Co-pay	$25	$75	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – AC Class 00418019, 00418020, 00418058 (DBC), 00418068 (DBC) 00C3 Co-Pay Option: $$10/$25/$25			
	Pharmacy Or Mail Order	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$10	$30	
Tier 2 Drug Co-pay	$25	$75	
Tier 3 Drug Co-pay	$25	$75	
Maximum Supply	30 Days	90 Days	

SCHEDULE OF PRESCRIPTION DRUG BENEFITS – AD Class 00418019, 00418020, 00418058 (DBC), 00418068 (DBC) 00D4 Co-Pay Option: $$10/$25/$25			
	Pharmacy Or Mail Order	**Mail Order**	**Limitations and Explanations**
Tier 1 Drug Co-pay	$10	$30	
Tier 2 Drug Co-pay	$25	$75	
Tier 3 Drug Co-pay	$25	$75	
Maximum Supply	30 Days	90 Days	

INTRODUCTION

Buffalo Board of Education has prepared this document to help you understand your benefits. **PLEASE READ IT CAREFULLY AS YOUR BENEFITS ARE AFFECTED BY CERTAIN LIMITATIONS AND CONDITIONS.** Also, benefits are not provided for certain kinds of treatments or services, even if your health care provider recommends them.

This Plan provides benefits only for covered expenses; payment is based on the lesser of actual charges or the applicable *fee schedule*. However, any amounts you are obligated to pay in excess of the amount listed in our *fee schedule* or in excess of any dollar limitation on benefits will not be counted in determining when you, or a member of your family, have reached the maximum payments in a calendar year. In addition, you will remain responsible for all charges in excess of the amount listed in the applicable *fee schedule* even after the thresholds are met.

This document is written in simple, easy-to-understand language. Technical terms are printed in *italics* and defined in the Definitions section. The headings in the Plan are inserted for convenience of reference only and are not to be construed or used to interpret any of the provisions of the Plan.

As used in this document, the word *year* refers to the *calendar year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *calendar year*. The word *lifetime* as used in this document refers to the period of time a covered person is a participant in this Plan sponsored by Buffalo Board of Education

Benefits described in this document are effective March 1, 2017. The terms and conditions of the Buffalo Board of Education Employees Employee Benefit Plan are governed by the provisions in this document. Any and all other written communication regarding the Plan or the benefits provided under the Plan are superseded and are of no force or effect.

This Plan is in compliance with all applicable federal laws. In the event of a change in federal law, the Plan will be deemed to be in compliance and administered accordingly.

ARTICLE I -- ELIGIBILITY AND PARTICIPATION

A. Who Is Eligible

You are eligible to participate in this Plan if you are a

1. regularly scheduled employee of the District. Eligibility is determined by the Collective Bargaining Agreement or individual employment contract.

    a. **BTF**: All full-time Permanent, Probationary and Temporary employees. Part-time who work at least half time .5 (day school only) @ 50% of the total premium cost (.6 @ 40%, etc.).

    b. **BCSA**: All full-time Permanent, Probationary and Temporary employees.

    c. **PCTEA**: All full-time Permanent and Provisional employees.

    d. **Local 264 - Laborers and Cook Managers**: All full-time Permanent and Provisional employees. Employees with spouses who are eligible for health insurance coverage through employment with the BCSD or the City of Buffalo must choose between enrollment with BCSD or the City. Only one spouse may enroll and then only for family coverage.

    e. **Local 409 Engineers**: All full-time Permanent and Provisional employees.

    f. **Exempt**: Eligible per individual contracts.

    g. **Substitute Teachers**: May enroll paying 100% of the cost. Must have worked 30 days in the prior school year.

    h. **Food Service Helpers**: May enroll paying 100% of the cost.

    i. **Tradesmen**: May enroll paying 100% of the cost.

    j. **BEST**: Employees who work at least six hours per day (30 hours per week) and meet all other eligibility requirements. Employees hired on or after 7/1/85 are eligible for the health plan through employment with the BCSD only if they are not eligible for a health plan with comparable benefits through a spouse, former spouse, another employer or agency, and contributions are less than or equal to 25% of the cost of the plan.

    k. **Custodians – Local 409 Employees**: Eligible employees work 40 hours per week. Part time, seasonal, and temporary employees are not eligible for coverage.

l. **Westminster Charter School**: While not employees of the BBOE, the Charter School provides health insurance coverage to employees as stated in the various contracts between each Union and the BBOE, including BTF, BCSA, PCTEA, Substitute Teachers, and BEST.

2. qualified *retiree* of Buffalo Board of Education as determined by the Collective Bargaining Agreement or individual employment contract.

a. **BTF**

i. Applicable to employees retired before July 1, 2001: a former employee who retires from the District with a minimum of 15 years of active full time service.

ii. Applicable to employees retired on or after July 1, 2001: a former employee who retires from the District with a minimum of 15 years of active full time service. To be eligible, retirees must also receive benefits from the New York State Teachers' Retirement System within 45 days of the date of separation.

b. **BCSA**: A former employee who retires directly into the New York State Teachers' Retirement System with a minimum of 17 years of active full time service with the Board.

c. **PCTEA**

i. Applicable to employees hired before July 1, 1998: a former employee who retires with a minimum of 10 years of active service.

ii. Applicable to employees hired on or after July 1, 1998: a former employee who retires with a minimum of 15 years of active service.

Length of service includes all continuous temporary, provisional, and permanent service with the Board and the City of Buffalo.

d. **Local 264 - Laborers and Cook Managers**

i. Applicable to permanent and provisional employees hired prior to January 1, 2003 and retired after January 15, 2003: a former employee who retires with a minimum of 10 years of full time service. Length of service includes all temporary, provisional, and permanent service with the District, the City of Buffalo, and the BMHA.

ii. Applicable to permanent and provisional employees hired after January 1, 2003: a former employee who retires with a minimum of 15 years of full time service with the District. If the employee receives a work-related disability retirement with the New York State Retirement System, then only 10 years of credited service will be required.

e. **Local 409 Engineers**

i. Applicable to employees hired before June 30, 2003: a former employee who retires directly into the New York State Employees' Retirement System with a minimum of 17 years of active full time service. Length of service includes all temporary, provisional, and permanent service with the District, the City of Buffalo, and other City agencies. However, at least 10 years of qualifying service must be with the District.

ii. Applicable to employees hired on or after June 30, 2003: a former employee who retires directly into the New York State Employees' Retirement System with a minimum of 17 years of active full time service with the District.

f. **Exempt**: A former employee who has 10 years of service all with BCSD.

g. **BEST**: A former employee who retires directly into the New York State Employees' Retirement System or New York State Teachers' Retirement System and completes the required years of active service with the District immediately prior to retirement as outlined below:

i. Applicable to employees retired on or after July 1, 1996: 12 years of active service.

ii. Applicable to employees retired on or after January 1, 2004: 13 years of active service.

If the employee did not join either System, the employee can still be eligible as long as the employee meets the criteria established for retirement by either System.

h. **Custodians – Local 409 Employees**: A former employee who has 20 years of full time continuous service and is retired into social security due to age (62) or full social security disability status. Surviving spouses of Qualified Retirees are not eligible for continued coverage but may elect COBRA.

i. **Westminster Charter School:** Health insurance coverage is extended to employees in retirement as stated in the various contracts between each Union and the BBOE, including BTF, BCSA, PCTEA, Substitute Teachers and BEST.

Your eligible dependents may also participate. Eligible dependents include:

1. A legal spouse.

2. A child from birth to age twenty-six (26).

   The term child includes:

   a. a natural child;

   b. a step-child by legal marriage;

   c. a child who is adopted or has been placed with you for adoption by a court of competent jurisdiction;

   d. a child for whom legal guardianship has been awarded, provided that to be eligible for coverage, the child must legally reside with you in a parent-child relationship and be primarily dependent on you for maintenance and support;

   e. a child who is the subject of a *Qualified Medical Child Support Order* (QMCSO) dated on or after August 10, 1993. To be "qualified," a state court medical child support order must specify: the name and last known mailing address of the Plan participant and each alternate recipient covered by the order, a reasonable description of the type of coverage or benefit to be provided to the alternate recipient, the period to which the medical child support order applies, and each plan to which the order applies; and

   f. an unmarried child who is incapable of self-sustaining employment by reason of mental or physical disability and is primarily dependent on you for maintenance and support may continue to be covered under this Plan regardless of age, so long as the disability persists, and the disability began before the child reached age twenty-six (26).

      In order to continue coverage, you must furnish written proof of the disability within thirty-one (31) days of the child's twenty-sixth (26th) birthday. The *Plan Administrator* may require you to furnish periodic proof of the child's continued disability but not more often than annually. If such proof is not satisfactory to the *Plan Administrator*, coverage for the child will end immediately.

You may not participate in this Plan as an employee and as a dependent. In addition, a person may not participate in this Plan as a dependent of more than one (1) employee.

No one who is on active duty with the armed forces will be eligible for coverage under this Plan.

B. Who Pays For Your Benefits

Buffalo Board of Education pays for or shares the cost of providing benefits for you and your dependents.

C. Enrollment Requirements

If you desire Plan benefits, you must enroll by properly completing and returning an enrollment form and supporting documentation to the Buffalo Board of Education Benefits Department, Room 806 City Hall, Buffalo, New York 14202. Although you may be eligible for the health plan on the date you begin your employment (or as stated per your individual contracts), it is essential that your completed application and supporting documentation be submitted timely to avoid a delay. In order to secure your health coverage, it is recommended that you return the required paperwork within thirty (30) days of your eligibility date. If you also desire coverage for your dependent(s), you must enroll them by this deadline. If you do not have any eligible dependents at the time of initial enrollment but acquire eligible dependents at a later date, you must enroll dependents, including newborns, by properly completing and returning an enrollment form to Buffalo Board of Education within thirty (30) days of the date they become your dependent(s).

Failure to enroll by the deadline noted above will subject you and your dependents to the Late Enrollment, or Special Enrollment Period provisions below. If a new employee returns an enrollment form later than 30 days from the initial eligibility date, then the new effective date of coverage shall be the first of the month following receipt of the enrollment form and supporting documentation, unless the plan administrator assigns a different date.

D. Late Enrollment

If an eligible employee or dependent declined coverage at the time initially eligible, coverage cannot become effective until the next annual *open enrollment period* unless application for coverage was due to a Special Enrollment as defined under the Special Enrollment Period provision below. The employee or dependent must request enrollment in this Plan within the *open enrollment period.* This provision does not apply to a dependent who becomes eligible for coverage as the result of a *Qualified Medical Child Support Order*, or who is adopted or is placed with you for adoption by a court of competent jurisdiction, as long as he is enrolled within thirty-one (31) days of his eligibility date. This provision does not apply to the employee who enrolled in the Waiver of Health Insurance Program with the BCSD.

The *enrollment date* for a *late enrollee* is the first day of coverage. Thus, the time between the date a *late enrollee* first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a *waiting period*.

E. Special Enrollment Periods

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*. Special Enrollment Periods apply to the following:

1. Individuals losing other coverage. An employee or dependent that is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

    a. The employee or dependent was covered under a group health plan, Medicaid including coverage under state funded Children's Health Insurance Plan (CHIP) 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. The coverage of the employee or dependent who has lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either 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 toward the coverage were terminated.

    d. The employee requests enrollment in this Plan not later than:

        i. thirty (30) days following the termination of coverage or employer contributions, as described above;
        ii. thirty (30) days following the date COBRA coverage was exhausted;
        iii. sixty (60) days following the termination of Medicaid or CHIP.

    NOTE: If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

2. Dependent beneficiaries. If:

    a. The employee is a participant under this Plan (or has met the *waiting period* applicable to becoming a participant under this Plan and 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 (and if not otherwise enrolled, the employee)

may be enrolled under this Plan as a covered dependent of the employee. In the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage.

The dependent Special Enrollment Period is a period of thirty (30) days and begins on the date of the marriage, birth, adoption or placement for adoption.

3. Coverage for a *special enrollee*, as stated above in Section 1., shall begin on the day following the loss of coverage. Coverage for a *special enrollee*, as stated above in Section 2., shall begin as of the date of the marriage, birth, adoption or placement for adoption.

F. When Coverage Begins

When the enrollment requirements are met, your coverage begins on your date of hire.

Coverage as a *retiree* under this plan begins on the first day of the month following your retirement date.

Coverage for your eligible dependents begins the later of when your coverage begins or the first day a dependent becomes your dependent.

However, should coverage commence under the Late Enrollment or Special Enrollment Period sections, the provision under these sections will apply.

G. When Coverage Ends

Applicable for Active Employees:

Your coverage ends the earliest of the last day of the month following your last day of full-time regular employment; the date you are no longer eligible to participate in the Plan; or the date the Plan ends.

Coverage for your dependents ends the earliest of the date your coverage ends; the date a dependent no longer meets the eligibility requirements; or the date the Plan ends.

Applicable for Retirees:

Your coverage ends the earliest of the day following your death, or the date the plan ends.

Coverage for your dependents ends the earliest of the date your coverage ends; the date a dependent no longer meets the eligibility requirements; or the date the Plan ends.

H. Extension Of Coverage

Your coverage may be extended if you are approved for a leave of absence, in accordance with FMLA, your labor agreement, or your individual contract.

I. Reinstatement Of Coverage

If you terminate employment due to a layoff and are rehired, coverage will be reinstated on the day of rehire provided you enroll within thirty-one (31) days of your eligibility date.

ARTICLE II -- MEDICAL MANAGEMENT PROGRAM

A. What Is Medical Management

Buffalo Board of Education desires to provide you and your family with a health care benefit plan that helps protect you from significant health care expenses and helps to provide you with quality care.

THE PROGRAM IS NOT INTENDED TO DIAGNOSE OR TREAT MEDICAL CONDITIONS, GUARANTEE BENEFITS, OR VALIDATE ELIGIBILITY. The medical professionals who conduct the program focus their review on the appropriateness of treatment. Any questions pertaining to eligibility, Plan limitations or *fee schedules* should be directed to the eligibility and claims department.

Your participating *physician* or *provider* is required to call to obtain certification prior to:

- Any *inpatient hospital* admission.
- Home health aide.
- MRI/MRA/CAT/PET, for local participating providers only.
- Any *skilled nursing facility* admission.
- Some *durable medical equipment.*
- Orthotics.
- External prosthetics.
- Non-emergency air ambulance transport.
- Injectable medications, non-self administered, for local participating providers only.

B. Reduced Benefits For Failure To Follow Required Review Procedures

When the required review procedures outlined above are followed, your benefits will be unaffected. However, failure to comply with this provision may result in a penalty being applied to eligible expenses related to the treatment:

- When services are received from a participating provider, precertification will be obtained by the *health care provider*. If certification is not received, the benefit paid to the provider may be reduced. You can not be billed for the amount of the benefit reduction.

- If services are not provided by a participating provider, no benefit will be paid toward treatment that is determined not to be *medically necessary*.

ARTICLE III – NETWORK PROVISIONS

Your provider network has an extensive directory of conveniently located, participating *physicians* and *hospitals*. If you have any questions regarding a local participating provider or local network availability, call the phone number indicated on your identification card.

A preferred provider organization (PPO) is a negotiated arrangement in which selected *health care providers* (e.g. *physicians* and *hospitals*) contract to provide services for you and your eligible dependents for a pre-determined price.

In the PPO Plan, you may see any *health care provider* for covered health care services whenever you like. However, when you see a *health care provider* who is not a participating provider, you will receive a lesser benefit as outlined on the Schedule of Medical Benefits, and your out-of-pocket expenses will be greater.

Referrals by participating providers to non-participating providers will be considered as non-network services or supplies and will be payable at the non-network benefit level. In order to have services and supplies paid at the network benefit level, ask your *physician* to refer you to participating providers (e.g. x-ray specialists, etc.).

Exceptions:

If you receive emergency room treatment at a network facility, any services rendered by a physician during the emergency room encounter will be reimbursed at the network benefit level, regardless of whether the provider is participating with the contracted network.

Professional components charges rendered in a network facility regardless of whether the provider is participating with the preferred provider organization will be reimbursed at the network benefit level.

ARTICLE IV -- MEDICAL BENEFITS

A. About Your Medical Benefits

All medical benefits provided under this Plan must satisfy some basic terms. The following terms which apply to your Plan's benefits are commonly included in medical benefit plans but often overlooked or misunderstood.

1. Medical Necessity

   Medically necessary care is care which according to criteria, is:

   - consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury,
   - in accordance with standards of good medical practice,
   - not for your convenience or that of your physician or other provider,
   - the most appropriate supply, level of care, or service which can be safely provided to you.

   The *Plan Administrator* may consult the *Medical Director* of the *Claims Processor* in order to determine the medical necessity of treatment. Medical treatments which are not proven, effective and appropriate are not covered by this Plan unless specifically mentioned.

2. Health Care Providers

   The Plan provides benefits only for covered services and supplies rendered by a *physician, practitioner, nurse, hospital,* or *specialized treatment facility* as those terms are specifically defined in the Definitions section.

3. Custodial Care

   The Plan does not provide benefits for services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider.*

4. Calendar Year

The word *year,* as used in this document, refers to the *calendar year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *calendar year.*

5. Alternate Benefit Provision

The *Plan Administrator* may elect to provide alternative benefits which are not listed as covered services in this contract. The alternative covered benefits should be determined on a case by case basis by the *Plan Administrator* for services which the *Plan Administrator* deems are *medically necessary*, cost effective and agreeable to the covered person and participating provider. The *Plan Administrator* shall not be committed to provide these same, or similar alternative benefits for another covered person nor shall the *Plan Administrator* lose the right to strictly apply the express provisions of this contract in the future.

B. Deductibles

A deductible is the amount of covered expenses you must pay during each *calendar year* before the Plan will consider expenses for reimbursement. Co-payments do not apply to the deductible.

If two (2) or more covered members of your family are injured in a common accident, the deductible will be applied only once to all involved persons for those injuries.

Applicable to all plans except Schedule of Medical Benefits – N:

C. Deductible Carry-Over

When covered expenses incurred in the last three (3) months of the *year* are applied to the deductible, that amount will also be used to satisfy the deductible for the following *year*.

D. Coinsurance

Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed the applicable *fee schedule.*

The coinsurance percentages are shown on the Schedule of Medical Benefits.

E. Maximum Out-Of-Pocket Amount

A maximum out-of-pocket amount is the maximum amount of covered expenses you must pay during a *calendar year,* excluding the deductible, before the payment percentage of the Plan increases. When a covered individual and/or family reaches their annual maximum out-of-pocket amount, the Plan will pay one hundred percent (100%) of additional covered expenses, subject to any applicable co-payments, for that individual and/or family during the remainder of that *calendar year.*

The maximum out-of-pocket amount excludes charges in excess of the *fee schedule* for out-of-network services, and any penalties for failure to comply with the requirements of the Medical Management Program.

The annual individual and family maximum out-of-pocket amounts are shown on the Schedule of Medical Benefits.

F. Benefit Maximums

Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime.* Whenever the word *lifetime* appears in this Plan in reference to benefit maximums, it refers to the time you or your dependents are covered by this Plan.

The benefit maximums applicable to this Plan are shown in the Schedule of Medical Benefits.

G. Covered Medical Expenses

When all of the requirements of this Plan are satisfied, the Plan will provide benefits as outlined on the Schedule of Medical Benefits but only for the services and supplies listed in this section.

Hospital Services

1. Room and board, not to exceed the cost of a semiprivate room or other accommodations unless the attending *physician* certifies the *medical necessity* of a private room. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in the geographic area.

   The Plan may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

The attending provider, after consulting with the mother, may discharge the mother and newborn earlier than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section.

2. *Intensive care unit* and coronary care unit charges.

3. Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.

4. Well-baby nursery and *physician* expenses during the initial *hospital* confinement of a newborn.

5. *Hospital* confinement expenses for dental services if the attending *physician* certifies that hospitalization is necessary to safeguard the health of the patient.

6. *Outpatient hospital* services.

Emergency Services

1. Treatment in a *hospital* emergency room or other emergency care facility.

2. Ground transportation provided by a professional ambulance service for the first trip to and from the nearest *hospital* or emergency care facility equipped to treat a condition that can be classified as a *medical emergency*.

Applicable to Schedule of Medical Benefits – A, B, D, E, F, G, J, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, AB, AC and AD

3. Transportation provided by a professional air ambulance service for the first trip to the nearest *hospital* or emergency care facility equipped to treat a condition that can be classified as a *medical emergency.*

Specialized Treatment Facilities

1. A *skilled nursing facility* or extended care facility.

2. An *ambulatory surgical facility*.

3. A *birthing center*.

4. A mental/nervous treatment facility.

5. A substance abuse treatment facility.

6. A *hospice facility.*

7. An urgent care facility.

Surgical Services

1. Surgeon's expenses for the performance of a surgical procedure.

2. Assistant surgeon's expenses not to exceed twenty percent (20%) of the *usual and customary charge* of the surgical procedure.

3. Two (2) or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the *usual and customary charge* for the largest amount billed for one (1) procedure plus fifty percent (50%) of the sum of *usual and customary charges* for all other procedures performed.

4. Anesthetic services, when performed by a licensed anesthesiologist or certified registered *nurse* anesthetist in connection with a surgical procedure.

5. *Oral surgery*, limited to the removal of tumors and cysts; incisions of sinuses, salivary glands, or ducts; frenectomy; cleft lip and palate; extracting partial or completely unerupted teeth; and treatment of an accidental *injury* to sound and natural teeth. Treatment of an accidental *injury* must be completed within six (6) months of the date of the *injury*.

6. Reconstructive *surgery:*

    a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part;

    b. when needed to correct damage caused by an *illness* or accidental *injury;* or

    c. breast reconstructive *surgery* in a manner determined in consultation with the attending *physician* and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, *surgery* and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998.

7. Non-experimental organ and tissue transplant services to an organ transplant recipient who is covered under this Plan. In addition, benefits will be provided for *inpatient hospital* expenses of the donor of an organ for transplant to a covered recipient and for *physician's* expenses for surgical removal of the donor organ if the donor does not have coverage through another group plan. This benefit begins on the day of *surgery* and continues for up to ten (10) additional consecutive days. No benefits will be provided for organ selection, transportation and storage costs, or when benefits are available through government funding of any kind, or when the recipient is not covered under this Plan.

8. Circumcision.

9. *Outpatient surgery*.

10. Amniocentesis when the attending *physician* certifies that the procedure is *medically necessary*.

11. Surgical treatment of *morbid obesity* limited to one (1) such procedure per *lifetime*.

12. Surgical treatment of temporomandibular joint dysfunction (TMJ) and other craniomandibular disorders.

13. Voluntary sterilization.

14. Voluntary termination of pregnancy.

15. Gender reassignment *surgery*, when *medically necessary*, for individuals with a documented diagnosis of gender dysphoria.

Applicable to Schedule of Medical Benefits – C, D, E, F, G, H, I, J, K, L, and M:

16. Cosmetic surgery.

Mental/Nervous Conditions and Substance (Drug or Alcohol) Abuse Treatment

1. *Inpatient* mental/nervous treatment.

2. *Inpatient* substance abuse detoxification treatment.

3. *Outpatient* mental/nervous and substance abuse treatment.

4. *Outpatient* treatment of substance abuse codependence.

5. *Outpatient* marriage counseling.

6. *Outpatient* family counseling.

7. Treatment of an eating disorder.

8. Electro-shock therapy.

Medical Services

1. *Physician* office visits relating to a covered *illness* or *injury*.

2. Initial physician examination and subsequent physician office visits for prescription of medication for the treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).

3. *Inpatient physician* visits by the attending or non-attending *physician*.

4. *Second/Third* (if *medically necessary*) *Surgical Opinions*.

5. Pregnancy and related maternity care for all covered females.

6. Services to achieve the diagnosis of infertility.

7. Artificial insemination including sperm washing, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram (hysterosonography), post coital tests, testis biopsy, semen analysis, blood tests, and ultrasound.

8. Dental services received after an accidental *injury* to sound and natural teeth including replacement of such teeth; and any related x-rays and dental services must be completed within twelve (12) months of the date of the *injury*.

9. Radiation therapy.

10. Chemotherapy.

11. Hemodialysis.

12. Chiropractic services excluding *maintenance care* and palliative treatment.

13. Podiatric services for treatment of an *illness or injury*, or due to metabolic or peripheral vascular disease.

14. Physical therapy received from a qualified *practitioner* under the direct supervision of the attending *physician*, excluding *maintenance care* and palliative treatment.

15. Cardiac rehabilitation therapy received from a qualified *practitioner* under the direct supervision of the attending *physician*.

16. Home health care that is provided by a *home health care agency* (four (4) hours = one (1) visit). The following are defined as covered home health care services and supplies upon referral of the attending *physician*:

    a. part-time nursing services provided by or supervised by a registered *nurse* (R.N.);

    b. part-time or intermittent home health aide services;

    c. physical, occupational, speech or respiratory therapy which is provided by a qualified therapist;

    d. nutritional counseling that is provided by or under the supervision of a registered dietician;

    e. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.

17. *Hospice care* provided that the covered person has a life expectancy of six (6) months or less and subject to the maximums, if any, as set forth in the Schedule of Benefits. Covered *hospice care*, and bereavement expenses are limited to:

    a. room and board for confinement in a *hospice facility*;

    b. ancillary charges furnished by the hospice while the patient is confined therein, including rental of *durable medical equipment* which is used solely for treating an *injury* or *illness*;

    c. nursing care by a registered *nurse*, a licensed practical *nurse*, or a licensed vocational *nurse* (L.V.N.);

    d. home health aide services;

    e. home care charges for home care furnished by a *hospital* or *home health care agency*, under the direction of a hospice, including custodial care if it is provided during a regular visit by a registered *nurse*, a licensed practical *nurse*, or a home health aide;

    f. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.

    g. medical social services by licensed or trained social workers, psychologists, or counselors;

    h. nutrition services provided by a licensed dietician;

i. counseling and emotional support services by a licensed social worker or a licensed pastoral counselor;

j. bereavement counseling visits by a licensed social worker or a licensed pastoral counselor for the covered person's immediate family following the patient's death;

18. Speech therapy from a qualified *practitioner* to restore normal speech loss due to an *illness*, *injury* or surgical procedure. If the loss of speech is due to a birth defect, any required corrective *surgery* must have been performed prior to the therapy.

19. Occupational therapy but not to include vocational, educational, recreational, art, dance or music therapy.

20. Pulmonary therapy.

21. Respiratory therapy.

Applicable to Schedule of Medical Benefits N, O, P, Q, R, S, T, U, V, W, X, Y, Z, and AA

22. Orthoptic therapy.

23. Initial examination for the treatment of eating disorders (e.g., bulimia, anorexia). Subsequent treatment is eligible for consideration as a mental/nervous disorder.

24. Allergy testing and treatment.

25. Preparation of serum and injections for allergies.

26. Sleep studies.

27. Temporomandibular joint dysfunction (TMJ): non-surgical treatment or treatment for prevention of TMJ, craniomandibular disorders, and other conditions of the joint linking the jawbone and skull, muscles, nerves, and other related tissues to that joint.

28. Diabetes education programs.

29. Charges related to a provider discount for covered medical expenses resulting in savings to this Plan.

Applicable to Schedule of Medical Benefits – N:

30. *Medically necessary* services rendered in connection with an *approved clinical trial*.

Diagnostic X-Ray and Laboratory Services

1. *Diagnostic charges* for x-rays.

2. *Diagnostic charges* for laboratory services.

3. Preadmission testing (PAT).

4. Ultrasounds, prenatal laboratory and pregnancy testing.

5. Genetic testing and counseling.

Equipment, Supplies and Miscellaneous Items

Applicable to all plans <u>except</u> Schedule of Medical Benefits – X, Y, and AC:

1. *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing physician determining whether the equipment will be rented or purchased. Initial replacement equipment is covered if the replacement equipment is required due to a change in the patient's physical condition; or, purchase of new equipment is less expensive than repair of existing equipment.

Applicable to all plans <u>except</u> Schedule of Medical Benefits – P, X, and Y:

2. Artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition; or, replacement is less expensive than repair of existing equipment.

3. Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.

4. Blood and/or plasma, if not replaced, and the equipment for its administration including autologous blood transfusions when performed at the participating facility where related surgery will be performed.

5. Insulin infusion pumps.

6. Initial prescription contact lenses or eye glasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery* or when required as the result of an *injury*.

7. Examination for or the purchase or fitting of hearing aids when required as the result of an *injury*.

8. Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances, when prescribed by a *physician*, to replace lost body parts or to aid in their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the physical condition of the covered person.

9. Sterile surgical supplies after *surgery*.

10. Jobst garments.

11. Injectible drugs and medicines (including injectible contraceptives), or supplies dispensed through the *physician's* office, for which the patient is charged.

12. Post mastectomy prosthetic and surgical bra.

13. Drugs, medicines, or supplies dispensed through the *physician's* office, for which the patient is charged.

Applicable to all plans <u>except</u> Schedule of Medical Benefits – P, X, Y, AC and AD:

14. Orthotics.

Preventive Care

Applicable to Schedule of Medical Benefits – N:

Preventive care includes all mandated preventive care as required under the Patient Protection and Affordable Care Act.

Applicable to all plans <u>except</u> Schedule of Medical Benefits – N:

Preventive care is subject to the limitations and maximums described in the Schedule of Benefits. Preventive care includes the following:

1. Routine physical examination including related laboratory and x-ray testing.

2. Routine gynecological examination.

3. Routine pap test.

4. Routine mammogram.

5. Routine well child immunizations.

6. Routine adult immunizations.

7. Routine *outpatient* well child care examinations.

8. Routine flu vaccination.

9. Routine colonoscopy.

H. Medical Expenses Not Covered

The Plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. The Plan only covers those expenses for services and supplies specifically described as covered in the preceding section. There may be expenses in addition to those listed below which are not covered by the Plan.

General Exclusions

1. Any condition, disability, or expense sustained as a result of being engaged in an activity primarily for wage, profit or gain, and for which the covered person benefits are provided under Worker's Compensation Laws or similar legislation.

2. Communication, transportation expense, or travel time of *physicians* or *nurses*.

3. Educational, vocational, training services, supplies, or treatment except as specifically mentioned in Covered Medical Expenses.

4. Expenses for telephone conversations, charges for failure to keep a scheduled appointment, or charges for completion of medical reports, itemized bills, or claim forms.

5. Expenses resulting from penalties, exclusions or charges in excess of allowable limits imposed by HMO, non-HMO, or PPO providers resulting from failure to follow the required procedures for obtaining services or treatment.

6. Experimental equipment, services, or supplies which have not been approved by the United States Department of Health and Human Services, the American Medical Association (AMA), or the appropriate government agency.

7. Mailing and/or shipping and handling expenses.

8. Professional services performed by a person who ordinarily resides in your household or is related to the covered person, such as a spouse, parent, child, brother, sister, or in-law.

9. Services, supplies, or treatment eligible for consideration under any other plan of the *employer.*

10. Services, supplies, or treatment exceeding the *fee schedule* for the geographic area in which services are rendered.

11. Services, supplies, or treatment for which there is no legal obligation to pay, or expenses which would not be made except for the availability of benefits under this Plan.

12. Services, supplies, or treatment furnished by or for the United States Government or any other government, unless payment is legally required.

13. Services or supplies rendered by a facility operated by the Veteran's Health Administration for an injury or illness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

14. Services, supplies, or treatment incurred as the result of an auto accident up to the amount of any state required automobile insurance with respect to those expenses.

15. Services, supplies, or treatment incurred for services rendered prior to the effective date of coverage under this Plan or expenses for services performed after the date coverage terminates.

16. Services, supplies, or treatment not *medically necessary*.

17. Services, supplies, or treatment not prescribed or recommended by a *health care provider*.

18. Services, supplies, or treatment unnecessary for diagnosis of an *illness* or *injury*, except as specifically mentioned in Covered Medical Expenses.

19. Services, supplies, or treatment used to satisfy Plan deductibles, co-payments, or applied as penalties.

Additional Exclusions

The following exclusions are in alphabetical order to assist you in finding information quickly; however, you should review the entire list of exclusions when trying to determine whether a particular treatment or service is covered as the wording of the exclusion may place it in a different location than you might otherwise expect.

1. Acupuncture and/or acupressure.

2. Adoption expenses.

3. Ambulance transport except as specifically mentioned in Covered Medical Expenses.

4. Biofeedback.

5. Blood and storage of self-donated blood, except as specifically mentioned in Covered Medical Expenses.

6. Breast prosthetic implant removals whether inserted for cosmetic reasons or due to a mastectomy are not covered, unless the removal is *medically necessary*.

Applicable to Schedule of Medical Benefits – A, B, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, AB, AC, and AD:

7. *Cosmetic* or reconstructive *surgery* except as specifically mentioned in Covered Medical Expenses.

8. Dental services, extraction of teeth, dental appliances or treatment including hospitalization for dental services, except as specifically mentioned in Covered Medical Expenses.

9. Dispensing fees for drugs, medicines and supplies received in a Physician's office.

10. Donor expenses except as specifically mentioned in Covered Medical Expenses.

11. Donor organ selection, transportation and storage costs.

12. Drugs, medicine, or supplies that do not require a *physician's* prescription.

13. Education, counseling, or job training for learning disorders or behavioral problems whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.

14. Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.

15. Eyeglasses or lenses, vision therapy or supplies unless specifically mentioned in Covered Medical Expenses.

16. Foot treatment, palliative or cosmetic, including flat foot conditions, supportive devices for the foot, orthopedic or corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

17. Gender reassignment *surgery*, except as specified in Covered Medical Expenses.

18. Hearing examinations, hearing aids, or related supplies except as specifically mentioned in Covered Medical Expenses.

19. Holistic medical treatment.

20. *Hospital* confinement for physiotherapy, hydrotherapy, convalescent care, or rest care.

21. Hypnosis.

22. Infertility treatment other than artificial insemination services specifically mentioned in the Covered Medical Expenses section.

23. Kerato-refractive eye *surgery* (to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis *surgery*).

24. Long term acute care facility.

25. Massage therapy or rolfing.

Applicable to Schedule of Medical Benefits – N:

26. Non-routine services rendered in connection with an *approved clinical trial*, including:

    - The *experimental* treatment, procedure, device or drug itself.
    - Items or services provided solely to satisfy data collection and analysis.
    - Items or services customarily provided by the research sponsors free of charge.
    - Items or services provided solely to determine trial eligibility.

27. Orthodontics for cleft palate.

Applicable to Schedule of Medical Benefits N, O, P, Q, R, S, T, U, V, W, X, Y, Z, and AA:

28. Orthoptic therapy.

29. Personal comfort or service items while confined in a *hospital* including, but not limited to, radio, television, telephone, and guest meals.

30. Prescription drugs or medicines other than specifically mentioned in any Covered Medical Expenses section.

31. Preventive care except as specifically mentioned in Covered Medical Expenses.

32. Private duty nursing.

33. Respite care.

34. Reversal of any elective surgical procedure.

35. Sales tax.

36. Sanitarium, rest, or *custodial care*.

37. Sex counseling.

Applicable to Schedule of Medical Benefits – N:

38. Smoking cessation programs, smoking cessation medications, or *physician's* office visits for smoking cessation treatment, except as required by the Patient Protection and Affordable Care Act.

Applicable to all plans <u>except</u> Schedule of Medical Benefits – N:

39. Surrogate expenses, including use of a surrogate by a covered individual or services as a surrogate by a covered individual.

Applicable to Schedule of Medical Benefits – C, H, I, K, and L:

40. Transportation provided by a professional air ambulance service

41. Vitamins and nutritional supplements, regardless of whether or not a *physician's* prescription is required.

42. Weight reduction or control, including treatments, instructions, activities, or drugs and diet pills, whether or not prescribed by a *physician*, except as specifically mentioned in Covered Medical Expenses.

43. Wigs and artificial hair pieces.

ARTICLE V -- PRESCRIPTION DRUG PLAN

A. About Your Prescription Drug Benefits

All Prescription Drug benefits provided under this Plan must satisfy some basic terms. The following terms which may apply to your Plan's benefits are commonly included in Prescription Drug benefit plans but often overlooked or misunderstood.

1. Maintenance Medication

   An extended-use medication for which there is a non-emergency ongoing need.

2. Managed Formulary

   A list of approved generic and brand-name prescription and non-prescription drugs.

3. Participating Mail Order Pharmacy

   A pharmacy which has entered into an agreement with the Plan Administrator to provide covered mail order prescription drugs.

4. Participating Pharmacy

   A pharmacy which has entered into an agreement with the Plan Administrator to provide you covered prescription drugs.

5. Pharmacy Benefits Manager

   A Pharmacy Benefits Manager (PBM) is a third party administrator selected to process outpatient medication bills. The Pharmacy Benefits Manager has been contracted to process prescription drug claims from participating pharmacies. The Pharmacy Benefits Manager also develops and maintains the formulary.

6. Prescription Drug

   A pharmaceutical substance approved by the United States Food And Drug Administration (USFDA) for the treatment of your condition and dispenses in accordance with labeling guidelines. A prescription drug requires a prescription in order to be sold to you, and the label must bear the statement “Caution – Federal Law Prohibits Dispensing without a Prescription.”

7. Prior Authorization

   A system whereby the prescribing *physician* must contact the Corporate Pharmacy Department for approval prior to the provision of certain prescription drugs covered under the plan.

B. Prior Authorization

Your *physician* is required to obtain prior authorization prior to your purchase of certain medications. To find out if a medication requires prior authorization or the status of a prescription, call Medco Pharmacy Member Services 1-800-939-3751.

C. Pharmacy Dispensing Limitations

Applicable to enrollees in Schedule of Prescription Drug Benefits J, K, L, M, N, and O:

Prescriptions are covered for up to a thirty-four (34) day supply, or 100 unit doses, whichever is greater; or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops. Prescriptions are covered for up to a ninety (90) day supply for certain chronic conditions when authorized by your *physician*. Three (3) co-pays will apply to the purchase of brand-name extended cycle oral contraceptives.

Applicable all other enrollees:

Prescriptions are covered for up to a thirty (30) day supply, or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops, or up to a ninety (90) day supply for certain chronic conditions when authorized by your *physician*. One co-pay will apply to each thirty (30) day supply. Three (3) co-pays will apply to the purchase of brand-name extended cycle oral contraceptives.

The Plan reserves the right to impose additional supply limitations based on relevant medical and/or scientific information available regarding the condition being treated and/or the appropriate medical use of the medication.

Exception: Drugs allowed by New York State law to be dispensed in ninety (90) or one hundred eighty (180) day supply will be dispensed in accordance with the regulation.

Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist.

D. Co-Payments

The co-payment amounts are shown on the Schedule of Prescription Drug Benefits.

Exception: The lesser of the prescription drug co-payment or the office visit co-payment applies to diabetic medications. The office visit co-payment will apply to diabetic supplies.

E. Covered Prescription Drugs

Prescriptions covered under your Plan include all drugs bearing the legend "Caution: Federal law prohibits dispensing without a prescription" except as identified in Prescription Drugs Not Covered. In addition, the following are specifically covered by this Plan when accompanied by a *physician's* prescription:

1. Diabetic medications, including insulin, glucagon, prefilled insulin pens/cartridges, and prescription oral agents to lower blood sugar.

2. Diabetic supplies, including needles, syringes, test strips, lancets, lancet devices, glucose tablets and alcohol swabs.

3. Contraceptives.

4. Infertility medications.

5. Impotence medications.

6. Anti-obesity medications, only when prescribed for the treatment of m*orbid obesity*.

7. Acne medications.

8. Smoking deterrents.

9. Prenatal vitamins.

10. Fluoride supplements.

11. Nutritional supplements, limited to *medical necessity*.

12. Anabolic steroids.

13. Growth hormones.

14. Self-injectable legend drugs, except those listed in Prescription Drugs Not Covered.

15. Compounded medication of which at least one (1) ingredient is a generic legend drug.

16. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a *physician* or other lawful prescriber.

F. Prescription Drugs Not Covered

1. Cosmetic medications, including but not limited to, anti-wrinkle agents, hair growth stimulants, hair removal products and pigmenting/depigmenting agents.

2. Immunization agents.

3. Blood or blood plasma.

4. Vitamins, except as specifically mentioned in Covered Prescription Drugs.

5. Allergy extracts.

6. Anti-obesity medications, except as specifically mentioned in Covered Prescription Drugs.

7. Infusion therapy.

8. Non-legend drugs except as specifically mentioned in Covered Prescription Drugs.

9. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except as specifically mentioned in Covered Prescription Drugs.

10. Charges for the administration or injection of any drug.

11. Drugs labeled "Caution: Limited by Federal law to investigational use," or *experimental* drugs even though a charge is made to the individual.

12. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed *hospital*, rest home, sanitarium, *skilled nursing facility*, convalescent *hospital*, nursing home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.

13. Any prescription refilled in excess of the number specified by the *physician*, or any refill dispensed more than one (1) year from the *physician's* original order.

G. Mail Order Prescription Drug Program

The mail order prescription drug program is offered when there is an ongoing need for medication. By using this service, you can obtain prescribed medication required on a non-emergency, extended-use basis. The quantity of a prescribed drug ordered through this program can be anything up to a ninety (90) day supply or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops.

The law requires that pharmacies dispense the exact quantity prescribed by the *physician*. So, if your *physician* authorizes the maximum order quantity, the prescription must be for a ninety (90) day supply for you to receive that quantity. For example, if you take one (1) tablet per day, your *physician* must write a prescription for ninety (90) tablets. If you take two (2) tablets per day, your *physician* must write a prescription for one hundred and eighty (180) tablets, etc. If your *physician* authorizes refills, these can be dispensed only when your initial order is nearly exhausted, so be sure to ask your *physician* to prescribe the normal supply, plus refills whenever appropriate.

There will be times when you need a new prescription filled immediately. If you need medication immediately but will be taking it on an ongoing basis, ask your *physician* for two (2) prescriptions. The first prescription should be for up to a thirty (30) day supply that you can have filled at a local pharmacy; the second prescription should be for your ongoing need, which will be dispensed in up to a ninety (90) day supply. Send the larger prescription through the mail service prescription drug program.

ARTICLE VI -- COORDINATION OF BENEFITS (COB)

A. General Provisions

When you and/or your dependents are covered under more than one (1) group health plan, the combined benefits payable by this Plan and all other group plans will not exceed one hundred percent (100%) of the eligible expense incurred by the individual. The plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group health plan. Any group health plan which does not contain a coordination of benefits provision will be considered primary.

When this Plan is the secondary payor, it will reimburse, subject to all Plan provisions, the balance of remaining expenses, not to exceed normal Plan liability.

Applicable to POS Network Providers:

When more than one coverage exists, one plan normally pays its benefits in full and the other plan pays a reduced benefit. If this Plan is the primary plan, it will consider benefits as if it were the only plan. If this Plan is the secondary plan, it may make additional payment for covered expenses after any applicable deductible, but only to bring the cumulative total paid by both plans combined to the amount that this Plan would have paid if it were the only plan.

For example, assume your spouse's employer plan is primary for your dependent children's expenses. If the expense is $150, a claim for this amount must be submitted first with the spouse's employer plan, which determines a benefit of $120 is payable. Next, a claim for the $150 along with proof of payment of $120 from the spouse's plan should be submitted for payment under this Plan. The benefit under this Plan will be determined as if it was the only Plan. If the benefit under this Plan is $120 or less, no additional benefit is payable. If the benefit payable under this Plan is $135, an additional $15 is payable from this Plan.

B. Automobile Coverage

Benefits payable under this Plan will be coordinated with benefits provided or required by any no-fault automobile coverage statute, whether or not a no-fault policy is in effect, and/or any other automobile coverage. This Plan will be secondary to any state mandated automobile coverage for services and supplies eligible for consideration under this Plan.

C. Federal Programs

The term "group health plan" includes the Federal programs *Medicare* and Medicaid. The regulations governing these programs take precedence over the order of determination of this Plan.

D. Order of Benefit Determination – Employee / Spouse

When all other group health plans covering you and/or your spouse contain a coordination of benefits provision, order of payment will be as follows:

1. The plan covering a person as an active employee will be primary over a plan covering the same person as a dependent, a retiree, a laid-off individual or in some other capacity.

2. When a person is an active employee under more than one (1) plan, the plan covering the individual for the longer period of time will be considered primary.

3. The plan covering a person as an employee or a dependent will be primary over the plan providing continuation coverage (COBRA).

E. Order of Benefit Determination – Children

The group health plan covering an individual as a dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

When all plans covering a person as a dependent child of divorced or separated parents contain a coordination of benefits provision, the order of payment will be:

1. The plan covering the dependent child of the natural parent designated by court order to be responsible for the child's health care expenses will be considered primary.

2. In the absence of a court order specifying otherwise, the plan covering the dependent child of the natural parent having legal custody of the child will be considered primary.

3. In the absence of a court order specifying otherwise, the plan covering the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child will be considered primary.

4. If there is a court decree stating that both parents share joint custody, without stipulating that one of the parents is responsible for the child's health care expenses, the Birthday Rule will be used to determine the order in which benefits are considered.

F. Order of Benefit Determination - Medicare

If you are entitled to *Medicare* for any reason but chose not to enroll under *Medicare* Parts A and B when entitled, this Plan will process your claims as though *Medicare* Parts A and B had been elected. If the Plan determines that *Medicare* would have been the primary payor, if enrolled, this plan will calculate the amount that Traditional *Medicare* Parts A and B would have paid and coordinate benefits accordingly.

Many factors determine whether this Plan or *Medicare* is the secondary payor for you and your spouse including the number of people employed by your *employer* and disabling *illness* for which an individual is treated. This plan does not discriminate against *Medicare* beneficiaries for whom *Medicare* is the secondary payer. This Plan will not coordinate benefits for prescription drugs for an individual enrolled in a *Medicare* D plan. If you or your dependent enrolls in a *Medicare* D plan, benefits available under this Prescription Drug Plan will be terminated – such termination may result in termination of all Plan coverage.

If you are entitled to *Medicare* and remain actively at work (for an employer which employs more than 20 employees) you or your spouse may choose to remain covered under this Plan without reduction in *Medicare* benefits or you may designate *Medicare* as the exclusive payor of benefits. If you choose *Medicare* as the exclusive payor of benefits, coverage under this Plan will end. If you do not specifically choose *Medicare* as the exclusive payor of benefits, this Plan will continue to be primary. If you are under age sixty-five (65) and your spouse is over age sixty-five (65), he or she can make their own choice.

G. Right To Make Payments To Other Organizations

Whenever payments which should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision.

Amounts paid will be considered benefits paid under this Plan and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

ARTICLE VII -- SUBROGATION

This Plan has a right to be reimbursed 100% of any amounts paid whenever another party or parties is legally responsible or agrees to pay money due to an *illness* or *injury* suffered by you or your dependent(s).

Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan, without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, provisions of state law or otherwise.

Acceptance of benefits under this Plan is constructive notice of this provision in its entirety and that you, your covered dependent, your representative, your covered dependent's representative or anyone else agrees:

1. That you will notify the Plan Administrator of any settlement with such third party and notify the Plan Administrator of any lawsuit filed by you or on your behalf against such third party.

2. To fully cooperate with the terms and conditions of this Plan. If you or your covered dependent choose not to act to recover money from any source, the Plan Administrator reserves the right to initiate its own direct action to obtain reimbursement. Failure to cooperate may also result in denial of related claims.

3. That the benefits paid or to be paid by this Plan will be secondary, not primary.

4. That reimbursement to this plan will be 100% of amounts paid, unless a lesser amount is accepted, without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, provisions of state law or otherwise.

5. That reimbursement to this plan will be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency.

6. That you or any attorney that is retained by you will not assert the Common Fund or Made-Whole Doctrine;

7. That any amount recovered by a dependent minor or on behalf of a dependent minor by a trustee, guardian, parent or other representative of the minor shall be reimbursed to the Plan regardless of whether the minor's representative has access or control of any recovery funds.

8. To sign any documents requested by the Plan Administrator, or any representative of the Plan Administrator including but not limited to reimbursement and/or subrogation agreements. In addition, you agree to furnish any other information that might be requested by the Plan Administrator or representative of the Plan Administrator. Failure or refusal to execute such agreements or furnish information does not preclude the Plan Administrator or any representative of the Plan Administrator from exercising its right to subrogation or obtaining full reimbursement.

9. To take no action which will, in any way, prejudice the rights of the Plan. (If it becomes necessary for the Plan Administrator or any representative of the Plan Administrator to enforce this provision by initiating any action against you, your covered dependent, your representative, your covered dependent's representative or anyone else, you will be responsible to pay the fees of the Plan Administrator's attorney and all costs associated with the action regardless of the outcome of the action.)

Any claims related to the accident or *illness* made after satisfaction of this obligation shall be the responsibility of the covered person, not the Plan.

ARTICLE VIII -- OTHER IMPORTANT PLAN PROVISIONS

A. Special Election For Employees Age Sixty-Five (65) And Over

If you remain actively at work after reaching age sixty-five (65), you or your spouse may choose to remain covered under this Plan without reduction in *Medicare* benefits or designate *Medicare* as the exclusive payor of benefits. **If you choose to remain covered under this Plan, this Plan will be the primary payor of benefits and *Medicare* will be secondary**. If you choose *Medicare* as primary, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you are under age sixty-five (65) and your spouse is over age sixty-five (65), he or she can make their own choice.

B. Medicaid-Eligible Employees And Dependents

If you or your dependents are Medicaid-eligible, you will be entitled to the same coverage under the Plan as all other employees and dependents. The benefits of this Plan will be primary to those payable through Medicaid.

C. Recovery Of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the Plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

D. Right To Receive And Release Necessary Information

The Plan may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement Plan provisions. When you request benefits, you must furnish all the information required to implement Plan provisions. Failure to provide requested information may result in denial of benefits.

E. Blue Card Pricing Disclosure

When you obtain health care services from a participating provider outside the geographic area BlueCross BlueShield of Western New York and BlueShield of Northeastern New York serves, the amount you pay for covered services is calculated on either:

- The billed charges for your covered services, or
- The negotiated price that the on-site BlueCross and/or BlueShield Licensee ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price considered by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any other contingent payments arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices, however, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Participant liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Participant liability calculation methods that differ from the usual Blue Card method noted above in paragraph one of this Exhibit or require a surcharge, BlueCross BlueShield of Western New York and BlueShield of Northeastern New York would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area BlueCross BlueShield of Western New York and BlueShield of Northeastern New York serves, if this plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area BlueCross BlueShield of Western New York and BlueShield of Northeastern New York serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area BlueCross BlueShield of Western New York and BlueShield of Northeastern New York serves. But in no event will you be entitled to benefits for health care services, whenever you receive them, which are specifically excluded or limited from coverage by this plan.

F. Severability

The provisions of this Plan will be considered severable; therefore, if a provision is deemed invalid or unenforceable, that decision will not affect the validity and enforceability of the other provisions of the Plan.

ARTICLE IX -- CLAIM SUBMISSION PROCESS

A. What Is A Claim For Benefits

Pre-Service Claims:

Pre-service claims are claims for which advance approval is required. Pre-service claims may be submitted by telephone or in writing.

Refer to your medical ID card for contact information.

Post-Service Claims:

A post-service claim is defined as any request for Plan benefits that complies with the Plan's procedure for making a claim for benefits. A participating *health care provider* will submit a claim directly to the Plan on your behalf. If you desire Plan benefits, you must submit a claim when services are rendered by a *health care provider* that does not participate in the network.

A claim for benefits includes:

1. Employee information: name, address, plan name, group number.

2. Patient information: patient name, address, birth date.

3. Treatment information: date(s) of service, procedure code, description of each supply or service, diagnosis code, charge for each supply or service.

4. *Health care provider* information: name, address, telephone number, federal tax identification number.

Send the complete claim for benefits to the address indicated on your ID card.

The *Plan Administrator* will determine if enough information has been submitted to enable proper consideration of the claim for benefits. If not, more information may be requested from the claimant.

The *Plan Administrator* reserves the right to have a Plan Participant seek a second medical opinion.

B. When A Claim For Benefits Should Be Filed

Pre-Service Claim:

When precertification of a claim is required, you should follow the procedures outlined in the Medical Management Program article of this Plan.

If you desire a predetermination of plan benefits, you should notify the *claims processor* at least 15 calendar days prior to receiving services.

Post-Service Claims:

A claim for benefits must be filed within 12 months of the date of service. A claim for benefits filed after that date may be declined or reduced unless:

1. It is not reasonably possible to submit the claim within 12 months of the date of service; or

2. The claimant is not legally capable of submitting the claim within 12 months of the date of service.

C. Claim For Benefits Procedure

There are different kinds of claim for benefits and each one has a specific timetable for approval, payment, request for further information, or denial. The period of time begins on the date the claim is filed. The following is a summary of the maximum response times allowed for each type of claim.

Pre-Service Urgent Care Claims

Notice to claimant of:

Insufficient information on the claim for benefits	24 hours
Extension for claimant to provide required information	48 hours
Benefit determination	72 hours

Pre-Service Non-Urgent Care Claims

Notice to claimant of:

Insufficient information on the claim for benefits	5 calendar days
Extension for claimant to provide required information	45 calendar days
Benefit determination	15 calendar days

Post-Service Claims

Notice to claimant of:

Benefit determination (all required information received)	30 calendar days
Extension for claimant to provide required information	45 calendar days
Benefit determination (requested information provided)	15 calendar days

D. Notice To Claimant Of Adverse Benefit Determination

The *Plan Administrator* shall provide written or electronic notice of any adverse benefit determination. The notice will state the following:

1. The specific reason(s) for the adverse determination.

2. Reference to the specific Plan provisions on which the determination was based.

3. A description of any additional information necessary for the claimant to perfect the claim for benefits, and an explanation of why such material or information is necessary.

4. A description of the Plan's appeal procedures, including a statement of the claimant's right to bring a civil action under section 502 of ERISA.

5. A statement that upon request, the claimant is entitled to receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

6. A statement that other voluntary dispute resolution options are available, such as mediation.

If the adverse benefit determination was based on an internal guideline, protocol, or other similar criterion, the specific guideline, protocol, or criterion will be provided. If this is not practical, a statement will be included that such a 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.

If the adverse benefit determination is based on the medical necessity, experimental, or investigational exclusions of the Plan, an explanation of the clinical judgment for the determination will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Applicable to all plans <u>except</u> Schedule of Medical Benefits – N:

E. Pre-Service and Post-Service Claim Appeal

You may appeal an adverse benefit determination. When a claimant receives an adverse benefit determination for a claim, the claimant has 180 days following receipt of the notification to appeal the decision. Otherwise, the initial adverse benefit determination shall be the final decision of the Plan.

When a claimant receives an adverse benefit determination for a pre-service claim, a grievance can be filed with the *claims processor* orally or in writing. A grievance for a post-service claim must be submitted in writing.

This Plan provides for two levels of internal appeals. If the adverse benefit determination is partially or fully upheld, a claimant may appeal the initial appeal decision. The decision of the Plan upon the second internal appeal shall be considered the final decision of the Plan. The following is a summary of the maximum response times allowed for each type of claim appeal.

Pre-Service Urgent Care Claims

Initial internal appeal	72 hours for phone response (written response within 3 business days of phone response)
Second internal appeal	72 hours for phone response (written response within 3 business days of phone response)

Pre-Service Non-Urgent Care Claims

Initial internal appeal	15 calendar days
Second internal appeal	15 calendar days

Post-Service Claims

Initial internal appeal	30 calendar days
Second internal appeal	30 calendar days

The period of time within which the Plan must make a benefit determination for an appeal begins at the time an appeal is filed in accordance with the procedures of the Plan. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any appeal is pending.

For any appeal, a claimant may submit written comments, documents, records, and other information related to the claim for benefits. If the claimant requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

A document, record, or other information shall be considered relevant to a claim for benefits 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;

3. Demonstrated compliance with the administrative processes and safeguards designed to ensure that benefit determinations are made in accordance with Plan documents, and that 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.

Any review shall take into account all 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 a Plan representative who is neither the individual who made the adverse determination nor a subordinate of that individual. The *claims processor* may hold a hearing of all parties involved, if the *claims processor* deems such hearing to be necessary.

If the determination was based on a medical judgment, including determinations with regard to whether a particular service or supply is experimental, investigational, or not medically necessary or appropriate, the representative of the Plan will 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 applicable field of medicine. Additionally, the Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination.

A written explanation of a claim appeal determination will include the following information:

1. The specific reason or reasons for the decision, including a response to any information and comments submitted by you or your duly authorized representative;

2. Reference to Plan provisions and records on which the decision is based;

3. A statement that you and your duly authorized representative are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; and

4. A statement regarding the Participant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.

No action at law or in equity can be brought to recover under this Plan after the expiration of three years after the claim has been filed with the *Plan Administrator*.

Applicable to Schedule of Medical Benefits – N:

E. First Level Internal Appeal

You or your authorized representative may appeal an adverse benefit determination. Upon request, the *claims processor* will complete a full and fair review. When a claimant receives an adverse benefit determination for a claim, the claimant has 180 days following receipt of the notification to appeal the decision. Otherwise, the initial adverse benefit determination shall be the final decision of the Plan.

When a claimant receives an adverse benefit determination for a pre-service claim, a grievance can be filed with the *claims processor* orally or in writing. A grievance for a post-service claim must be submitted in writing.

This Plan provides for two levels of internal appeals. If the adverse benefit determination is partially or fully upheld, a claimant may appeal the initial appeal decision. If the benefit determination is partially or fully upheld upon second appeal, a claimant may appeal under the external review provisions of this Plan. The following is a summary of the maximum response times allowed for each type of claim appeal.

Pre-Service Urgent Care Claims

Initial internal appeal	24 hours for phone response (written response within 3 business days of phone response)
Second internal appeal	24 hours for phone response (written response within 3 business days of phone response)

Pre-Service Non-Urgent Care Claims

Initial internal appeal	15 calendar days
Second internal appeal	15 calendar days

Post-Service Claims

Initial internal appeal	30 calendar days
Second internal appeal	30 calendar days

The period of time within which the Plan must make a benefit determination for an appeal begins at the time an appeal is filed in accordance with the procedures of the Plan. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any appeal is pending.

For any appeal, a claimant may submit written comments, documents, records, and other information related to the claim for benefits. If the claimant requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

A document, record, or other information shall be considered relevant to a claim for benefits 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;

3. Demonstrated compliance with the administrative processes and safeguards designed to ensure that benefit determinations are made in accordance with Plan documents, and that 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.

Any review shall take into account all 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 a Plan representative who is neither the individual who made the adverse determination nor a subordinate of that individual. The *claims processor* may hold a hearing of all parties involved, if the *claims processor* deems such hearing to be necessary.

If the determination was based on a medical judgment, including determinations with regard to whether a particular service or supply is experimental, investigational, or not medically necessary or appropriate, the representative of the Plan will 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 applicable field of medicine. Additionally, the Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination.

A written explanation of a claim appeal determination will include the following information:

1. The specific reason or reasons for the decision, including a response to any information and comments submitted by you or your duly authorized representative;

2. Reference to Plan provisions and records on which the decision is based;

3. A statement that you and your duly authorized representative are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; and

4. A statement regarding the Participant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.

No action at law or in equity can be brought to recover under this Plan after the expiration of three years after the claim has been filed with the *Plan Administrator*.

F. Second Level External Review

You may file a request for an external review by an independent review organization (IRO) no later than four months following the date you receive a notice of an adverse benefit determination or final internal adverse benefit determination.

Within five business days following receipt of your external review request, the *claims processor* must complete a preliminary review of your request. If the appeal is granted, the *claims processor* must assign an IRO to conduct the external review and will submit all information to the IRO.

Within one business day following the preliminary review, the *claims processor* must issue a written notification to you indicating the status of your request. If additional information is required, the written notification will include a description of the material or information necessary for you to perfect your external review request within the four-month filing period.

Upon receipt of the material or information requested, the *claims processor* will review the information and forward it to the IRO within one business day. If, upon receipt of this information, the *claims processor* reverses the internal adverse benefit determination, the claims processor must send written notification to the IRO and to you within one business day after making such a decision. The assigned IRO must terminate the external review upon receipt of the notice from the *claims processor.*

For any other appeal not reversed by the *claims processor*, the IRO must provide written notice of the final external review decision within 45 days after receipt of the request for external review. The IRO must deliver this final notice to you and the *claims processor*. The decision of the IRO shall be the final decision of the Plan.

The IRO will conduct their review and will not be bound by any decisions or conclusions previously reached by the *claims processor.*

G. Second Level Expedited External Review

The external review process will be expedited if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

2. The internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service which you received on an emergency basis, but have not yet been discharged from a facility.

Upon receipt of your request for expedited external review, the *claims processor* must immediately verify eligibility for external review, issue a notification in writing to you, and assign an IRO. The IRO is required to provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision within 48 hours after the date of providing that notice to you and the *claims processor*.

ARTICLE X -- COBRA CONTINUATION OF BENEFITS
(Consolidated Omnibus Budget Reconciliation Act)

A. Definitions

For purposes of this Continuation Coverage Under COBRA provision, the following definitions apply:

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

2. "Code" means the Internal Revenue Code of 1986, as amended.

3. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.

4. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.

5. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.

6. "Qualified Beneficiary" means:

    a. A Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan;

    b. A covered spouse or dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below; or

    c. A newborn or newly adopted child of a Covered Employee who is continuing coverage under COBRA.

7. "Qualifying Event" means the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

    a. Termination of a Covered Employee's employment (other than for gross misconduct) or reduction in his hours of employment;

    b. The death of the Covered Employee;

    c. The divorce or legal separation of the Covered Employee from his spouse;

d. A child ceasing to be eligible as a dependent child under the terms of the Group Health Plan; or

e. Your *employer* filing a Chapter 11 bankruptcy petition. Coverage may continue for covered retirees and/or their dependents if coverage ends or is substantially reduced within one year before or after the initial filing for bankruptcy.

8. "Totally Disabled" or "Total Disability" means Totally Disabled as determined under Title II or Title XVI of the Social Security Act.

B. Right To Elect Continuation Coverage

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the 60-day period beginning on the later of:

1. The date of the Qualifying Event; or

2. The date he was notified of his right to continue coverage.

C. Notification Of Qualifying Event

If the Qualifying Event is divorce, legal separation or a dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company of the Qualifying Event within 60 days of the event in order for coverage to continue. You must report the Qualifying Event to the Plan Administrator in writing. The statement must include:

1. Your name;

2. Your identification number;

3. The dependent's name;

4. The dependent's last known address;

5. The date of the Qualifying Event; and

6. A description of the event.

In the case of a request for extension of the COBRA period as a result of a finding of disability by the Social Security Administration, you must also submit the disability determination. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the section below entitled "Total Disability" in order for coverage to continue.

Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

D. Length Of Continuation Coverage

1. A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Group Health Plan for up to 36 months from the date of the Qualifying Event in accordance with New York State COBRA regulations.

2. A Qualified Beneficiary who loses coverage due to the Covered employee's death, divorce, or legal separation, and dependent children who have become ineligible for coverage may continue coverage under the Group Health Plan for up to 36 months from the date of the Qualifying Event.

E. Total Disability

1. In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled within 60 days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for dependents who were covered under the Continuation Coverage) for a total of 36 months in accordance with New York State COBRA regulations.

2. If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

    a. The Qualified Beneficiary shall notify the *employer* of this determination within 30 days; and

    b. Continuation Coverage shall terminate the last day of the month following 30 days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

F. Coordination Of Benefits

Benefits will be coordinated with any federal program, automobile coverage or group health plan in accordance with the provisions described in the Article entitled - Coordination of Benefits.

G. Termination Of Continuation Coverage

Continuation Coverage will automatically end earlier than the applicable period for a Qualified Beneficiary if:

1. The required monthly contribution for coverage is not received by the Company within 30 days following the date it is due;

2. The Qualified Beneficiary becomes covered under any other Group Health Plan as an employee or otherwise. If the other Group Health Plan contains an exclusion or limitation relating to a *pre-existing condition* (other than a *pre-existing condition* exclusion or limitation which the Qualified Beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996), and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the *pre-existing condition* applies to the Qualified Beneficiary (or, if sooner, until the expiration of the applicable COBRA period).

3. For Totally Disabled Qualified Beneficiaries continuing coverage, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such beneficiary is no longer Totally Disabled;

4. The Qualified Beneficiary becomes entitled to *Medicare* benefits; or

5. The Company ceases to offer any Group Health Plans.

H. Continuation Coverage

The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated Covered Employees and their dependents. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add dependents for Continuation Coverage, such dependents must meet the definition of dependent under the Group Health Plan.

I. Carryover Of Deductibles And Plan Maximums

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable deductible and co-payment features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

J. Payment Of Premium

1. The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

    a. The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.

    b. For Qualified Beneficiaries whose coverage is continued pursuant to the section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for Continuation Coverage months 19-29.

    c. Contributions for coverage may, at the election of the Qualified Beneficiary, be paid in monthly installments.

2. If Continuation Coverage is elected, the monthly contribution for coverage for those months up to and including the month in which election is made must be made within 45 days of the date of election.

3. Without further notice from the Company, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within 30 days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage", subsection A. This 30-day grace period does not apply to the first contribution required under subsection B.

4. No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

ARTICLE XI -- PROTECTED HEALTH INFORMATION

This Employee Benefit Plan collects and maintains a great deal of personal health information about you and your enrolled dependents. Federal HIPAA regulations on privacy and confidentiality limit how an Employee Health Plan and its *Plan Administrator* may use and disclose this information. This Article describes provisions that protect the privacy and confidentiality of your personal health information and complies with applicable federal law.

A. Definitions

For purposes of this Article, the following terms shall have the meaning set forth below unless otherwise provided by the Plan:

1. "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in any electronic media.

2. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

3. "Member" means a covered employee or the covered dependents of a covered employee.

4. "*Plan Sponsor*" is Buffalo Board of Education

5. "Plan" is Buffalo Board of Education Employee Benefit Plan.

6. "Plan Documents" means the group health plan's governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to the Buffalo Board of Education Plan Document.

7. "Protected Health Information" means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify a member. Protected Health Information includes information of persons living or deceased. The following components of a member's information also are considered Protected Health Information:

    a. Names;

    b. Street address, city, county, precinct, zip code;

    c. Dates directly related to a member, including birth date, health facility admission and discharge date, and date of death;

d. Telephone numbers, fax numbers, and electronic mail addresses;

e. Social Security numbers;

f. Medical record numbers;

g. Health plan beneficiary numbers;

h. Account numbers;

i. Certificate/license numbers;

j. Vehicle identifiers and serial numbers, including license plate numbers;

k. Device identifiers and serial numbers;

l. Web universal resource locators (URLs);

m. Biometric identifiers, including finger and voice prints;

n. Full face photographic images and any comparable images; and

o. Any other unique identifying number, characteristic, or code.

8. "Regulation" means the Health Insurance Portability and Accountability Act of 1996, as amended.

9. "Security Incidents" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. The Plan Sponsor will report a successful Security Incident to the Plan within a reasonable period of time after learning of the successful security incident. Data relating to an unsuccessful attempt may be aggregated and reported to the Plan on a less frequent basis.

10. "Summary Health Information" means information that may be individually identifiable health information, and

    a. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

    b. From which the information described in the regulation has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

B. Permitted And Required Uses And Disclosure Of Protected Health Information

Subject to obtaining written certification, this Plan may disclose Protected Health Information to the *Plan Sponsor*, provided the *Plan Sponsor* does not use or disclose such Protected Health Information except for the following purposes:

1. Performing Plan administrative functions which the *Plan Sponsor* performs for the Plan.

2. Obtaining bids for providing employee coverage under this Plan; or

3. Modifying, amending, or terminating the Plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the *Plan Sponsor* be permitted to use or disclose Protected Health Information in a manner that is inconsistent with the regulation.

C. Conditions Of Disclosure

The Plan, or any employee coverage with respect to the Plan, shall not disclose Protected Health Information to the *Plan Sponsor* unless the *Plan Sponsor* agrees to:

1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

2. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to Protected Health Information.

3. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the *Plan Sponsor*.

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

5. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with the Regulation.

6. Make available to a Plan participant who requests an amendment to the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with the Regulation.

7. Make available to a Plan participant who requests an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with the Regulation.

8. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Regulation.

9. If feasible, return or destroy all Protected Health Information received from the Plan that the *Plan Sponsor* still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.

10. Ensure that the adequate separation between the Plan and the *Plan Sponsor* required in the Regulation is satisfied.

D. Certification Of Plan Sponsor

The Plan shall disclose Protected Health Information to the *Plan Sponsor* only upon the receipt of a certification by the *Plan Sponsor* that the Plan has been amended to incorporate the provisions of the Regulation, and that the *Plan Sponsor* agrees to the conditions of disclosure set forth in item C. above.

E. Permitted Uses And Disclosure Of Summary Health Information

The Plan may disclose Summary Health Information to the *Plan Sponsor*, provided such Summary Health Information is only used by the *Plan Sponsor* for the purpose of:

1. Obtaining bids for providing employee coverage under this Plan; or

2. Modifying, amending, or terminating the Plan.

F. Permitted Uses And Disclosure Of Enrollment And Disenrollment Information

The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the *Plan Sponsor*, provided such enrollment and disenrollment information is only used by the *Plan Sponsor* for the purpose of performing administrative functions that the *Plan Sponsor* performs for the Plan.

G. Adequate Separation Between The Plan And The Plan Sponsor

The *Plan Sponsor* shall limit access to Protected Health Information to only those employees authorized by the *Plan Sponsor*. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the *Plan Sponsor* performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the *Plan*

Sponsor for non-compliance pursuant to the *Plan Sponsor's* employee discipline and termination procedures.

H. Security Standards For Electronic Protected Health Information

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

2. Plan Sponsor shall ensure that the adequate separation that is required by the Regulation is supported by reasonable and appropriate security measures;

3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

    b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.

This Plan will comply with the requirement of 45 C.F.R. / 164.314 (b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164.

ARTICLE XII -- DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under Covered Medical Expenses.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Approved Clinical Trial

A clinical trial that is conducted in relation to treatment of cancer or other life-threatening disease or condition that is:

- A federally funded trial approved or funded by one or more of the following:
    - The National Institutes of Health (NIH).
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare and Medicaid Services.
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veteran Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
    - The Department of Defense, the Department of Energy, or the Department of Veteran Affairs if 1) the study has been approved through a system of peer review determined to be comparable to the system used by NIH and 2) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.

- A study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration.

- A study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Birthing Center

A public or private facility, other than private offices or clinics of *physicians*, which meets the free standing *birthing center* requirements of the State Department of Health in the state where the covered person receives the services.

The *birthing center* must provide: A facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a *physician* or certified nurse midwife at all births and immediate post partum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified *nurse* midwife; arrangements for diagnostic x-ray and lab services; the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for emergency transfers, and maintain medical records on each patient and child.

Calendar year

The twelve (12) month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the *calendar year*.

Claims Processor

BlueCross BlueShield of Western New York

Cosmetic Surgery

A procedure performed primarily to improve appearance which does not meaningfully promote the proper function of the body or prevent or treat an *illness, injury* or disease.

Custodial Care

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Dentist

A person acting within the scope of his/her license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

Diagnostic Charges

The *fee schedule* for x-ray or laboratory examinations made or ordered by a *physician* in order to detect a medical condition.

Durable Medical Equipment

Equipment able to withstand repeated use for the therapeutic treatment of an active *illness* or *injury*. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an *illness* or *injury* and could be purchased without a *physician's* prescription.

Employer

Buffalo Board of Education.

Enrollment Date

The first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*.

Experimental/Investigational

Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue.

Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Experimental/investigational items and services are not covered under this plan unless identified as a covered service elsewhere in this Plan.

Fee Schedule

The *fee schedule* is the calculation of the maximum amount payable toward any claim of benefits. The *fee schedule* is the negotiated price for local participating providers and a participating provider outside the geographic area that the network serves. The *fee schedule* reflects the maximum amount payable toward a covered expense. Participating providers can only bill you for the difference between the benefit paid and the *fee schedule* for any service. Allowed expense for non-participating providers is based on the usual and customary charge in the geographic area where the services or

supplies are provided. The usual and customary charge is the charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by *physicians*, *health care providers* or *dentists*.

General Anesthesia

An agent introduced into the body which produces a condition of loss of consciousness.

Genetic Information

The information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Health Care Provider

A *physician*, *practitioner*, *nurse*, *hospital* or *specialized treatment facility* as those terms are specifically defined in this section.

Home Health Care Agency

An agency or organization that provides a program of home health care and that:

1. is approved as a *home health care agency* under *Medicare*;

2. is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; or

3. meets all of the following requirements:

    a. it is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;

    b. it has a full-time administrator;

    c. it maintains written records of services provided to the patient;

    d. its staff includes at least one registered *nurse* or it has nursing care by a registered *nurse* available; and

    e. its employees are bonded and it provides malpractice and malplacement insurance.

Hospice Care

A program approved by the attending *physician* for care rendered in the home, *outpatient* setting or institutional facility to a terminally ill covered person with a medical prognosis that life expectancy is six (6) months or less.

Hospice Facility

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six (6) months or less.

The facility must have an interdisciplinary medical team consisting of at least one (1) *physician,* one (1) registered *nurse,* one (1) social worker, one (1) volunteer and a volunteer program.

A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital

The term *hospital* means:

1. an institution constituted, licensed, and operated in accordance with the laws pertaining to *hospitals*, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *injury* or *illness*, and which provides such treatment for compensation, by or under the supervision of *physicians* on an *inpatient* basis with continuous 24-hour nursing service by registered *nurses*;

2. an institution which qualifies as a *hospital* and a provider of services under *Medicare*, and is accredited as a *hospital* by the Joint Commission on the Accreditation of Health Care Organizations;

3. a *rehabilitation facility*.

The term *hospital* shall also include a *residential treatment* facility specializing in the care and treatment of mental/nervous conditions or substance abuse treatment, provided such facility is duly licensed if licensing is required, or otherwise lawfully operated if licensing is not required.

Regardless of any other Plan provision or definition, the term *hospital* will not include an institution which is other than incidentally, a place of rest, place for the aged, long term acute care facility or a nursing home.

Illness

Any bodily sickness, disease or mental/nervous disorder. For the purposes of this Plan, pregnancy will be considered an *illness*.

Injury

A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or accident.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A section, ward, or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate *nurses* or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purposes of providing normal post-operative recovery treatment or service.

Late Enrollee

An individual who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime

The period of time you or your eligible dependents participate in this Plan.

Maintenance Care

Services and supplies primarily to maintain a level of physical or mental function.

Medical Director

A Physician, compensated by the *Claims Processor*, who provides health care utilization advise to the *Plan Administrator*. In addition, the Medical Director:

- Monitors and evaluates health care utilization including quality of care and safety issues, adherence to clinical guidelines, protocols, etc.

- Provides guidance of case management, utilization management, medical management, treatment plans, quality and safety related to appropriate utilization and review of an adverse benefit determination.
- Establishes best practices and documents appropriate guidelines.

- Reviews and evaluates new applications of existing technology and new medical procedures for medical policy.

Medical Emergency

An *illness* or *injury* which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible *hospital* equipped to furnish care to prevent the death or serious impairment of the covered person.

Such conditions include, but are not limited to, suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsion, or such other acute medical conditions as determined to be *medical emergencies* by the *Plan Administrator*.

Medically Necessary (Medical Necessity)

Any service or supply required for the diagnosis or treatment of an active *illness* or *injury* that is rendered by or under the direct supervision of the attending *physician*, generally accepted by medical professionals in the United States and non-experimental.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended.

Morbid Obesity

A condition in which the body weight exceeds the normal weight by either 100 pounds, or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.

The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Nurse

A person acting within the scope of his/her license and holding the degree of Registered Graduate *Nurse* (R.N.), Licensed Vocational *Nurse* (L.V.N.) or Licensed Practical *Nurse* (L.P.N.).

Open Enrollment Period

A 30-day period beginning November 1st and ending November 30th. Coverage effective date is January 1st.

Oral Surgery

Necessary procedures for *surgery* in the oral cavity, including pre- and post-operative care.

Outpatient

Treatment either outside a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Physically or Mentally Handicapped

The inability of a person to be self-sufficient as the result of a condition such as, but not limited to, mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition preventing the individual from being self-sufficient or other *illness* as approved by the *Plan Administrator*.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who is legally entitled to practice medicine under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator

The *Plan Administrator*, Buffalo Board of Education, is the sole fiduciary of the Plan, and exercises all discretionary authority and control over the administration of the Plan and the management and disposition of the Plan assets. The *Plan Administrator* shall have the sole discretionary authority to determine eligibility for Plan benefits or to construe the terms of the Plan.

The *Plan Administrator* has the right to amend, modify or terminate the Plan in any manner, at any time, regardless of the health status of any Plan participant or beneficiary.

The *Plan Administrator* may hire someone to perform claims processing and other specified services in relation to the Plan. Any such contractor will not be a fiduciary of the Plan and will not exercise any other discretionary authority and responsibility granted to the *Plan Administrator*, as described above.

Plan Sponsor

Buffalo Board of Education

Plan Year

The twelve (12) month period for Buffalo Board of Education, beginning July 1 and ending June 30.

Practitioner

A *physician* or person acting within the scope of applicable state licensure/certification requirements and/or holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Optician, Certified Nurse Midwife (C.N.M.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist or Registered Respiratory Therapist.

Professional Components

Services rendered by a professional technician (e.g. radiologist, pathologist, anesthesiologist) in conjunction with services rendered at a *hospital, ambulatory surgical center* or *physician's* office.

Qualified Medical Child Support Order

A medical child support order that either creates or recognizes the right of an alternate recipient (i.e., a child of a covered participant who is recognized under the order as having a right to be enrolled under the Plan) or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the Plan.

A "medical child support order" is a judgment, decree or order (including a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law in that state, that provides for child support related to health benefits with respect to the child of a group health plan participant, or required health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or that enforces a state medical child support law enacted under Section 1908 of the Social Security Act with respect to a group health plan.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate governmental agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part time care services, or an institution which primarily provides treatment of mental/nervous conditions, substance abuse treatment or tuberculosis except if such facility is licensed, certified or approved as a *rehabilitative facility* for the treatment of medical conditions, mental/nervous conditions or substance abuse treatment in the jurisdiction where it is located, or is credited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Respite Care

Respite care rendered through a licensed *hospice facility* for home custodial care which provides relief to an immediate family in caring for the day to day needs of a terminally ill individual.

Second/Third Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the diagnosis of the proposed *surgery* to evaluate alternatives and/or the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility/Extended Care Facility/Convalescent Nursing Hospital

An institution that:

1. primarily provides skilled (as opposed to custodial) nursing service to patients;

2. is approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAH) and/or *Medicare*.

In no event shall such term include any institution or part thereof that is used principally as a rest facility or facility for the aged or, any treatment facility for mental/nervous condition or substance abuse treatment.

Special Enrollee

A Special Enrollee i**s** an employee or dependent who is entitled to and who requests special enrollment:

1. within thirty-one (31) days of losing other health coverage because their COBRA coverage is exhausted, they cease to be eligible for other coverage, or employer contributions are terminated;

2. for a newly acquired dependent, within thirty-one (31) days of the marriage, birth, adoption, or placement for adoption; or

3. within sixty (60) days of losing other health coverage through Medicaid or CHIP.

4. for a *transitional rule dependent,* within thirty (30) days of receiving a written notification of the transitional rule.

Specialized Treatment Facility

Specialized treatment facilities as the term relates to this Plan include *birthing centers, ambulatory surgical facilities, hospice facilities*, or *skilled nursing facilities* as those terms are specifically defined.

Surgery

Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision. Surgery includes closed reduction of fractures, dislocation of bones, endoscopic procedures, and any incision or puncture of the skin or other tissue except for inoculation, vaccination, collection of blood, drug administration or injection.

Total Disability (Totally Disabled)

The inability to perform all the duties of the covered person's occupation as the result of an *illness* or *injury*. *Total disability* means the inability to perform the normal duties of a person of the same age.

Usual and Customary Charge

The charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other *physicians*, *practitioners* or *dentists*.

Waiting Period

A period of continuous, full-time employment before an employee or dependent is eligible to participate in the Plan, or for purposes of determining *creditable coverage*, the *waiting period* under any other health plan.

Year

See *calendar year*.

ARTICLE XIII -- GENERAL INFORMATION

Name and Address of the Plan Sponsor

Buffalo Board of Education
806 City Hall
Buffalo, NY 14202

Name and Address of the Plan Administrator

Buffalo Board of Education
806 City Hall
Buffalo, NY 14202

Name and Address of the Person Designated as the Agent for Service of Legal Process

Buffalo Board of Education
806 City Hall
Buffalo, NY 14202

Claims Processor

BlueCross BlueShield of Western New York
P.O. Box 80
Buffalo, NY 14240

Internal Revenue Service Number

The corporate tax identification number assigned by the Internal Revenue Service is 16-6001554.

Plan Year

The twelve (12) month period for Buffalo Board of Education, beginning July 1 and ending June 30.

Method of Funding Benefits

The funding for the benefits is derived from the funds of the *employer*. The Plan is not insured.

Plan Modification And Termination

The *Plan Administrator* intends to continue the Plan indefinitely. Nevertheless, Buffalo Board of Education reserves the right to amend, modify, or terminate the Plan at any time, which may result in the termination or modification of your coverage. The *Plan Administrator* will notify all covered persons as soon as possible, but in no event later than sixty (60) days after the effective date the plan change was adopted. Expenses incurred prior to the Plan termination, modification or amendment will be paid as provided under the terms of the Plan prior to its termination, modification or amendment.

Discretion of Plan Administrator

The *Plan Administrator* shall be the sole determiner of all matters concerning medical benefits and coverage under this Plan. The *Plan Administrator* shall have broad discretion in interpreting the provisions of this Plan, which discretion shall be exercised in good faith. The *Plan Administrator's* discretionary authority includes, but is not limited to, resolving questions of coverage and benefits, determining matters relating to eligibility, deciding questions of administration, and deciding other questions under the Plan.

SIGNATURE PAGE

The effective date of the Buffalo Board of Education Employee Benefit Plan is March 1, 2017.

It is agreed by Buffalo Board of Education that the provisions of this document are correct and will be the basis for the administration of the Buffalo Board of Education Employee Benefit Plan.

Dated this 24 day of May, 2017

BY: A Baudo

TITLE: Acting Benefits Manager

WITNESS: Nathaniel Kuzma

TITLE: General Counsel / Notary Public

NATHANIEL JAMES KUZMA
NOTARY PUBLIC, STATE OF NEW YORK
QUALIFIED IN ERIE COUNTY
Reg. No. 02KU6335269
MY COMMISSION EXPIRES 01-25-20 20

BUFFALO BOARD OF EDUCATION EMPLOYEE BENEFIT PLAN

COSMETIC SURGERY AMENDMENT TO THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2018

Effective January 1, 2018, medical expenses for *cosmetic surgery* will be processed in accordance with the following:

1) To be covered as a nontaxable benefit under the terms of the Plan, the Provider/Doctor must certify, in writing, to BlueCross BlueShield of Western New York that the *cosmetic surgery* is *medically necessary* ("Provider Certification"). The Provider Certification must be furnished at the time and in the form required by the District.

2) If the Provider Certification is not provided, the *cosmetic surgery* claim will be processed as follows: The value of the procedure (i.e., the approved provider charges) will be reported as taxable income on a Form W-2 issued to the member. The District will pay 60% of the approved provider charges to the provider; the balance (a 40% coinsurance processing charge) will be withheld by the District to ensure that the District can satisfy all applicable employment tax and tax withholding obligations. The member will be responsible to the provider for the eligible charges not paid by the District.

3) Notwithstanding any other provision of the Plan to the contrary, the coinsurance processing charge paid by a member for *cosmetic surgery* that is not *medically necessary* does not count toward the annual deductible or out-of-pocket maximum (i.e., is payable even if the deductible or out-of-pocket maximum is fully met).

Dated this 5 day of June, 2018.

BUFFALO BOARD OF EDUCATION

BY: _____

TITLE: Acting Benefits Manager

WITNESS: _____

TITLE: ASSISTANT LEGAL COUNSEL

Approved As To Form
Office of Legal Counsel
5-4-18

Notice of Nondiscrimination

BlueCross BlueShield of Western New York

BlueCross BlueShield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BlueCross BlueShield of Western New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BlueCross BlueShield of Western New York:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please call the customer service number on the back of your ID card or contact the Director, Corporate Compliance and Privacy Officer.

If you believe that BlueCross BlueShield of Western New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Director, Corporate Compliance and Privacy Officer, 257 West Genesee Street, Buffalo, NY 14202, 1-800-798-1453, (716) 887-6056 (fax), complaint.compliance@bcbswny.com. You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Notice of Nondiscrimination

For assistance in English, call customer service at the number listed on your ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

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