Plan Document and
Summary Plan Description for the
Kenmore Town of Tonawanda Union-Free School District
First Choice Plans

- Medical and Prescription Drug Benefits
- Vision Benefits

Effective Date: 07/01/2015

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Introduction

Kenmore Town of Tonawanda Union Free School District (the "Employer" or "Company") is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your medical and prescription drug benefits, vision benefits and serves as the Summary Plan Description (SPD) and Plan document for the Kenmore Town of Tonawanda Union-Free School District First Choice Plans ("the Plan").

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

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Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee;
- A part-time active employee;
- Covered as an employee under the terms of a collective bargaining agreement between the Company and the applicable collective bargaining agreement;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency or leasing organization, persons hired on a seasonal or temporary basis, independent contractors and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Eligibility for Retiree Coverage

A person is eligible for retiree coverage from the first day that he or she meets the following requirements:

1. All full-time and regularly scheduled part-time employees completing 15 years of service in the District and retiring with benefits from the New York State Teacher's Retirement System will be eligible for this retirement benefit, provided a written notification of retirement is submitted prior to March 1 of the year of eligibility. Retirees must be at least 55 years of age, but under age 65.

Retiree Dependents and spouse are eligible until they age out - turn 26 or 65 for spouse, or when the retiree ages off then coverage ends. Dependent and spouse coverage ends when the retiree ages to 65/Medicare plan.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan; or
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

"Principally supported by you" means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Company, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

An Employee's spouse must meet the following requirements:

1. Employee and spouse shall not have been engaged in a trial separation for more than 12 consecutive months upon the date a Complete Claim for Eligible Expense(s) provided to spouse are received by the Plan.
2. Employee and spouse shall have been cohabitating at the same residence for the majority of the applicable plan year. When an Employee or spouse is traveling or residing elsewhere as part of their profession, to care for a family member (due, for instance, to illness or injury), and/or is residing elsewhere due to their own illness or injury, for more than half of the applicable plan year (and thus residing with each other for less than the majority of the applicable plan year), but the primary residence of the Employee is also the spouse's primary residence for all legal, regulatory, and statutory purposes, this constitutes cohabitation as required by this provision.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

It is your responsibility to notify the Company if your dependent becomes ineligible for coverage.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

When Coverage Begins

For You

Your health care coverage begins on the first day of your employment and after you meet all eligibility requirements.

If you have a probationary period that impacts when benefits begin, your coverage will begin upon successful completion of the probationary period.

If you terminate employment and are subsequently rehired, you will need to satisfy any eligibility requirements to be covered under the Plan.

For Your Dependents

Coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage.

If you acquire a new dependent through marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 30 days of the date on which they became eligible. If you wait longer than 30 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

A newborn child will be automatically covered by the Plan while the birth mother is hospital-confined. Coverage will continue only if you enroll him or her on your coverage within 30 days of birth. If you wait longer than 30 days after the date of birth, you may not be able to enroll your newborn child until the next annual open enrollment period.

Charges for nursery or physician care will be initially applied toward the plan of the covered parent. If the newborn child is not enrolled in the Plan on a timely basis, the covered parent will be responsible for all costs.

Your Cost for Coverage

Both the Company and you share in the cost of your health care benefits. Each year, the Company will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through after-tax or pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and/or prescription drug and/or vision coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any required premiums from your pay.

The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverages designated by the Plan Administrator, as shown in your enrollment materials.

You will automatically receive identification (ID) cards for you and your eligible dependents when your enrollment is processed.

Late Entrant

Your enrollment will be considered timely if your completed enrollment form is received within 30 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 30 days after you first become eligible
- You again elect coverage after canceling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period (but no longer than 12 months) to enroll in coverage.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on the following July 1 and stay in effect through June 30, unless you have a qualifying change in status.

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This allows you to elect to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status;
- The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information. Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Your coverage under this Plan ends on the last day of the month in which your employment terminates or you cease to be an eligible employee unless benefits are extended as described below.

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Company terminates this Plan or, if earlier, the effective date you request termination of coverage for you and your covered dependents.

If your coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Termination Dates for Retiree Coverage

The coverage of any retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.
2. The date of death of the covered retiree.
3. The date of the expiration of the last period for which the retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The date the covered retiree becomes eligible for Medicare coverage or becomes eligible for coverage under another Employer's health plan.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals

procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, health care coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you continue to be paid while you are absent from work, any premium payments will continue to be deducted from your pay on a pre-tax basis. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

If You Are Temporarily Laid Off

If you are laid off for a temporary period of time, your health care coverage will continue through the end of the month in which your layoff begins.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

If You Are Permanently Laid Off

If you are permanently laid off (separated from service), your health care coverage will continue through the end of the month in which your layoff begins.

Your Medical Benefits

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

You are required to select a Primary Care Physician who will coordinate your care under the Plan. You have the right to designate any PCP (including a pediatrician) who participates in the network and who is available to accept you or your family members. You do not need prior authorization from the Plan or claims administrator, or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in- or out-of-network. Refer to the Medical Plan Schedule of Benefits and the Medical Plan Covered Services sections for a more detailed summary of your health care benefits and how benefit are paid in- and out-of-network.

To select a PCP, or to obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the claims administrator for the network shown on your ID card.

If you use in-network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or claims administrator may require you to do so.

If you receive professional services for anesthesiology, radiology, emergency room physician services, or pathology which are provided by an out-of-network provider but rendered at in-network facility, those services will be paid at the in-network level of benefits.

If you use out-of-network providers, the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the Maximum Allowable Charge (see explanation below). You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher deductible and out-of-pocket maximum (if applicable) out-of-network, and you may be required to file claim forms. Refer to your Medical Plan Schedule of Benefits for additional information.

However, if you travel into an area that offers an in-network provider, and you choose not to use the in-network provider, then all services will be covered at the out-of-network level of benefits as described above.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular provider is an In-Network Eligible Provider and the Participant receives such item or

service in reliance on that information, the Participant's Coinsurance, Co-payment, Deductible, and Out-of-Pocket Maximum will be calculated as if the provider had been In-Network despite that information proving inaccurate.

No Surprises Act – Emergency Services and Surprise Bills

For non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Eligible Provider and will be calculated as if the Plan's Eligible Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits providers from pursuing Participants for the difference between the Maximum Allowable Charge and the provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Eligible Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a non-Network Eligible Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered non-Network air ambulance services.

Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a plan year basis.

Your Co-payment

Some services may require a co-payment – a fixed dollar amount you must pay before the Plan pays for that service. Copayments may apply regardless of whether the deductible has been satisfied. Please refer to the Summary of Medical Benefits chart for any required copayments and if the deductible may need satisfied before copayments are applied.

Your Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care in-network, which means your percentage will be lower.

The amount or percentage you pay depends on the type of provider you see, where you receive services, and how you are billed for these services. Your Medical Plan Schedule of Benefits will show the co-payment and coinsurance amounts for common medical services both in-network and out-of-network.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay in annual medical deductibles, coinsurance and copayments. It is calculated on a plan year basis. When your share of eligible out-of-pocket medical expenses reaches the out-of-pocket maximum, your coinsurance percentage and copayments become zero for the rest of the year – and the Plan pays 100% of covered expenses. Your Medical Plan Schedule of Benefits will show any applicable out-of-pocket maximum amounts.

Maximum Allowable Charge

The "Maximum Allowable Charge" shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" provision above), if no negotiated rate exists, the Maximum Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS") either multiplied by 150%, or multiplied by a percentage that the particular Eligible Provider and/or others in the area customarily accept from all payers.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on one of the following:

- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS;
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care; or

- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings.

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services are subject to the Maximum Allowable Charge (see above). Refer to the Medical Plan Schedule of Benefits and the Medical Plan Covered Services section for additional information.

Balance Billing

In the event that a claim submitted by a Network or non-Network Eligible Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Eligible Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Eligible Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Eligible Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Eligible Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Eligible Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and Out-of-Pocket Maximums and may be billed for any or all of these.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from an Eligible Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Eligible Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 7 calendar days after termination that the Eligible Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Eligible Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending of 90 days, but no longer than 1 year or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific provider,
2. is undergoing a course of institutional or inpatient care from a specific provider,
3. is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,

4. is pregnant and undergoing a course of treatment for the pregnancy from a specific provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the provider pursues a balance bill.

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the claims administrator at the number listed on the back of your ID card.

Expenses Not Covered

Ineligible expenses and expenses not covered by the plan are shown in the Medical Plan Schedule of Benefits and the Medical Plan Covered Services section.

Precertification

You and your covered dependents are required to obtain precertification for inpatient hospitalization and certain other treatments included, but not limited to as shown below:

- Applied Behavior Analysis (ABA) for Diagnosis and Treatment of Autism Spectrum Disorder
- Assistive Communication Devices (ACD) for Autism Spectrum Disorder
- CAR-T-Cell Therapy
- Clinical Trials
- Continuous glucose monitoring devices, short term
- Durable Medical Equipment
    - Customized items/equipment
    - Electrical Stimulators
    - Total electric Hospital Beds,
    - Jaw Motion Rehabilitation system and accessories
    - Lift equipment/devices
    - Negative Pressure Wound Therapy (Wound Vac)
    - Non-standard wheel chair accessories
    - Oral appliances for sleep apnea
    - Power wheelchairs and accessories

- Wearable Defibrillator Vests
- Elective hospital/facility admissions to include but not limited to:
  - Admissions for transplants
  - Inpatient rehabilitation and habilitation admissions (Physical, Speech and Occupational Therapy)
  - Mental health admissions except for member under age 18 at Independent Health participating hospitals licensed by the Office of Mental Health (OMH)
  - Medical admissions
  - Skilled nursing facility admissions
  - Substance use inpatient admission except for Independent Health participating providers which are New York State Office of Addiction Services and Supports credentialed facilities
  - Surgical admissions
- Extracorporeal Shock Wave Therapy (ECSWT) for Chronic Plantar Fasciitis
- Gamma Knife
- Gender Dysphoria – Surgical Treatments
- Genetic Testing
- Home Births
- Home Health Care Services including Home Infusion Nursing Visits
- Hyperbaric Oxygen Therapy (Systemic and Topical)
- Therapeutic Radiopharmaceuticals: Zevalin, Lutathera, Hicon, Xofigo
- MRI/PET/CT scan
- Non-Emergent Ambulance, Planned Transfer
- Partial Hospitalization for Mental Health Services
- Partial Hospitalization for Substance Use
- Prescription Specialty Drugs
- Prosthetic Devices External
- Electronic Artificial Limbs
- Custom Orthopedic Braces
- Residential Treatment except inpatient substance use admissions to Independent Health contracted, New York State Office of Addiction Services and Supports credentialed facilities
- Sleep Studies
- Surgical Procedures:
  - Back and Neck Surgery
  - Bariatric Surgery (weight loss surgery)
  - Breast Surgery: Implant Removal, non-cancer diagnosis Breast Reconstruction, Breast Reduction Mammoplasty (male and female)
  - Cosmetic Procedures (medically necessary)
  - Oral Surgeries
  - Reconstructive Procedures

    - Septorhinoplasty & Rhinoplasty
    - Spinal Cord Stimulation
    - Temporomandibular Joint (TMJ) Disorder
    - Uvulopalatopharyngoplasty (UPPP)
  - Total Artificial Heart
  - Transcatheter Aortic Valve Replacement (TAVR) and MitraClip
  - Transcranial Magnetic Stimulation
- Transplant Procedures
- Use of Implantable Devices
- Varicose Vein Procedures
- Wireless Capsule Endoscopy (WCE)

In some cases, the in-network provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the Plan.

To receive the maximum benefit and avoid any penalty for failure to precertify, you must call the number listed on the back of your ID card to precertify an admission or treatment:

- at least 2 weeks prior to any scheduled or non-emergency hospital admission or treatment.
- within 48 hours of an emergency or unscheduled admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.

Precertification - Pregnancy and Childbirth

Precertification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

Penalty for Noncompliance with Precertification

If precertification requirements are not met, any covered expenses incurred will be reduced by 50%. In addition, if it is determined subsequently that all or part of the hospital stay was not medically necessary, all or part of the hospital confinement expenses will be denied and benefits will not be paid beyond the number of days considered medically necessary.

The precertification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your stay will be denied and you may file an appeal of the denial through the Plan's appeal process.

Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The Plan Administrator may arrange for review and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- burns;
- coma;
- inpatient confinement expected to exceed 14 days;
- multiple sclerosis/Amyotrophic Lateral Sclerosis (Lou Gehrig's diseas
- neonatal birth;
- organ transplant;
- progressive neurological debilitative disease;
- certain psychiatric conditions;
- quadriplegic/paraplegic conditions;
- stroke; and
- multiple traumas from a vehicular accident.

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Benefits provided under the program are subject to all other Plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network and out-of-network services that meet the established criteria.

Your Prescription Drug Benefits

How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

Additional information about covered drugs and supplies can be found in the Prescription Drug Schedule of Benefits and the Prescription Drug Covered Services section.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.

You may purchase covered prescription drugs through the network in one of two ways:

- at a network retail pharmacy; or
- through the mail-service program for maintenance medications or any prescription not needed immediately.

A list of participating pharmacies can be found at www.pbdrx.com.

The coverage categories, any deductible, your coinsurance or co-payments, maximum payments, and other cost-sharing provisions are explained in the Prescription Drug Schedule of Benefits.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chains and many local pharmacies. You will receive a prescription drug identification (ID) card from the Claims Administrator. Present this card to the network pharmacy when you purchase covered prescription drugs. There are no claim forms to complete.

If You Use an Out-of-Network Retail Pharmacy

Coverage for prescriptions purchased at out of network pharmacies are not covered under this plan.

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately. Non-formulary drugs are not eligible to be filled through the mail service program.

To fill a prescription through the mail-service program, you must complete an order form and include your co-payment (using a credit card, check, or money order). With your first order, you also must include the original prescription order written by your doctor and a completed patient profile form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid.

Prior Authorization and Limits

Certain prescriptions may require prior authorization by the Claims Administrator. This process allows the Plan to verify that the drug is a part of a specific treatment plan and is medically necessary. Your physician will need to contact the Claims Administrator with written documentation of the reason for prescribing the medication and the length of time it should be covered. If you discover that a prescription requires prior authorization while you are at a retail pharmacy, you or the pharmacist will need to contact your doctor, who must then contact the Claims Administrator.

If your prescription is authorized by the Plan, you will be able to fill your prescription at any participating pharmacy or through the mail service program. If authorization is not received, you will be required to pay the full cost of the prescription.

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period, or lifetime as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance.

Expenses Not Covered

Ineligible medications and expenses not covered by the plan are shown in the Prescription Drug Exclusions section.

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

Your Vision Benefits

If you elect medical coverage under the Plan, you are automatically enrolled in the Vision program. Your vision benefits are delivered through a network of participating ophthalmologists, optometrists, and other providers who have agreed to provide services at a discounted cost.

Network Providers

You should refer to the Vision Care Schedule of Benefits for a more detailed summary of what vision benefits are covered under the Plan and how benefits are paid when you use participating providers. The Vision Care Schedule of Benefits contains any deductible, copayments or coinsurance that apply to covered benefits, limitations, maximum benefits payable, or any other discounts that may apply.

To locate a provider or to find out if your provider participates in the network, contact Eyemed Vision Care at 1-877-842-3348 or visit their website at Eyemedvisioncare.com Benefits are available through participating providers only. Eligible Expenses

Eligible expenses are those provided for services and supplies that are authorized by and approved by your physician or other approved provider. Expenses must be medically necessary for the care and treatment of a covered procedure or condition. Refer to the Vision Care Schedule of Benefits and the Vision Care Exclusions section for detailed information regarding benefits covered and excluded under the Plan.

For More Information

If you have questions about a covered or excluded benefit or service, or for more information about a specific procedure, contact the Claims Administrator at the number listed on the back of your ID card.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under Federal laws such as COBRA.

Plan Sponsor and Administrator

Kenmore Town of Tonawanda Union Free School District is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Kenmore Town of Tonawanda Union Free School District
1500 Colvin Boulevard
Buffalo, NY 14223
716-874-8400

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is July 1 through June 30.

Type of Plan

This Plan is called a “welfare plan”, which includes group health plans; they help protect you against financial loss in case of sickness or injury.

Plan Status under the ACA

Non-Grandfathered

Applicable Law

Federal and the State of New York

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participants’ rights in the Plan are governed by the plan documents and applicable State law and regulations.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 16-6002097 PLAN NUMBER: 501

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The Company and employees both contribute to the Plan. The Company will use these contributions to pay benefits to or on behalf of Plan Participants from the Company's general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

Claims Administrators

The Plan Administrator has contracted with the following company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below. Your Claims Administrator is listed on your ID card.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Claims Administrator is Not a Fiduciary

The Claims Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Medical /Utilization Review

Claims Administrator

Independent Health
P.O. Box 9066
Buffalo, NY 14231

716-631-2661
www.independenthealth.com

Prescription Drug Administrator

Pharmacy Benefit Dimensions
511 Farber Lakes Drive
Buffalo, NY 14221
716-631-2661
www.pbdrx.com

COBRA Administrator

Nova Healthcare Administrators, Inc.
6400 Main Street
Suite 210
Buffalo, NY 14221
716-932-5000
www.novahealthcare.com

Vision Administrator

EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040

877-842-3348
www.eyemedvisioncare.com

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

Kenmore Town of Tonawanda Union Free School District
1500 Colvin Boulevard
Buffalo, NY 14223
716-874-8400

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Company to continue your employment or interfere with the Company's right to terminate your employment, with or without cause.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned. If you receive care from a non-network provider, it is your responsibility to pay the non-

network provider for the charges you incurred, including any difference between what you were billed and what the Plan paid. You may not assign your benefits under the Plan to a non-network provider without the Company's consent. The Company (or a Claims Administrator) reserves the right, in its discretion, to pay a non-network provider directly for services rendered to you. Direct payment to a non-network provider shall not be deemed to constitute consent by the Company or waive the consent requirement for assigning benefits.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with Federal Mandates

The Plan is designed to comply to the extent possible with the requirement of all applicable laws, including but not limited to: Affordable Care Act (ACA), Consolidated Appropriations Act, 2021 (CAA 2021), COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law, and Title I of GINA.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

In-Network Claims — Generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims — If you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the appropriate Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact your Claims Administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

For medical expenses, your Claims Administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate Claims Administrator listed on your ID card along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

Appointment of Authorized Representative

A claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a claimant's treating health care practitioner to act as the claimant's authorized representative without completion of the authorized representative form.

Should a claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the claimant, unless the Plan Administrator is otherwise notified in writing by the claimant. A claimant can revoke the authorized representative at any time. A claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a provider accepting an assignment of benefits, requiring a release of information, or requesting completion a similar form. An assignment of benefits by a claimant shall not be recognized as a designation of the provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Time Frames for Submitting a Claim

Claims should be filed with the Claims Administrator in accordance to the following guidelines:

1. Participating Provider – submission time is based on the PPO Network contract.
2. Non-Participating Provider – within 120 days of the date charges for the services were incurred.
3. Member Submitted claims – within 120 days of the date charges for the services were incurred.

Claims filed later than the above dates may be declined or reduced unless:

1. It's not reasonably possible to submit the claim in that time and
2. The claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		

Claim Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart. If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Claims				
Appeal Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Plan Administrator's decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

External Review Rights

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, you may be entitled to request an external review of the Claims Administrator's decision. You will be notified in writing that your claim is eligible for an external review and you will be informed of the time frames and the steps necessary to request an external review. In most cases, you must complete all levels of the internal claims and appeal procedure before you can request a voluntary external review.

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator and the Plan.

There are two types of external review:

- Standard external review
- Expedited external review

You or your representative may request a standard external review, or an expedited external review in urgent situations, by following the directions in the determination letter. A request for an external review must be made within four months after the date you received Claims Administrator's decision.

Standard External Review

A standard external review involves the following steps:

- The Claims Administrator performs a preliminary review.
- The Claims Administrator refers the review request to the IRO.
- The IRO makes a decision.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether you meet all of the following requirements:

- You were covered under the Plan at the time the health care item or service was provided (or requested for a pre-service claim).
- The adverse benefit determination does not relate to your failure to meet the Plan’s eligibility criteria.
- You have exhausted the Plan’s applicable internal appeals process (unless the Claims Administrator did not adhere to the claims and appeals requirements).
- You have provided all the information and forms required so that the Claims Administrator may process your external review request.

After the Claims Administrator completes the preliminary review, it will issue a notification in writing to you. If your request is complete but not eligible for external review, the Claims Administrator’s notice will provide (1) the reasons your request is ineligible

and (2) contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the missing information or materials. The Claims Administrator will then allow you to complete the request for external review before the end of the original four-month filing period or within 48 hours, whichever is later.

If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review and provide the IRO with the materials considered during the internal appeals process. The IRO will timely notify you in writing to (1) confirm your request is eligible for external review and (2) inform you that you may submit in writing, within ten business days following the date of receipt, additional information that the IRO should consider when conducting the external review. The IRO will forward any additional information you provide to the Claims Administrator so that it may consider whether to approve your claim based on the new information.

The IRO will provide written notice of its determination within 45 days after it receives the request for the external review. The IRO will deliver the notice of its determination to you and the Claims Administrator, and it will include the clinical basis for the determination.

If the IRO's decision reverses the Claims Administrator's determination, the Plan will provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the IRO's determination is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the health care item or service.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive any of the following:

- An adverse benefit determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the guidelines for an expedited internal appeal and you have filed a request for an expedited internal appeal;
- A final internal adverse benefit determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the guidelines for a standard external review; or

- A final internal adverse benefit determination involving an admission, availability of care, continued stay, or a health care item or service for which you received emergency services, but have not been discharged from the facility.

Immediately upon receipt of your request, the Claims Administrator will determine whether the request is eligible for expedited external review and will immediately send you a notice of its eligibility determination.

If the Claims Administrator determines that your request is eligible for an expedited external review, the Claims Administrator will assign an IRO. The IRO will render a decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the assigned IRO will provide you, the Claims Administrator, and the Plan with written notification of its decision within 48 hours.

For additional information about the external IRO process, contact the Claims Administrator at the telephone number shown on your ID card.

Assignments

For this purpose, the term “Assignment of Benefits” (or “AOB”) is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Co-payments and Coinsurance amounts, to a medical provider. If a provider accepts said arrangement, the provider’s rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Co-payments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the claimant or dependent on whose behalf such payment was made.

A claimant, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a claimant, provider or other person or entity to enforce the provisions of this section, then that claimant, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, claimants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other

party and/or recovery for which the claimant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a claimant or by any of his covered dependents if such payment is made with respect to the claimant or any person covered or asserting coverage as a dependent of the claimant.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the claimant for any outstanding amount(s).

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a Plan participant is covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug benefits.

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- the primary plan is determined and pays the full amount it normally would pay;
- the secondary plan calculates the amount it normally would pay and then pays any portion of that amount not paid by the primary plan (but not to exceed 100% of charges); and
- you pay any remaining expenses.

If another plan is primary and this plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.

- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
    - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
    - When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

Applicable to Active Employees and Their Spouses Ages 65 and Over

An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any

benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled "Coordination of Benefits"). If the Eligible Provider accepts assignment with Medicare, Eligible Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

Excess Insurance

If at the time of injury, illness or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of coverage, including, but not limited to, the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds

- Any medical, applicable disability or other benefit payments
- School insurance coverage

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage;
- any co-payment under the automobile coverage;
- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the plan year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the plan year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Third Party Recovery, Subrogation and Reimbursement

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the illness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds

- Any medical, applicable disability or other benefit payments
- School insurance coverage

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness, injury, or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement,

the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of injury, illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim

shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the illness, disability, or injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset
If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status
In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation
The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan

administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:

- Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
- Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
- Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
- Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
- If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

i. Privacy Officer.
ii. Superintendent
iii. Assistant Superintendent of Finance
iv. Assistant Superintendent of Human Resources
v. Other Designated Clerk in the Human Resources Department

b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
- Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the HIPAA Plans any security incident of which it becomes aware.

Privacy Officer Contact Information:

School Business Administrator

Kenmore Town of Tonawanda Union Free School District
1500 Colvin Blvd.
Buffalo, NY 14203
716.874.8400
www.ktufsd.org

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Company is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- enrollment in Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become entitled to Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Company within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage. (Also see "Coverage While You Are Not at Work" in the Plan Overview for additional information.)

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Company terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

Accident
An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work
A participant is considered actively at work if he or she:

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
    - a scheduled vacation;
    - an absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
    - a scheduled day off within the participant's working schedule; or
    - an absence excused by the Company.

Adverse Benefit Determination
Any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

Affordable Care Act
See “PPACA”

Approved Clinical Trial
A phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration, or is exempt from investigational new drug application requirements.

Certified IDR Entity
An entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

COBRA
The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Coinsurance
The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

Complete Claim (Proper Claim)
A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim
A claim for a benefit that involves an ongoing course of treatment.

Co-payment
The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Deductible
The dollar amount (for individual or family) a participant must pay each year before the Plan begins to pay benefits.

Doctor/Physician
A doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.), or a podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Eligible Provider
Any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, osteopath, podiatrist, chiropractor, hospital, or laboratory.

Emergency
A situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services
"Emergency Services" means, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the

Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a non-Network Eligible Provider or Non-Participating Health Care Facility (regardless of the department of the hospital in which items or services are furnished) after the Participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Eligible Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Eligible Provider to be treated as a non-Network Eligible Provider.

Employee

A person who works for the Company in an employer-employee relationship.

Essential Health Benefits

As stated under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of New York as permitted by the Departments of Labor, Treasury, and Health and Human Services.

Experimental and/or Investigational

Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.

2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished.
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or diagnosis.

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean one or more of the following:

1. Only published reports and articles in the authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a "covered servicemember". Additional military caregiver leave is available to care for a covered servicemember with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

Formulary

A list of prescription drugs that represent safe, effective therapeutic medications covered by the Plan.

Genetic Information

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

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Incurred
An Eligible Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Eligible Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Eligible Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department
A health care facility that is geographically separate and distinct, and licensed separately, from a hospital under applicable state law, and which provides any Emergency Services.

In-Network Provider
A health care professional or facility that is contracted by the Plan to provide health care benefits under the Plan.

Leased Employee
Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Leave of Absence
A period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

Legal Separation and/or Legally Separated
An arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Managed Care
A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Medicare
The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Medical Record Review

The process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medically Necessary

"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, diagnosis or treatment of that Participant's illness or injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Participant's illness or injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Participant's illness or injury without adversely affecting the Participant's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a physician for the diagnosis or treatment of an illness or injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Eligible Expense.

For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a physician does not necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary."

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

"Mental Disorder," "Behavioral Disorder," or "Neurodevelopmental Disorder"

Any illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder, Behavioral Disorder, or Neurodevelopmental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

Network

A group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

Network Pharmacy

A pharmacy contracted by the Plan to provide prescription drug benefits under the Plan.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Other Plan
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Participant.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Out-of-Pocket Maximum
The maximum amount a participant pays for covered medical expenses (including expenses for covered dependents) in a Plan year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the plan year.

Participant
An eligible employee, dependent, individual that is covered under the Plan through COBRA continuation, or retiree, who elects to participate in the Plan by completing the necessary enrollment forms.

Participating Health Care Facility
A hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, or other Eligible Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Post-Service Health Claim
A claim for a benefit under the Plan that is not a pre-service claim.

PPACA
The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Pre-Service Health Claim
A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit.

Preventive Care
Certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

For more information, Participants may contact the Plan Administrator / Employer.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)
Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a

QMCSO or an NMSN. A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Qualifying Payment Amount
The median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Claims Administrator (if calculated by the Claims Administrator), for the same or a similar item or service provided by an Eligible Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Recognized Amount
Except for non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of an Eligible Provider's billed charge or the Qualifying Payment Amount.

Substance Abuse and/or Substance Use Disorder
Any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
A Federal law covering the rights of participants who have a qualified uniformed services leave.

Urgent Care Claim
A claim for medical treatment which, if the regular time periods observed for claims were adhered to, 1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or 2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed. Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual

acting on behalf of the Plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

The Kenmore Town of Tonawanda Union-Free School District First Choice Plans, as stated herein, is hereby adopted as of 07/01/2022. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this _____ day of _____, 20 .

BY: _____

TITLE: _____

Medical Plan Schedule of Benefits

Provider Network

First Choice

Ambulatory Surgery Center of WNY

Bertrand Chaffee (Will not be part of First Choice as of 10/1/2023)

Buffalo Surgery Center (on Excelsior Campus)

Buffalo Ambulatory Center

Buffalo MRI (as of 8/1/2022)

Center for Ambulatory Surgery

Eastern Niagara Hospitals (Lockport Memorial and Intercommunity Newfane Hospital)

Jennie B Richmond (Will not be part of First Choice as of 10/1/2023)

Kenmore Mercy

Medina Memorial Hospital (Will not be part of First Choice as of 10/1/2023)

Mercy Hospital

Mt St Mary's

Niagara Regional Surgery Center

Seton Imaging

Sisters

Southtowns Radiology

St Joseph

Sterling Surgical Center, LLC

Windsong Radiology

Specialty Services

Brylin (MH/SA)

ECMC (burns, trauma, transplants and MH/SA)

John R Oishei Children's Hospital (pediatric care)

Roswell (cancer treatment)

Non First Choice

Some examples are:

Kaleida Hospitals

VNA Home Care

Physician/Ancillary

Some examples are:

Benson Surgical

Buffalo Medical Group

Catholic Medical Partners

Quest Diagnostics

First Choice POS Option

	Network	Out-of-Network
Deductible • Individual • Family Unit	 $2,000 $4,000	
Payment Level (unless otherwise stated)	20%	20%
Maximum Out-of-Pocket		

• Individual • Family Unit	$5,000 $10,000

Covered Medical Expenses	Network	Out-of-Network	Limits
Advanced Radiology Professional	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Technical *(**NOTE**: Advanced Radiology Services include: MRI, MRA, CT Scan, PET Scan and Myocardial Nuclear Perfusion Imaging.)*	First Choice: $20 Co-payment Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: $20 co-payment	Subject to Deductible; 20% Coinsurance	
Allergy Services – Testing & Treatment	Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Ambulance	Physician/Ancillary: $100 Co-payment per trip	Payable as an In-Network benefit	
Ambulatory Surgical Center **(Free Standing Facility)**	First Choice: $125 Co-payment per encounter Specialty Services: $125 Co-payment per encounter Non First Choice: 20% Coinsurance after Deductible	Subject to Deductible; 20% Coinsurance	
Autologous Blood	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: 20% Coinsurance	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Breast Feeding, Lactation Support & Supplies	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Breast Prosthesis	Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Cardiac Rehabilitation	First Choice: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment	Subject to Deductible; 20% Coinsurance	36 visits per year
Chemotherapy Administration	First Choice: Covered in full Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Medication	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Chiropractic Care	Physician/Ancillary: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Compression Stockings	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% coinsurance after Deductible	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Physician/Ancillary: Covered in full		
Contraceptives			
Provider Dispensed	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Self-Administered	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Dental			
Accidental	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Payable as an In-Network benefit	
Congenital Disease & Anomaly	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Diabetic			
Equipment *(e.g., Blood Glucose Monitor,*	Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Insulin Pump.)			
Insulin, Oral Agents	Physician/Ancillary: See Pharmacy Benefit	Not covered	
Teaching	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Diabetic Supplies			
Insulin Dependent	Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	300 test strips per 30 day period; 900 test strips per 90 day period; limit is combined In-Network and Out-of-Network
Non-Insulin Dependent	Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	100 test strips per 30 day period; 300 test strips per 90 day period; limit is combined In-Network

Covered Medical Expenses	Network	Out-of-Network	Limits
			and Out-of-Network
Diagnostic Testing: **Technical Services**	First Choice: Covered in full Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Dialysis Facility/Home Physician	 First Choice: Covered in full Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment Physician/Ancillary: Covered in full	 Subject to Deductible; 20% Coinsurance Subject to Deductible; 20% Coinsurance	
Durable Medical Equipment	Physician/Ancillary: 20% Coinsurance	Subject to Deductible; 50% Coinsurance	
Emergency Room: Facility *(**NOTE:** Includes Observation Stay)*	First Choice: $250 Co-payment per encounter Specialty Services: $250 Co-payment per encounter Non First Choice: $250 Co-payment per encounter	Payable as an In-Network benefit	
Emergency Room: Follow-Up Visit	First Choice: Office visit or emergency room member liability may apply Specialty Services: Office visit or emergency room member liability may apply Non First Choice: Office visit or emergency room member liability may apply	Payable as an In-Network benefit	
Home Health Care or Aide	First Choice: $20 Co-payment	Subject to Deductible;	Up to four (4)

Covered Medical Expenses	Network	Out-of-Network	Limits
	Non First Choice: Erie/Niagara: 20% coinsurance after deductible; All other WNY: $20 copay Physician/Ancillary: $20 Co-payment	20% Coinsurance	continuous hours
Home Infusion Therapy Administration	First Choice: Covered in full Non First Choice: Erie/Niagara: 20% coinsurance after deductible; All other WNY: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Medication *(**NOTE:** Intravenous infusions administered in the home which required the skills of a licensed registered professional nurse. Home Infusion Administration includes Nursing services/visits and other services (supplies and per diem items.))*	First Choice: Covered in full Non First Choice: Erie/Niagara: 20% coinsurance after deductible; All other WNY: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Hospice Inpatient	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full	Subject to Deductible; 20% Coinsurance	
Outpatient/Home	Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Hospital Inpatient Medical Rehab Facility	First Choice: Covered in full Specialty Services: $500 Co-payment per admission	Subject to Deductible; 20% Coinsurance	45 days combined In-Network

Covered Medical Expenses	Network	Out-of-Network	Limits
	Non First Choice: 20% Coinsurance after Deductible		and Out-of-Network per plan year
Immunizations Adults Travel Children	 Physician/Ancillary: Covered in full Physician/Ancillary: Covered in full Physician/Ancillary: Covered in full	 Subject to Deductible; 20% Coinsurance Subject to Deductible; 20% Coinsurance Subject to Deductible; 20% Coinsurance	
Infertility Services: Basic and Comprehensive *Basic service: initial evaluation along with diagnostic tests; i.e. semen analysis and hysterosalpingogram. Comprehensive service: ovulation induction and monitoring, pelvic ultrasound, artificial insemination, hysteroscopy, laparotomy.*	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Infusion Therapy & OP Administration	 First Choice: Covered in full Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	 Subject to Deductible; 20% Coinsurance Subject to Deductible;	

Covered Medical Expenses	Network	Out-of-Network	Limits
Medication	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full	20% Coinsurance	
Injections Office & OP			
Administration	First Choice: Covered in full Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Medication	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Inpatient Facility Services *(**NOTE**: Services include facility charges for: Acute Admissions; Mental Health Admissions; Substance Abuse Detox Admissions; Substance Abuse Rehab Admissions)*	First Choice: Covered in full Specialty Services: $500 Co-payment per admission Non First Choice: 20% Coinsurance after Deductible	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Laboratory & Pathology	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Independent Lab: 20% Coinsurance after Deductible; Doctor's Office: Covered in full	Subject to Deductible; 20% Coinsurance	
Mammogram: Technical Charges			
Screening	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Diagnostic	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Mammogram: Professional Charges			
Screening	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Diagnostic	First Choice: Covered in full Specialty Services: Covered in full	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Non First Choice: Covered in full Physician/Ancillary: Covered in full		
Maternity			
Prenatal & Postnatal Visits	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	Covered in full after initial diagnosis
Sonogram(s)	First Choice: $20 Co-payment Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Inpatient Facility	First Choice: Covered in full Specialty Services: 20% Coinsurance after Deductible Non First Choice: 20% Coinsurance after Deductible	Subject to Deductible; 20% Coinsurance	
Home Birth	Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Birthing Center	Non First Choice: 20% Coinsurance after Deductible	Subject to Deductible; 20% Coinsurance	
	First Choice: Covered in full		

Covered Medical Expenses	Network	Out-of-Network	Limits
Home Visit	Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: covered in full	Subject to Deductible; 20% Coinsurance	
Medical Supplies	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: covered in full	Subject to Deductible; 20% Coinsurance	
Mental Health Outpatient	First Choice: Adult: $10 Co-payment; Child: $20 Co-payment Specialty Services: Adult: $10 Co-payment; Child: $20 Co-	Subject to Deductible;	

Covered Medical Expenses	Network	Out-of-Network	Limits
Partial Hospitalization (ECT) Facility	payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment; Child: $20 Co-payment First Choice: Adult: $10 Co-payment; Child: $20 Co-payment Specialty Services: Adult: $10 Co-payment; Child: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment; Child: $20 Co-payment Specialty Services: Adult: $10 Co-payment; Child: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment; Child: $20 Co-payment	20% Coinsurance Subject to Deductible; 20% Coinsurance Subject to Deductible; 20% Coinsurance	
Newborn: Inpatient Facility	First Choice: Covered in full Specialty Services: Covered in full at JROCH only Non First Choice: 20% Coinsurance after Deductible	Subject to Deductible; 20% Coinsurance	
Nutritional Counseling	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Nutritional Supplies	First Choice: Covered in full	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Enteral & Parenteral Infusion	Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full		
Office & Home Visits	First Choice: $20 Co-payment Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 20% Coinsurance	
OP Surgical Facility	First Choice: $125 Co-payment per encounter Specialty Services: $125 Co-payment per encounter Non First Choice: 20% Coinsurance	Subject to Deductible; 20% Coinsurance	
OP Surgery: Physician Office Charges	First Choice: Adult: $10 Co-payment; Child: $20 Co-payment Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Ostomy Supplies	Physician/Ancillary: 20% Coinsurance	Subject to Deductible; 50% Coinsurance	
Other Unlisted OP Hospital Services *(e.g., IV Therapy, Hyperbaric Oxygen Therapy, blood transfusions, etc.)*	First Choice: $20 Co-payment Physician/Ancillary: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Post-Mastectomy Supplies (Bras)	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Preventive Care *(**NOTE:** Includes, but is not limited to, the following preventive care services: Routine physicals; immunizations; annual GYN exam; PSA test; mammograms; pap smears; contraceptive management; colonoscopy; miscellaneous preventive labs, diagnostics and X-Ray; pre-natal and post-natal examinations; tubal ligations; and more.)*	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Professional Services *(**NOTE**: Includes, but not limited to, the following 'professional' services: Anesthesia; Routine Radiology; Allergy Serum; IP Professional services including consultations and surgeries; OP Professional services including Physician charges for surgery, ER, OR and other OP facility settings.)*	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Prosthetics and Appliances	Physician/Ancillary: 20% Coinsurance	Subject to Deductible; 20% Coinsurance	
Pulmonary Rehabilitation	First Choice: Covered in full Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment	Subject to Deductible; 20% Coinsurance	24 visits per year
Radiation Therapy:	First Choice: Covered in full	Subject to Deductible;	

Covered Medical Expenses	Network	Out-of-Network	Limits
Professional Charges	Specialty Services: Covered in full Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full	20% Coinsurance	
Radiation Therapy: **Technical Charges**	First Choice: Covered in full Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Rehabilitative Physical, **Occupational, and Speech Therapies**	First Choice: $20 Co-payment Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment	Subject to Deductible; 20% Coinsurance	20 visits per year, combined for all therapies, in and out of network
Routine Physicals	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance	
Roswell's Inhale Life **Program**	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Not covered	
Routine Radiology: **Technical Services**	First Choice: $20 Co-payment Specialty Services: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Physician/Ancillary: $20 Co-payment		
Skilled Nursing Facility Physician/Ancillary Visits	First Choice: Covered in full Specialty Services: $500 Co-payment per admission Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Covered in full	Subject to Deductible; 20% Coinsurance Subject to Deductible; 20% Coinsurance	90 days per plan year First Choice tier; 45 days combined all other tiers per plan year. 45 days count toward 90 day limit
Smoking Cessation	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Not covered	
Substance Abuse Outpatient *(**NOTE**: Partial Hospitalization: Minimum of at least three (3) continuous hours at an approved facility, receiving care that is provided in lieu of inpatient substance abuse hospitalization. Care that is provided in lieu of inpatient mental health hospitalization at an approved*	First Choice: Adult: $10 Co-payment; Child: $20 Co-payment Specialty Services: Adult: $10 Co-payment; Child: $20 Co-payment Non First Choice: 20% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment; Child: $20 Co-payment	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
facility.) Family Therapy	First Choice: $10 Co-payment; Child: $20 Co-payment Specialty Services: $10 Co-payment; Child: $20 Co-payment Non First Choice: 20% Coins Physician/Ancillary: $10 Co-payment; Child: $20 Co-payment	Subject to Deductible; 20% Coinsurance	20 visits combined In-Network and Out-of-Network per plan year
Telemedicine (Teladoc) **Telemedicine (Teladoc) Dermatology** **Telemedicine (Teladoc) Behavioral Health**	Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment Physician/Ancillary: $20 Co-payment Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	Not applicable Not applicable Not applicable	
Termination of Pregnancy Facility Charges Physician Office Based Charges	Specialty Services: $125 Co-payment per encounter Non First Choice: $125 Co-payment per encounter Physician/Ancillary: PCP Adult: $10 Co-payment; PCP Child: $20 Co-payment; Specialist: $20 Co-payment	Subject to Deductible; 20% Coinsurance Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Transplant			
Donor	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Recipient	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Urgent Care Center			
In-Area	Physician/Ancillary: $50 Co-payment	Subject to Deductible; 20% Coinsurance	
Out-of-Area	Physician/Ancillary: $20 Co-payment	Payable as an In-Network benefit	
Vasectomy			
Facility	Non First Choice: $125 Co-payment per encounter	Subject to Deductible; 20% Coinsurance	
Physician in Office	Physician/Ancillary: PCP: $10 Co-payment; Specialist: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Vision: Medical	Physician/Ancillary: $20 Co-payment	Subject to Deductible; 20% Coinsurance	
Vision Routine	Physician/Ancillary: EyeMed	Not covered	
Well Baby/Child Care	First Choice: Covered in full	Subject to Deductible; 20% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full		

First Choice HDHP HSA Option

	Network	Out-of-Network
Deductible • Individual • Family Unit	 $1,400 $2,800	
Payment Level (unless otherwise stated)	30%	30%
Maximum Out-of-Pocket • Individual • Family Unit	 $5,275 $10,500	

Covered Medical Expenses	Network	Out-of-Network	Limits
Advanced Radiology Professional	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Technical *(**NOTE**: Advanced Radiology Services include: MRI, MRA, CT Scan, PET Scan and Myocardial Nuclear Perfusion Imaging.)*	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Allergy Services – Testing & Treatment	Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Ambulance	Physician/Ancillary: $100 Co-payment per trip	Payable as an In-Network benefit	
Ambulatory Surgical Center **(Free Standing Facility)**	First Choice: Covered in full after Deductible Specialty Services: $75 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	
Autologous Blood	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	
Breast Feeding, Lactation Support & Supplies	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Breast Prosthesis	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Cardiac Rehabilitation	First Choice: Covered in full after Deductible	Subject to Deductible;	36 visits

Covered Medical Expenses	Network	Out-of-Network	Limits
	Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	30% Coinsurance	per year
Chemotherapy Administration	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Medication	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Chiropractic Care	Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Compression Stockings	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Contraceptives			
Provider Dispensed	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Self-Administered	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Dental			
Accidental	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Payable as an In-Network benefit	
Congenital Disease & Anomaly	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Diabetic			
Equipment *(e.g., Blood Glucose Monitor, Insulin Pump.)*	Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Insulin, Oral		Not covered	

Covered Medical Expenses	Network	Out-of-Network	Limits
Agents Teaching	Physician/Ancillary: See Pharmacy Benefit First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Diabetic Supplies			
Insulin Dependent	Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	300 test strips per 30 day period; 900 test strips per 90 day period; limit is combined In-Network and Out-of-Network
Non-Insulin Dependent	Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	100 test strips per 30 day period; 300 test strips per 90 day period; limit is combined In-Network and Out-of-

Covered Medical Expenses	Network	Out-of-Network	Limits
			Network
Diagnostic Testing: **Technical Services**	First Choice: Covered in full after Deductible Specialty Services: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Dialysis Facility/Home	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Physician	Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Durable Medical Equipment	Physician/Ancillary: 20% Coinsurance after Deductible	Subject to Deductible; 50% Coinsurance	
Emergency Room: Facility *(**NOTE:** Includes Observation Stay)*	First Choice: $250 Co-payment per encounter after Deductible Specialty Services: $250 Co-payment per encounter after Deductible Non First Choice: $250 Co-payment per encounter after Deductible	Payable as an In-Network benefit	
Emergency Room: Follow-Up Visit	First Choice: Office visit or emergency room member liability may apply Specialty Services: Office visit or emergency room member liability may apply Non First Choice: Office visit or emergency room member liability may apply Physician/Ancillary: Office visit or emergency room member liability may apply	Payable as an In-Network benefit	
Home Health Care or Aide	First Choice: Covered in full after Deductible Non First Choice: Erie/Niagara: 30% Coinsurance after Deductible; All other WNY: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	First Choice: Limit 90 visits combined in/out of

Covered Medical Expenses	Network	Out-of-Network	Limits
	Physician/Ancillary: $20 Co-payment after Deductible		network per year All other tiers: 40 visits combined in/out of network per year
Home Infusion Therapy Administration Medication *(**NOTE:** Intravenous infusions administered in the home which required the skills of a licensed registered professional nurse. Home Infusion Administration includes Nursing services/visits and other services (supplies and per diem items.))*	First Choice: Covered in full after Deductible Non First Choice: Erie/Niagara: 30% Coinsurance after Deductible; All other WNY: Covered in full after Deductible Physician/Ancillary: Covered in full after Deductible First Choice: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible; All other WNY: Covered in full after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance Subject to Deductible; 30% Coinsurance	
Hospice Inpatient	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance Subject to Deductible;	

Covered Medical Expenses	Network	Out-of-Network	Limits
Outpatient/Home	Physician/Ancillary: Covered in full after Deductible	30% Coinsurance	
Hospital Inpatient Medical Rehab Facility	First Choice: Covered in full after Deductible Specialty Services: $250 Co-payment per admission after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	45 days combined In-Network and Out-of-Network per plan year
Immunizations			
Adults	Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Travel	Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Children	Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Infertility Services: Basic and Comprehensive *Basic service: initial evaluation along with diagnostic tests; i.e. semen analysis and hysterosalpingogram. Comprehensive service: ovulation induction and monitoring, pelvic ultrasound, artificial insemination, hysteroscopy, laparotomy.*	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Infusion Therapy & OP			
Administration	First Choice: $20 Co-payment after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Medication	Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Injections Office & OP Administration Medication	First Choice: $20 Co-payment after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance Subject to Deductible; 30% Coinsurance	
Inpatient Facility Services *(**NOTE**: Services include facility charges for: Acute Admissions; Mental Health Admissions; Substance Abuse Detox Admissions; Substance Abuse Rehab Admissions)*	First Choice: Covered in full after Deductible Specialty Services: $250 Co-payment per admission after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Laboratory & Pathology	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Independent Lab: 30% Coinsurance after Deductible; Doctor's Office: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Mammogram: Professional Charges			
Screening	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Diagnostic	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Mammogram: Technical Charges			
Screening	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Diagnostic		Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full		
Maternity			
Prenatal & Postnatal Visits	First Choice: Covered in full after initial diagnosis Specialty Services: Covered in full after initial diagnosis Non First Choice: Covered in full after initial diagnosis Physician/Ancillary: Covered in full after initial diagnosis	Subject to Deductible; 30% Coinsurance	
Sonogram(s)	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Inpatient Facility	First Choice: Covered in full after Deductible Specialty Services: 30% Coinsurance after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	
Home Birth	Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Birthing Center	Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Home Visit	First Choice: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Medical Supplies	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Mental Health			
Outpatient	First Choice: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible Specialty Services: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Partial Hospitalization	First Choice: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible Specialty Services: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
	Specialty Services: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
(ECT) Facility	Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible		
Newborn: Inpatient Facility	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible at JROCH only Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	
Nutritional Counseling	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Nutritional Supplies Enteral & Parenteral Infusion	First Choice: Covered in full after Deductible Specialty Services: Covered in full Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Office & Home Visits	First Choice: $20 Co-payment after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
OP Surgical Facility	First Choice: Covered in full after Deductible Specialty Services: $75 Co-payment per encounter after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	
OP Surgery: Physician Office Charges	First Choice: $20 Co-payment after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Ostomy Supplies	Physician/Ancillary: 20% Coinsurance after Deductible	Subject to Deductible; 50% Coinsurance	
Other Unlisted OP Hospital Services *(e.g., IV Therapy, Hyperbaric Oxygen Therapy, blood transfusions, etc.)*	First Choice: $20 Co-payment after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Post-Mastectomy Supplies (Bras)	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Preventive Care *(**NOTE:** Includes, but is not limited to, the following preventive care services: Routine physicals; immunizations; annual GYN exam; PSA test; mammograms; pap smears; contraceptive management; colonoscopy; miscellaneous preventive labs, diagnostics and X-Ray; pre-natal and post-natal examinations; tubal ligations; and more.)*	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	
Professional Services *(**NOTE**: Includes, but not limited to, the following 'professional' services: Anesthesia; Routine Radiology; Allergy Serum; IP Professional services including consultations and*	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
surgeries; OP Professional services including Physician charges for surgery, ER, OR and other OP facility settings.)			
Prosthetics and Appliances	Physician/Ancillary: 20% Coinsurance after Deductible	Subject to Deductible; 50% Coinsurance	
Pulmonary Rehabilitation	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	24 visits per year
Radiation Therapy: **Professional Charges**	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	
Radiation Therapy: **Technical Charges**	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Rehabilitative Physical, **Occupational, and Speech Therapies**	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	20 visits per year, combined for all therapies, in and out of network
Routine Physicals	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Physician/Ancillary: Covered in full		
Roswell's Inhale Life Program	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Not covered	
Routine Radiology: Technical Services	First Choice: Covered in full after Deductible Specialty Services: $20 co-payment after Deductible Non First Choice: 30% Coinsurance after deductible Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Skilled Nursing Facility	First Choice: Covered in full after Deductible Specialty Services: $250 Co-payment per admission after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 30% Coinsurance	90 days per plan year First Choice tier; 45 days combined all other tiers per plan year. 45 days count toward 90 day limit
Physician/Ancillary Visits	Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 30% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Smoking Cessation	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Not covered	
Substance Abuse Outpatient *(**NOTE**: Partial Hospitalization: Minimum of at least three (3) continuous hours at an approved facility, receiving care that is provided in lieu of inpatient substance abuse hospitalization. Care that is provided in lieu of inpatient mental health hospitalization at an approved facility.)*	First Choice: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible Specialty Services: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Family Therapy	First Choice: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible Specialty Services: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Adult: $10 Co-payment after Deductible; Child: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	20 visits combined In-Network and Out-of-Network per plan year
Telemedicine (Teladoc)	Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Not applicable	

Covered Medical Expenses	Network	Out-of-Network	Limits
Telemedicine (Teladoc) **Dermatology**	Physician/Ancillary: $20 Co-payment after Deductible	Not applicable	
Telemedicine (Teladoc) **Behavioral Health**	Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Not applicable	
Termination of Pregnancy Facility Charges	Specialty Services: $75 Co-payment after Deductible Non First Choice: $75 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Physician Office Based Charges	Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Transplant Donor	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Recipient	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered	Follows benefit for service rendered	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Physician/Ancillary: Follows benefit for service rendered		
Urgent Care Center In-Area Out-of-Area	 Physician/Ancillary: $35 Co-payment after Deductible Physician/Ancillary: $20 Co-payment after Deductible	 Subject to Deductible; 30% Coinsurance Payable as an In-Network benefit	
Vasectomy Facility Physician in Office	 Non First Choice: $75 Co-payment per encounter after Deductible Physician/Ancillary: PCP Adult: $10 Co-payment after Deductible; PCP Child: $20 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	 Subject to Deductible; 30% Coinsurance Subject to Deductible; 30% Coinsurance	
Vision: Medical	Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 30% Coinsurance	
Vision Routine	Physician/Ancillary: EyeMed	Not covered	
Well Baby/Child Care	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 30% Coinsurance	

Retiree First Choice HDHP Option

	Network	Out-of-Network
Deductible • Individual • Family Unit	 $1,300 $2,600	
Payment Level (unless otherwise stated)	30%	40%
Maximum Out-of-Pocket (***NOTE: Medical and Prescription Drug benefit expenses are subject to the same Maximum Out-of-Pocket)*** • Individual • Family Unit	 $6,750 $13,500	

Covered Medical Expenses	Network	Out-of-Network	Limits
Advanced Radiology			
Professional	Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Technical	First Choice: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
*(**NOTE**: Advanced Radiology Services include: MRI, MRA, CT Scan, PET Scan and Myocardial*	Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible		

Covered Medical Expenses	Network	Out-of-Network	Limits
Nuclear Perfusion Imaging.)	Physician/Ancillary: $20 Co-payment after Deductible		
Allergy Services – Testing & Treatment	Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Ambulance	Physician/Ancillary: $250 Co-payment per trip after Deductible	Payable as an In-Network benefit	
Ambulatory Surgical Center (Free Standing Facility)	First Choice: $75 Co-payment per encounter after Deductible Specialty Services: $75 Co-payment per encounter after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	
Autologous Blood	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	
Breast Feeding, Lactation Support & Supplies	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Breast Prosthesis	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Cardiac Rehabilitation	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	36 visits combined In-Network and Out-of-Network

Covered Medical Expenses	Network	Out-of-Network	Limits
Chemotherapy Administration	First Choice: $20 Co-payment after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Chemotherapy Medication	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Chiropractic Care	Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Compression Stockings	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Contraceptives Provider Dispensed	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Self-Administered	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Dental: Accidental	First Choice: Follows benefit for service rendered	Payable as an In-Network benefit	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered		
Dental: Congenital Disease & Anomaly	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Diabetic Equipment *(e.g., Blood Glucose Monitor, Insulin Pump.)*	Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Diabetic: Insulin, Oral Agents	Physician/Ancillary: See Pharmacy Benefit	Not covered	
Diabetic Supplies Insulin Dependent Non-Insulin Dependent	 Physician/Ancillary: Covered in full Physician/Ancillary: Covered in full	 Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	Insulin Dep: 300 test strips per 30 day period; 900 test strips per 90 day period; limit is combined In-Network and Out-of-Network Non insulin dep: 100 test strips per 30 day period; 300 test strips per 90 day period; limit is combined in and oon

Covered Medical Expenses	Network	Out-of-Network	Limits
Diagnostic Testing: **Technical Services**	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Dialysis Facility/Home Physician	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	
Durable Medical Equipment	Physician/Ancillary: 20% Coinsurance after Deductible	Subject to Deductible; 50% Coinsurance	
Emergency Room: Facility *(**NOTE:** Includes Observation Stay)*	First Choice: $250 Co-payment per encounter after Deductible Specialty Services: $250 Co-payment per encounter after Deductible Non First Choice: $250 Co-payment per encounter after Deductible	Payable as an In-Network benefit	
Emergency Room: Follow-Up Visit	First Choice: Office visit or emergency room member liability may apply Specialty Services: Office visit or emergency room member liability may apply Non First Choice: Office visit or emergency room member liability may apply	Payable as an In-Network benefit	
Home Health Care or Aide	First Choice: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	90 visits

Covered Medical Expenses	Network	Out-of-Network	Limits
	Non First Choice: Erie/Niagara: 30% Coinsurance after Deductible; All other WNY: $20 Co-payment after Deductible Physician/Ancillary: $20 Co-payment after Deductible		combined In-Network and Out-of-Network per plan year First Choice tier; 40 visits combined per plan year all other tiers
Home Infusion Therapy Administration Medication *(**NOTE:** Intravenous infusions administered in the home which required the skills of a licensed registered professional nurse. Home Infusion Administration includes Nursing services/visits and other services (supplies and per diem items.))*	First Choice: Covered in full after Deductible Non First Choice: Erie/Niagara: 30% Coinsurance after Deductible; All other WNY: $20 Co-payment after Deductible Physician/Ancillary: Covered in full after Deductible First Choice: Covered in full after Deductible Non First Choice: Erie/Niagara: 30% Coinsurance after Deductible; All other WNY: $20 Co-payment after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	
Hospice Inpatient	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Outpatient/Home	Non First Choice: Covered in full after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Hospital Inpatient Medical Rehab Facility	First Choice: Covered in full after Deductible Specialty Services: $250 Co-payment per admission after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	45 days per year, combined in and out of network
Immunizations Adults Travel Children	Physician/Ancillary: Covered in full Physician/Ancillary: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	
Infertility Services: Basic and Comprehensive *Basic service: initial evaluation along with diagnostic tests; i.e. semen analysis and hysterosalpingogram. Comprehensive service: ovulation induction and monitoring, pelvic ultrasound, artificial insemination, hysteroscopy, laparotomy.*	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Infusion Therapy & OP Administration	First Choice: $20 Co-payment after Deductible Specialty Services: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Medication	Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Injections Office & OP Administration Medication	First Choice: $20 Co-payment after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	
Inpatient Facility Services *(**NOTE**: Services include facility charges for: Acute Admissions; Mental Health Admissions; Substance Abuse Detox Admissions; Substance Abuse Rehab Admissions)*	First Choice: Covered in full after Deductible Specialty Services: $250 Co-payment per admission after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
Laboratory & Pathology	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Independent Lab: 30% Coinsurance after Deductible; Doctor's Office: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Mammogram: Technical Charges			
Screening	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Diagnostic	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Mammogram: Professional Charges			
Screening	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Diagnostic	First Choice: Covered in full	Subject to Deductible; 40% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full		
Maternity			
Prenatal & Postnatal Visits	First Choice: Covered in full after initial diagnosis Specialty Services: Covered in full after initial diagnosis Non First Choice: Covered in full after initial diagnosis Physician/Ancillary: Covered in full after initial diagnosis	Subject to Deductible; 40% Coinsurance	
Sonogram(s)	First Choice: $20 co-payment after Deductible Specialty Services: $20 co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Inpatient Facility	First Choice: Covered in full after deductible Specialty Services: 30% Coinsurance after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	
Home Birth Birthing Center	Physician/Ancillary: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	
Home Visit	First Choice: Covered in full after Deductible Specialty Services: 30% Coinsurance after Deductible		

Covered Medical Expenses	Network	Out-of-Network	Limits
	Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible		
Medical Supplies	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Mental Health Outpatient Partial Hospitalization (ECT) Facility	 First Choice: $10 Co-payment after Deductible Specialty Services: $10 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $10 Co-payment after Deductible First Choice: $10 Co-payment after Deductible Specialty Services: $10 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $10 Co-payment after Deductible Specialty Services: $75 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible	 Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	
Newborn: Inpatient Facility	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible at JROCH only Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	
Nutritional Counseling	First Choice: Covered in full	Subject to Deductible; 40% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full		
Nutritional Supplies Enteral & Parenteral Infusion	Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Office & Home Visits	First Choice: $20 Co-payment after Deductible Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
OP Surgical Facility	First Choice: $75 Co-payment per encounter after Deductible Specialty Services: $75 Co-payment per encounter after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	
OP Surgery: Physician Office Charges	First Choice: $20 Co-payment after Deductible Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Ostomy Supplies	Physician/Ancillary: 20% Coinsurance after Deductible	Subject to Deductible; 50% Coinsurance	
Other Unlisted OP Hospital Services *(e.g., IV Therapy, Hyperbaric Oxygen Therapy, blood transfusions, etc.)*	First Choice: $20 Co-payment after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Post-Mastectomy Supplies Bras	First Choice: Covered in full after Deductible Specialty Services: Covered in full after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Physician/Ancillary: Covered in full after Deductible		
Preventive Care *(**NOTE:** Includes, but is not limited to, the following preventive care services: Routine physicals; immunizations; annual GYN exam; PSA test; mammograms; pap smears; contraceptive management; colonoscopy; miscellaneous preventive labs, diagnostics and X-Ray; pre-natal and post-natal examinations; tubal ligations; and more.)*	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Professional Services *(**NOTE**: Includes, but not limited to, the following 'professional' services: Anesthesia; Routine Radiology; Allergy Serum; IP Professional services including consultations and surgeries; OP Professional services including Physician charges for surgery, ER, OR and other OP facility settings.)*	Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Prosthetics and Appliances	Physician/Ancillary: 20% Coinsurance after Deductible	Subject to Deductible; 50% Coinsurance	
Pulmonary Rehabilitation	First Choice: Covered in full after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible	Subject to Deductible; 40% Coinsurance	24 visits per plan year, combined in and out of network

Covered Medical Expenses	Network	Out-of-Network	Limits
	Physician/Ancillary: $20 Co-payment after Deductible		
Radiation Therapy: **Professional Charges**	Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance	
Radiation Therapy: **Technical Charges**	First Choice: $20 Co-payment after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Rehabilitative Physical, **Occupational, and Speech Therapies**	First Choice: $20 Co-payment after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	20 combined visits for all therapies, combined in and out of network
Roswell's Inhale Life **Program**	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Not covered	
Routine Physicals	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	
Routine Radiology: **Technical Services**	First Choice: $20 Co-payment after Deductible Specialty Services: $20 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: PCP: $10 Co-payment after Deductible;	Subject to Deductible; 40% Coinsurance	

Covered Medical Expenses	Network	Out-of-Network	Limits
	Specialist: $20 Co-payment after Deductible		
Skilled Nursing Facility Physician/Ancillary Visits	First Choice: Covered in full after Deductible Specialty Services: $250 Co-payment per admission after deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: Covered in full after Deductible	Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	90 days per plan year First Choice tier; 45 days combined all other tiers per plan year. 45 days count toward 90 day limit
Substance Abuse Outpatient *(**NOTE**: Partial Hospitalization: Minimum of at least three (3) continuous hours at an approved facility, receiving care that is provided in lieu of inpatient substance abuse hospitalization. Care that is provided in lieu of inpatient mental health hospitalization at an approved facility.)* Family Therapy	First Choice: $10 Co-payment after Deductible Specialty Services: $10 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $10 Co-payment after Deductible First Choice: $10 Co-payment after Deductible Specialty Services: $10 Co-payment after Deductible Non First Choice: 30% Coinsurance after Deductible Physician/Ancillary: $10 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	 20 visits per year, combined in and out of network
Smoking Cessation	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Not covered	

Covered Medical Expenses	Network	Out-of-Network	Limits
Telemedicine (Teladoc)	Physician/Ancillary: PCP: $10 Co-payment after deductible; Specialist: $20 Co-payment after Deductible	Not applicable	
Telemedicine (Teladoc) Dermatology	Physician/Ancillary: $20 Co-payment after Deductible	Not applicable	
Telemedicine (Teladoc) Behavioral Health	Physician/Ancillary: $10 co-payment after Deductible	Not applicable	
Termination of Pregnancy			
Facility Charges	Specialty Services: $75 Co-payment after Deductible Non First Choice: $75 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance Subject to Deductible; 40% Coinsurance	
Physician Office Based Charges	Physician/Ancillary: PCP: $10 Co-Payment after Deductible; Specialist: $20 Co-payment after Deductible		
Transplant			
Donor	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	
Recipient	First Choice: Follows benefit for service rendered Specialty Services: Follows benefit for service rendered Non First Choice: Follows benefit for service rendered Physician/Ancillary: Follows benefit for service rendered	Follows benefit for service rendered	

Covered Medical Expenses	Network	Out-of-Network	Limits
Urgent Care Center In-Area Out-of-Area	 Physician/Ancillary: $35 Co-payment after Deductible Physician/Ancillary: $35 Co-payment after Deductible	 Subject to Deductible; 40% Coinsurance Payable as an In-Network benefit	
Vasectomy Facility	Non First Choice: $75 Co-payment per encounter after Deductible	Subject to Deductible; 40% Coinsurance	
Vasectomy Physician in Office	Physician/Ancillary: PCP: $10 Co-payment after Deductible; Specialist: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Vision: Medical	First Choice: $20 Co-payment after Deductible Physician/Ancillary: $20 Co-payment after Deductible	Subject to Deductible; 40% Coinsurance	
Vision Routine	Physician/Ancillary: EyeMed	Not covered	
Well Baby/Child Care	First Choice: Covered in full Specialty Services: Covered in full Non First Choice: Covered in full Physician/Ancillary: Covered in full	Subject to Deductible; 40% Coinsurance	

MEDICAL PLAN COVERED SERVICES

Covered Services are subject to the Maximum Allowable Charge for the following items of service and supply. **These Covered Services are subject to the limitations (as set forth in the Medical Plan Schedule of Benefits), Exclusions and other provisions of this SPD.** A charge is incurred on the date that the service or supply is performed or furnished. In addition to the provisions set forth below, the Plan utilizes certain Independent Health policies and procedures with respect to Covered Services under the Plan.

1. **Alcohol and Substance Abuse.**
2. **Allergy** (testing, injections, and serum).
3. **Ambulance.** Use of Ambulance services (land or air) may be reviewed retrospectively for Medical Necessity.

4. **Anesthesia.**

5. **Assistant Surgeon.**

6. **Autologous Blood.**

7. **Blood and Plasma.**

8. **Cardiac Rehabilitation.**

9. **Chemotherapy and Radiation**. The materials and services of technicians are included.

10. **Chiropractic Care.**

11. **Clinical Trials.** The Plan will cover "Routine Patient Costs" for a "Qualified Individual" participating in an "Approved Clinical Trial." For purposes of this coverage, the following definitions apply:

    a. **Routine Patient Costs** means all items and services consistent with Plan coverage that is typically covered for a Participant who is not enrolled in a Clinical Trial.

    b. **Qualified Individual** means a Participant who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to treatment of cancer or other Life-Threatening Condition and either the (i) Participant's Physician has concluded that participation is appropriate, or (ii) Participant provides medical and scientific information establishing that their participation is appropriate.

    c. **Approved Clinical Trial** means a Phase I, II, III or IV Clinical Trial for the prevention, detection or treatment of cancer or other Life-Threatening Condition or disease (or other condition described in the Affordable Care Act) such as federally funded trials (identified in the Affordable Care Act), trials conducted under an Investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application.

    d. **Life-Threatening Condition** means any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

12. **Contraceptives.**

13. **COVID-19 (2019 Novel Coronavirus).** Eligible Expenses associated with testing for COVID-19 include the following:

- *Diagnostic Tests.* The following items are covered at 100%, Deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require precertification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Eligible Provider's website, or such other amount as may be negotiated by the Eligible Provider and Plan.

- In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
    - That are approved, cleared, or authorized by the FDA;
    - For which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
    - That are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
    - That are deemed appropriate by the Secretary of Health and Human Services.
- Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

- *Over-the-Counter Tests (OTC Tests)*. The Plan will cover OTC Tests for the detection of SARS-CoV-2 or the virus that causes COVID-19, which satisfy any **one** of the following conditions:
    - that are approved, cleared, or authorized by the FDA (including an emergency authorization);
    - for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
    - that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
    - that are deemed appropriate by the Secretary of Health and Human Services.
- OTC Tests neither require precertification nor involve an individualized clinical assessment from an Eligible Provider. The Plan will cover up to 8 (eight) OTC Tests, per Participant per 30 days This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by an Eligible Provider. OTC Tests purchased In-Network are covered by the Plan at the point of sale at 100%, deductible waived. When the Plan is billed for an out-of-network OTC Test, the Plan will pay the cash price publicly posted on the Eligible Provider's website, or such other amount as may be negotiated by the Eligible Provider and Plan. If the Participant pays for an out-of-network OTC Test, the Participant will be limited to reimbursement for the actual out-of-pocket cost of the OTC Test, up to a maximum of $12 per OTC Test. If the OTC Test is acquired with the involvement of or prescription by an Eligible Provider or if the Plan has not arranged for adequate In-Network access, the Plan will reimburse the Participant at full cost.
- The following limitations also apply:
    - Coverage will be denied if reasonable evidence exists that the purchase was solely for employment purposes; and
    - Coverage will be denied if reasonable evidence exists of fraud, abuse, or that the purchase was made for use by someone other than the Participant or their dependents. **NOTE:** The Plan may require reasonable documentation of proof

of purchase with a claim for reimbursement for the cost of an OTC Test, including the UPC code for the OTC Test to verify that the item is one for which coverage is required under FFCRA, and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC Test. Further, the Plan may require a written attestation from the Participant describing the OTC Test, the price paid by the Participant, and the intended use (including for whom the OTC Test will be used).

- *Qualifying Coronavirus Preventive Services.* The following items are covered at 100%, Deductible waived, and do not require precertification.
  - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
  - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

The above benefits are specific to diagnosis of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

14. **Dental.** Medically Necessary Dental care and treatment due to accidental Injury to sound natural teeth occurring within 12 months from the date of the accidental Injury, and Dental care and treatment Medically Necessary due to congenital disease or anomaly.

15. **Diabetic Equipment and Supplies.**

16. **Diabetic Teaching.** (covered under Preventive Care).

17. **Diagnostic Testing.**

18. **Dialysis.**

19. **Durable Medical Equipment.** Rental of Durable Medical Equipment or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Claims Administrator.

20. **Electroconvulsive Therapy.**

21. **Emergency Care** (facility and Physician/Provider).

22. **Experimental and/or Investigational.** Experimental and/or Investigational treatments, procedures, drugs and devices are generally not a Covered Service. See Plan Exclusion for exceptions.

23. **Family Counseling.**

24. **Hearing.** Medically Necessary hearing tests ordered by a Physician/Provider.

25. **Hearing Aids.** Only Cochlear Implant and Bone Anchored Hearing Aid (BAHA) are covered. Must be FDA approved.

26. **Home Health Care.** When ordered by a Physician/Provider in accordance with a treatment plan approved in writing by the Medical Director as an alternative to (or to prevent) hospitalization or treatment in a Skilled Nursing Facility. Services eligible for coverage include: a) part-time or intermittent home nursing care by or under the supervision of a registered professional nurse; b) part-time or intermittent home health aide which consists primarily of caring for the Plan Participant; c) physical, Medical Supplies or Speech Therapy which consists primarily of caring for the Plan Participant; d) Medical Supplies that are rendered in the home; e) drugs and medications, including Home Infusion Therapy prescribed by a Physician/Provider; and f) Laboratory Services by or on behalf of the Home Health Agency, to the extent such items would have been covered or provided if the Plan Participant were hospitalized or confined in a Skilled Nursing Facility.

27. **Home Infusion Therapy.**

28. **Home Visits.**

29. **Hospice.** Coverage for Advanced Care Planning, inpatient care, outpatient care, home care, and bereavement counseling.

30. **Hospital** (facility and Physician/Provider).

31. **Immunizations.**

32. **Infertility.** Evaluation, testing and diagnostic services as set forth below (see Medical Plan Exclusions for specific services not covered). The Infertility benefit does not cover treatment for the partner, if the partner is not a Plan Participant under the Plan.

33. **Injections.**

34. **Laboratory and Pathology.**

35. **Mammograms.**

36. **Mastectomy.** This Plan covers: a) all stages of reconstruction of the breast on which the Mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; b) Prostheses; and c) treatment for physical complications at all stages of Mastectomy, including lymphedemas, in the manner determined in consultation with the attending Physician/Provider and the Plan Participant.

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

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

Home births are a Covered Service under the Plan when performed by a Physician/Provider who meets credentialing standards established by Nova Healthcare.

38. **Medical Services and Supplies.**

39. **Mental Health.**

40. **MRI / MRA / CAT / Nuclear.**

41. **Nutritional Counseling** (covered under Preventive Care).

42. **Occupational Therapy.**

43. **Office Visits.**

44. **Orthotics.** See Plan Exclusions for specific services not covered

45. **Ostomy Supplies.** See Prosthetics and Appliances.

46. **Outpatient Surgical Procedures.**

47. **Pap Smear.**

48. **Physical Therapy.**

49. **Physician/Provider Visit.** Coverage is available for Physician/Provider's services when a Plan Participant is in the Hospital, Skilled Nursing Facility, outpatient facility, in Physician's office or Participant's home.

50. **Podiatry.** See Plan Exclusions for specific services not covered.

51. **Preadmission Testing.**

52. **Preventive Care.** The services will include all services designated as Preventive by the United States Preventive Services Task Force and their corresponding limitations.

53. **Prostate Screening.**

54. **Prosthetics and Appliances (P&A).** Includes: a) the purchase, fitting and repair of fitted Prosthetic devices and Medical appliances which replace body parts, including Ostomy supplies; and b) replacement, repair and maintenance are covered when functionally necessary if it is not covered under manufacturer's warranty or purchase agreement and not the result of misuse. Medically Necessary orthopedic devices dispensed at a Physician/Provider's office will be covered under the Physician Visit benefit

55. **Pulmonary Rehabilitation.**

56. **Radiation Therapy.**

57. **Radiology** (X-Rays).

58. **Routine Physicals.**

59. **Second Surgical Opinions.**

60. **Skilled Nursing Facility.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when: a) the Plan Participant is confined as a bed patient in a facility; b) the attending Physician/Provider certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and c) the attending Physician/Provider completes a treatment plan which includes a Diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

61. **Sleep Studies.** Medically Necessary for the Diagnosis and treatment of sleep disorders.

62. **Speech Therapy**. Therapy must be ordered by a Physician/Provider and follow either: a) Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; b) an Illness or Injury; or c) an Illness that is other than a learning or Mental Health Condition.

63. **Sterilization.**

64. **Temporomandibular Joint (TMJ) Treatment.** Will only be covered if the TMJ is the direct cause ofanother medical condition.

65. **Termination of Pregnancy.** Only covered when the women's life would be in danger if the fetus was carried to term, or when the pregnancy is the result of rape or incest, or for medical complications that arise from an abortion.

66. **Tobacco Cessation.** Charges incurred for tobacco cessation classes and products are covered as described in the Schedule of Benefits.

67. **Transplants.** Benefits for service rendered in a Center of Excellence will be based on the service rendered (Example: surgeon's charges under the physician benefit). Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

    a. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.

    b. No transportation, companion food or lodging charges will be considered.

    c. Claims need to be submitted to the donor's insurance carrier. An EOB from the other insurance carrier then needs to be submitted to Nova Healthcare. Nova Healthcare will reimburse for the donation charges under the recipient's ID number if the other insurance carrier denies the claim or if there is a balance remaining once the other carrier has paid. Nova Healthcare will coordinate benefits.

    The Plan will always pay secondary to any other coverage. Donor coverage for transplants provided only if not covered under donor's plan. Donor charges in those cases will be coordinated with any primary plan and covered under the recipient's identification number.

Organ recipients must be a Covered Person under the Plan.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

a. evaluating the organ or tissue;

b. removing the organ or tissue from the donor; and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

68. **Urgent Care.**

69. **Vasectomy.**

70. **Vision.** Medically Necessary eye examinations for the treatment of Illness or Injury.

71. **Well Child Care.**

72. **Women's Wellness.**

MEDICAL PLAN EXCLUSIONS

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

1. **Acupuncture.**

2. **Alcohol.** Charges arising from care, supplies, treatment, and/or services that involve a Participant who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions).

3. **Applied Behavioral Analysis, treatment or communication devices.**

4. **Broken Appointments.** Charges arising from care, supplies, treatment, and/or services that are charged solely due to the Participant's having failed to honor an appointment.

5. **Clinical Trials**. Clinical Trials that do not meet the definition of an Approved Clinical Trial (see Medical Benefits). In additional, the following shall be excluded when provided in the context of a Clinical Trial:

    a. The investigational item, devise or service itself;
    b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

6. **Complications of Non-Covered Services**. Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

7. **Convenience Items**. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

8. **Cosmetic**. Any health care service rendered for Cosmetic purposes including any procedures which are not Medically Necessary services, or any services or items connected with a Cosmetic operation. A Cosmetic health care service is covered only when it is Medically Necessary, for example: reconstructive Surgery when incidental to or when it follows Surgery resulting from trauma, infection or other diseases of the involved part, including but not limited to, breast reconstruction Surgery after a Mastectomy and reconstructive Surgery because of congenital disease or anomaly of a covered family Dependent child which results in a functional impairment. Examples of Cosmetic services and items that are not covered unless Medically Necessary include, but are not limited to: a) rhinoplasty; b) reconstructive Surgery for scar repair or revision where no physiological functional defect is present; c) cranial Prosthesis, wigs and hair replacements; d) Cosmetic devices; e) sex change procedures; and f) drugs and biologicals used for Cosmetic purposes, even if the drug or biological is otherwise covered.

9. **Custodial Care**.

10. **Deductible.** Charges arising from care, supplies, treatment, and/or services that are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Participant's responsibility in accordance with the terms of the Plan.

11. **Dental**. Any regular Dental care and treatment including, but not limited to: a) orthodontia; b) prosthodontics; c) periodontics; d) dentures; e) devices and appliances used in conjunction with the teeth; f) procedures involving teeth or areas surrounding teeth; g) orthognathic Surgery, including shortening of the mandible or maxillae for correction of malocclusion; and h) all professional, Hospital and Anesthesia services, except for Medically Necessary Dental care and treatment due to accidental Injury to sound natural teeth occurring within 12 months from the date of the accidental Injury, and Dental care and treatment Medically Necessary due to congenital disease or anomaly. Care for TMJ can be either Medical or Dental in nature. Coverage for TMJ is excluded when it is Dental in nature.

12. **Diabetic Shoes and custom molded shoe Inserts.**

13. **Durable Medical Equipment.** Computer assisted communication devices or electronic communication devices, items such as air conditioners, humidifiers, and athletic equipment.

14. **Educational or Vocational Testing**. Services for educational or vocational testing or training, unless otherwise specified.

15. **Excess Charges.** The part of an expense for care and treatment of an Illness or Injury that is in excess of the Maximum Allowable Charge.

16. **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician/Provider-supervised Cardiac Rehabilitation, Medical Supplies or Physical Therapy covered by this Plan.

17. **Experimental and/or Investigational.** Experimental and/or Investigational treatments, procedures, drugs and devices. As an exception, Investigational or Experimental procedures which are proven to be safe and efficacious, based on reliable evidence for a particular Illness or Injury, may be covered. The Plan Administrator and/or Claims Administrator reserves the right to determine Coverage on a case-by-case basis, based upon Medical documentation and reliable evidence.

    Additionally, with respect to Clinical Trials, the Plan will cover "Routine Patient Costs" for a "Qualified Individual" participating in an "Approved Clinical Trial" (see MEDICAL BENEFITS), as well as any side effects and/or complications associated with the Approved Clinical Trial.

18. **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

19. **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining Medical services.

20. **Genetic Testing**. Except as otherwise covered under the Preventive Care benefit.

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

22. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, that are for male pattern baldness, female pattern baldness or natural aging whether or not prescribed by a Physician/Provider.

23. **Hearing Aids and Evaluations**. Charges for services or supplies in connection with hearing aids or evaluations for their fitting.

24. **Hospital Employees**. Professional services billed by a Physician/Provider or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

25. **Illegal Acts.** Charges for services received as a result of Illness or Injury occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this Exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this Exclusion to apply. Proof beyond a reasonable doubt is not required. This Exclusion does not apply if the Illness or Injury resulted from an act of domestic violence or a Medical (including both physical and Mental Health) Condition.

26. **Illegal Drugs or Medications.** Services, supplies, care or treatment to a Plan Participant for Illness or Injury resulting from that Plan Participant's voluntarily taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician/Provider. Expenses will be covered for injured Plan Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury resulted from being the victim of an act of domestic violence or a documented Medical (including both physical and Mental Health) Condition.

27. **Incurred by Other Persons.** Charges arising from care, supplies, treatment, and/or services that are expenses actually Incurred by other persons.

28. **Infertility.** Infertility treatment except as described under Medical Plan Covered Services.

29. **Maintenance Therapy.** Services primarily to maintain a level of physical or mental function.

30. **Marital or Pre-marital Counseling.** Care and treatment for marital or pre-marital counseling.

31. **Medical Record Expenses.** The costs associated with the reproduction and furnishing of X-Rays and Medical records.

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

33. **Non-compliance.** All charges in connection with treatments or medications where the Plan Participant either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against Medical advice. Any expense as a result of your failure to vacate any Hospital or Skilled Nursing Facility bed beyond the discharge date established by the facility, Participating Provider, your Physician/Provider, and us.

34. **No-Fault.** Charges required to be paid in connection with No-Fault insurance.

35. **No Obligation to Pay.** Charges incurred for which the Plan has no legal obligation to pay.

36. **No Physician/Provider Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician/Provider; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician/Provider. Regular care means ongoing Medical supervision or treatment which is appropriate care for the Illness or Injury.

37. **Not Acceptable.** Charges arising from care, supplies, treatment, and/or services that are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

38. **Occupational/Workers' Compensation.** Care and treatment of an Illness or Injury that is occupational (arises from work for wage or profit including self-employment).

39. **Organ Transplant Expenses.** Costs and/or services related to searches and/or screenings for donors of organs to be transplanted.

40. **Other than Attending physician.** Charges arising from care, supplies, treatment, and/or services that are other than those certified by a physician who is attending the Participant as being required for the treatment of injury or illness, and performed by an appropriate Eligible Provider

41. **Physical Therapy**. Recreational programs, maintenance therapy or supplies used in Physical Therapy.

42. **PKU Food Supplements.**

43. **Plan Design Excludes**. Charges excluded by the Plan design as mentioned in this document.

44. **Podiatry.** Routine and palliative foot care: including but not limited to services or care in connection with any of the following: corns; calluses; flat feet; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet, or orthotics.

45. **Private Duty Nursing.** Charges in connection with care, treatment or services of a private duty nurse.

46. **Prohibited by Law.** Charges arising from care, supplies, treatment, and/or services that are to the extent that payment under this Plan is prohibited by law.

47. **Provider Error.** Charges arising from care, supplies, treatment, and/or services that are required as a result of unreasonable provider error.

48. **Recreational Programs**.

49. **Relative Giving Services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister.

50. **Respite Care.**

51. **Reversal of Elective Sterilization.**

52. **Self-administered Injectables.** Except as specifically provided in this Plan or the third party administrator's formulary.

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

54. **Services and Items that are Not Medically Necessary**. Health care services and items that are not Medically Necessary for the Diagnosis and treatment of an accidental Illness or Injury, or to maintain your health are excluded. This Plan covers only Medically Necessary services unless otherwise specified.

55. **Services and Items that are Not Safe and/or Efficacious.** Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies not proved to be safe and/or efficacious, or, because of your condition, an efficacious procedure that will have no effect on the outcome of your Illness or Injury are not covered. Benefits are limited to scientifically established procedures that have been evaluated by recognized authorities or governmental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular Illness or Injury. Procedures that are ineffective or in the state of being tested or researched with question(s) as to safety and/or efficacy are not covered. Experimental and/or Investigational procedures, which are proven to be safe and efficacious for a particular Illness or Injury, may be covered. See Experimental and/or Investigational under Plan Exclusions for procedures which may be covered.

56. **Services and Items Not Specified as Covered**. This Plan will not provide coverage for any service or item that is not specifically described by this Plan as covered, even when: a) a Physician/Provider prescribes the service or item, or otherwise considers it to be Medically Necessary and

appropriate; or b) the service or item is not specifically identified by this Plan as excluded.

57. **Services and Items Required by Third Parties.** Physical and mental examinations and Immunizations, and drug testing required by Third Parties for obtaining or maintaining employment or insurance, Medical research, travel, school, or camp, court ordered examinations, and hospitalizations except when Medically Necessary.

58. **Services for Which Payment has Been Made.** Any fees for the services of a health care Physician/Provider employed by a Hospital or institution to which a global or case-based payment is made.

59. **Sex Changes.** Care, services or treatment for non-congenital transsexuals, gender dysphasia or sexual reassignment or change. This Exclusion includes medications, implants, hormone therapy, Surgery, Medical or psychiatric treatment.

60. **Storage of Blood or Blood Products.** This does not apply to Autologous Blood (one's own) donations. Benefits for transfusion services, including storage, for Autologous donations of Blood and Blood Products are available when associated with a scheduled, covered surgical procedure.

61. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Charges arising from care, supplies, treatment, and/or services that are for an illness or injury not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

62. **Television or Phone Charges.**

63. **Transplants.** Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered and no transportation, companion food or lodging charges will be considered.

64. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician/Provider, except for Ambulance charges as defined as a Covered Service.

65. **Unreasonable.** Charges arising from care, supplies, treatment, and/or services that are required to treat illness or injuries arising from and due to error(s) caused at the time of treatment by the treating Eligible Provider, including, but not limited to, a physician or hospital, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense, which was caused directly or indirectly by the treating Eligible Provider, and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Eligible Provider whose error caused the loss(es).

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

67. **Weight Loss Programs and/or Dietary Control Programs or Other Programs with Dietary Supplements.**

68. **Wheelchair Van Transportation.**

With respect to any illness or injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the illness or injury if the illness or injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

FIRST CHOICE POS

Retail Pharmacy Option – 30 day supply

Tier 1: Preferred Generic and Select OTCs Copay	Plan Participant pays $5.00
Tier 2: Preferred Branded Drugs Copay	Plan Participant pays $25.00
Tier 3: Non-Preferred Drugs Copay	Plan Participant pays $50.00
Tier 4: Non-Preferred Drugs Copay	Plan Participant pays $500.00

Mail Order Prescription Drug - 90-Day Supply Option

Tier 1: Preferred Generic and Select OTCs Copay	Plan Participant pays $12.50
Tier 2: Preferred Branded Drugs Copay	Plan Participant pays $62.50
Tier 3: Non-Preferred Drugs Copay	Plan Participant pays $125.00

Pharmacy Out of Pocket Maximum

Individual	$1,600.00
Family	$3,200.00

FIRST CHOICE HDHP
PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Retail Pharmacy Option – 30 day supply

Tier 1: Preferred Generic and Select OTCs Copay	Plan Participant pays $5.00
Tier 2: Preferred Branded Drugs Copay	Plan Participant pays $25.00
Tier 3: Non-Preferred Drugs Copay	Plan Participant pays $50.00

Mail Order Prescription Drug - 90-Day Supply Option

Tier 1: Preferred Generic and Select OTCs Copay	Plan Participant pays $12.50
Tier 2: Preferred Branded Drugs Copay	Plan Participant pays $62.50
Tier 3: Non-Preferred Drugs Copay	Plan Participant pays $125.00

Pharmacy Out of Pocket Maximum

Individual	$1,775.00
Family	$3,550.00

RETIREE FIRST CHOICE HDHP
PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Retail Pharmacy Option – 30 day supply

Tier 1: Preferred Generic and Select OTCs Copay	Plan Participant pays $5.00
Tier 2: Preferred Branded Drugs Copay	Plan Participant pays $25.00
Tier 3: Non-Preferred Drugs Copay	Plan Participant pays $50.00

Mail Order Prescription Drug - 90-Day Supply Option

Tier 1: Preferred Generic and Select OTCs Copay	Plan Participant pays $12.50
Tier 2: Preferred Branded Drugs Copay	Plan Participant pays $62.50
Tier 3: Non-Preferred Drugs Copay	Plan Participant pays $125.00

PRESCRIPTION DRUG COVERED SERVICES

1. **Acne Products**.
2. **ADD Drugs**.
3. **Anabolic Steroids**. Requires prior authorization for medical necessity. Not covered for the purpose of body building.
4. **Compounded Products**. Prescriptions containing at least one prescription ingredient in a therapeutic quantity.
5. **Contraceptives. Devices, injectables, oral medication and patches**. Refer to Medical Plan benefits for Contraceptives administered in the Physician/Provider's office.
6. **Cox-2 Inhibitors**.
7. **Dental Specific Products**. Includes, but not limited to, gels, pastes, rinses, etc.
8. **Diabetic Needs**
9. **Diabetic (oral)**
10. **Disposable Medical Supplies**. Includes, but not limited to, spacers, peak flow meters, etc.
11. **Diabetic Equipment and Supplies** (can be supplied by a Pharmacy or Medical vendor, copayment is based on the servicing provider)
12. **Insulin**
13. **Experimental and/or Investigational**. Generally not a Covered Service. See Pharmacy Exclusions for exceptions.
14. **Impotence Agents**.
15. **Infertility**.
16. **Mail Order**. Available for maintenance medications.
17. **Migraine Agents**.
18. **Nutritional Formulas**. Enteral formulas, food supplements, and PKU supplements.
19. **Prescription Vitamins**.

20. **Proton Pump Inhibitors**.
21. **Specialty Drugs**. Must be obtained through a Specialty Pharmacy.
22. **Substance Abuse / Addiction Medication**.
23. **Tablet Splitting**.
24. **Smoking Cessation**.
25. **Vaccines Administered at a Pharmacy**.

PRESCRIPTION DRUG EXCLUSIONS

Drugs purchased from a Non-Participating Pharmacy are not covered, except for drugs required for urgent and emergent services as determined by the Claims Administrator.

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

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

2. **Anorexiants/Antiobesity Agents.** Agents used to suppress appetite and control fat absorption.

3. **Cosmetic.**

4. **Experimental and/or Investigational.** Drug or pharmacological therapies not proved to be safe and/or efficacious, or, because of the Plan Participant's condition, an efficacious procedure that will have no effect on the outcome of the Plan Participant's Illness or Injury are not covered**.** An Investigational drug is a drug or medicine labeled: "Caution - limited by federal law to Investigational use." **Investigational or Experimental procedures which are proven to be safe and efficacious for a particular Illness or Injury which have received approval from the FDA and/or the National Institute of Health Technology Assessment are covered.** The Medical Director reserves the right to determine coverage on a case-by-case basis.

5. **Inpatient Medication.** While confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

6. **No Charge.** A charge for Prescription Drugs which may be properly received without charge.

7. **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

8. **Non-Participating Pharmacy**. Except for drugs required for urgent and emergent services as determined by the Claims Administrator.

9. **Over the Counter (OTC) Drugs**. Select OTC drugs are covered with a written prescription based on the Plan Formulary.

10. **Services and Items Not Specified as Covered**. This Plan will not provide coverage for any service or item that is not specifically described by this Plan as covered, even when: a) a Physician/Provider prescribes the service or item, or otherwise considers it to be Medically Necessary and appropriate; or b) the service or item is not specifically identified by this Plan as excluded.

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

VISION CARE SCHEDULE OF BENEFITS

FIRST CHOICE POS & HDHP

Benefits for these charges are payable up to the maximum benefit amounts shown below for each Vision care service or supply. Frame, lenses and lens options must bepurchased in same transaction to receive full discount. Benefits are available through participating providers only.

Routine Exam (once every 12 months)	Plan participant pays $0 per visit
Frames (once every 12 months)	Plan participant pays 60% of retail price
Standard Plastic Lenses (once every 12 months)	
Single vision	Plan participant pays $0
Bifocal	Plan participant pays $0
Standard progressive	Plan participant pays $65
Contact Lenses (discount applies to materials only)	Plan participant has $40 allowance, 15% off balance over $40
Laser Vision Correction	Plan participant pays 85% of retail price

VISION CARE EXCLUSIONS

The following is a list of certain Exclusions under the Plan:

1. **Health Plan.** Any charges that are covered under any other health plan that reimburses a greater amount than this Plan.

2. **Medical Eye Examination**.

3. **No Prescription.** Charges for any Vision benefits not accompanied by a prescription.

4. **Orthoptics.** Charges for orthoptics (eye muscle exercises).

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

6. **Services and Items Not Specified as Covered**. This Plan will not provide coverage for any service or item that is not specifically described by this Plan as covered, even when: a) a Physician/Provider prescribes the service or item, or otherwise considers it to be Medically Necessary and appropriate; or b) the service or item is not specifically identified by this Plan as excluded.

7. **Training.** Charges for Vision training or subnormal Vision aids.

8. **Any eye or Vision examination, or any corrective eyewear required as a condition of employment.**

9. **Safety eyewear**.

10. **Fitting for follow up visits contact lenses.**