Benefits

NEW YORK STATE OF OPPORTUNITY. | NY Power Authority

IBEW Benefit Handbook

Active Employees

January 2021

IBEW Local 2032 and Local 2104

Maintenance Of Benefits

The parties have negotiated changes to the wording and format of this Benefits Handbook in order to make it more readable and user friendly. It contains negotiated changes as contained in the March 31, 2015 general contract negotiations and the May 15, 2018 Memorandum of Agreement. The parties agree that nothing contained in this new Benefits Handbook was intended to reduce or otherwise modify the benefits available to participants. Any dispute regarding the continuation of such benefits will be subject to the grievance and arbitration provisions of the collective bargaining agreement between the parties on an expedited basis.

Grievance Process

A past practice exists where the member or a representative of the member enters into an informal discussion with Benefits to discuss the denial of coverage or denial of a benefit without first having to go through all of the plan appeals and the grievance procedure to resolve a benefits issue. The formalization of the grievance process is not intended to restrict or eliminate the existing informal practice. The Parties agree that the Union may, at its sole discretion, file a grievance and proceed to arbitration on an expedited basis regarding any full or partial denial of any medical benefits claims made by bargaining unit members. The time for the union to bring a benefit related grievance shall be no later than thirty (30) days after the employee was notified of the disposition of the first level appeal. It is the obligation of the member to provide timely notification of the disposition of the first level appeal to the local union. It is also the obligation of the member to provide a signed HIPAA Release. The local union then has 15 working days to file a grievance which shall commence at Step (d). Management has the right to defer the grievance for up to 60 days in order to conduct a medical review.

Please note that this grievance process is applicable throughout this book. All decisions of the Medical Claims Administrator will be reviewed by NYPA before a final decision is issued, which final decision shall be subject to the grievance and arbitration provisions of the CBA.

TABLE OF CONTENTS

SECTION 1 - INTRODUCTION

The Plan consists of the following benefits:

- Medical, including prescription drug coverage
- Dental
- Vision Care
- Hearing Aids
- Flexible Spending Accounts
- Short Term and Long Term Disability
- Life Insurance
- Supplemental Insurance Options – Cancer and Accident Expense Plans
- Employee Assistance Program
- Medicare and Retiree Benefits

Using this Benefits Handbook

The major sections of this Benefits Handbook are summarized below.

- **Benefits Overview**: General information about eligibility, enrolling in and making changes to your benefits, leaves of absence, and other basic information related to your benefits.
- **Medical Benefits**: A summary of the Medical Plan options, including information about the cost you pay for coverage or your ability to opt-out. Refer to the medical sections for information about the Medical Plan, instructions on filing claims and appeals procedures.
- **Prescription Drug Benefits**: A summary of the Prescription Drug Plan. Refer to the prescription drug section for information about the Prescription Drug Plan, instructions on filing claims and appeals procedures.
- **Dental Benefits**: A summary of the Dental Plan. Refer to the dental section for information about the Dental Plan, instructions on filing claims and appeals procedures.
- **Vision Benefits**: Information about the Vision Care Plan, including details about the Vision Plan and instructions on filing claims for reimbursement.
- **Hearing Aids**: Information about hearing benefits (via a Health Reimbursement Account), including details about what it covers and instructions on filing for reimbursement.
- **Flexible Spending Accounts (FSA)**: Detailed information about how the Health Care and Dependent Care Flexible Spending Accounts work, including listings of eligible and ineligible expenses, using the FSA debit card, the rollover feature, and instructions on filing claims for reimbursement.
- **Disability Benefits**: An overview of the benefits provided for short term and long term disability.
- **Life Insurance Benefits**: A brief description of the life insurance benefits available.
- **Supplemental Benefits**: A summary of the supplemental insurance options available to you; the Cancer Plan and the Accident Expense Plan.

- **Employee Assistance Program**: Information about services offered under the Employee Assistance Program.
- **Additional Information About Your Benefits**: Information about general exclusions, continuing health care coverage through COBRA, the Young Adult Option, USERRA, and more.
- **Medicare and Retiree Benefits**: General information about Medicare, eligibility for retiree benefits, and a summary of the benefits available to retirees.
- **Glossary**: Definitions of terms used throughout the book.
- **Directory of Providers**: Contact information for each of the providers, including addresses, phone numbers, and websites.

Many of the sections of this Benefits Handbook are related to other sections. You may not have all the information you need by reading just one section.

SECTION 2 – BENEFITS OVERVIEW

Who is Eligible

Employees

Unless otherwise noted in the specific benefit section, you and your dependents are eligible to participate in the benefits offered under the Benefits Program if you are a full-time employee whose employment is covered by the collective bargaining agreement between New York Power Authority (NYPA) and International Brotherhood of Electrical Workers Locals 2032 and 2104. Benefits begin on the first day of service for eligible employees

Provisional employees are eligible for medical (hospital, surgical, prescription drug, and major medical) and short term disability benefits on their first day of employment. They are also eligible to join the New York State Retirement System. Provisional employees are not eligible for dental, hearing aids, vision, long term disability, life insurance, supplemental insurance options, or educational assistance benefits.

Part-time, temporary, and seasonal employees that meet the Affordable Care Act (ACA) guidelines of Full-time Equivalent, as defined by the ACA, will be offered medical (hospital, surgical, prescription drug, and major medical) benefits only as required by law. Employees meeting the eligibility requirements can enroll in the NYPA Medical Plan only.

Dependents

Your eligible dependents generally include:

- Your legal spouse.

- Your dependent children, as described below:
  - Your children are eligible for medical coverage until reaching age 26, and age 23 for dental, regardless of full-time student status, residency or marital status. Your children are your natural children, stepchildren, foster children, legally adopted children, or a child for whom you have started adoption procedures and who depends on you for maintenance and support. Children who must be covered as a result of a qualified medical child support order (QMCSO) are also eligible.
  - If your domestic partnership application has been approved by the Power Authority, the unmarried children of your domestic partner who permanently reside in your home and are primarily dependent upon you for support may also be covered under the Plan. The Power Authority will require documentation of this support.
  - Your unmarried child, regardless of age, who is unable to support himself or herself because of mental illness, physical handicap, or developmental disability (as defined in the New York State mental hygiene law), and who depends on you for support. Your child must have become incapable of self-support either before age 19 or while he or she was covered as a dependent under the Medical Plan. Re-certification is required every two years. This provision only applies to medical coverage.

- Domestic Partner (age 18 or older).

  - In order for a domestic partner to be eligible, employees must submit the required proof and signed affidavit. Generally, qualified Domestic Partners are persons who are single, in a long-term committed relationship, have been in the relationship for at least one year, reside in the same household, are financially interdependent and meet the criteria outlined in NYPA's application forms. Domestic Partners can be of the same or opposite sex. Persons who live together for economic reasons, but who have not made a commitment to an exclusive domestic partnership will not be eligible for enrollment under this benefit. Domestic Partners cannot be anyone related to you directly by blood or any degree of kinship, (i.e. Domestic Partner cannot be a sibling, parent, aunt, uncle, etc.).
  - The Benefits Department is responsible for making the final determination as to whether the documentation is acceptable. You can request a domestic partner packet (Information Guide, Financial Interdependency Proof, and Affidavit) from the Benefits Department in White Plains which explains in more detail the criteria to add a domestic partner as a dependent, and provides details concerning requirements and costs for domestic partner enrollment.

  Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of health insurance benefits is treated as income for tax purposes. Ask your tax consultant how enrolling your domestic partner will affect your taxes.

Retirees

Employees (and their eligible dependents) who retire from the Power Authority may be eligible for certain benefits. See Section 20, *Medicare and Retiree Benefits* for eligibility requirements and details.

When Coverage Begins

Employee Coverage

Coverage begins for you, the employee, on the day you start working as a full-time employee.

For employees that qualify for medical coverage under the ACA, your coverage will begin once you meet the ACA Full-time Equivalent criteria.

Dependent Coverage

Coverage for your eligible dependent(s) begins on the date that your coverage begins, or on the date that a family member satisfies the requirements for dependent coverage.

At any time, the Plan may require proof that a spouse, domestic partner, or a child qualifies or continues to qualify as a dependent as defined by the Plan.

When Coverage Ends

Employee Coverage

Coverage for you, the employee, ends on your last day worked.

For employees eligible under ACA regulations, coverage ends when employee no longer meets ACA requirements, or if this provision of the ACA regulation is no longer required, coverage will end.

Dependent Coverage

Coverage for your dependents ends:

- When your coverage ends
- When your dependent child reaches the limiting age
- When you divorce your spouse
- When your domestic partnership ends

Continuing Your Coverage

Under federal law, if certain qualifying events should occur, you will be eligible to temporarily extend your medical benefits under COBRA. For information regarding continuation of coverage under COBRA, see Section 19, *Additional Information About Your Benefits*.

How to Enroll

New Hire Enrollment

On the first day of employment, you will be provided with information about the benefit plans and costs. You must select your benefits online on or before the date specified by the site HR Representative. (Paper enrollment is available if necessary.)

Default Options

If you do not complete your benefit enrollment within 30 days of your first day of employment, you will default to employee-only coverage in the following benefits:

- NYPA Medical Plan
- Dental Plan
- Vision Care Plan
- Life Insurance
- Short Term Disability
- Long Term Disability
- Hearing Aids

If you receive default benefits, you are not eligible to join an HMO, choose the Cancer Plan or the Accident Expense Plan, open a Flexible Spending Account(s), or waive medical coverage until the next open enrollment period.

Open Enrollment

Once a year, during Open Enrollment, you can change your benefit elections, elect to enroll in a Flexible Spending Account(s), or elect the waive coverage option for the following Plan Year. You must make your benefit elections for the next Plan Year by completing your benefit elections online. The benefits you elect during Open Enrollment go into effect on January 1 and remain effective for one calendar year.

Default Options

If you do not complete your benefits online by the close of the Open Enrollment period, your current year's elections will carry over into the following Plan Year, with the exception of the Flexible Spending Account(s). You must re-elect Flexible Spending Account(s) each year if you wish to participate in the account(s) in the following year. The plan includes an FSA HealthCare Account rollover feature, which allows you to rollover up to $550 (effective 2021; as periodically adjusted by IRS) of your unused healthcare contributions from the previous year.

Cost of Coverage

Contributions

An annual health care contribution is required for all participants in the NYPA Medical Plan and all HMOs. The cost will be deducted over 26 pay periods on a pre-tax basis. If the cost of an HMO is more expensive than the NYPA Medical Plan, you will pay the difference. See Section 3, *How The Medical Plan Works*, Paying for Coverage for NYPA Medical costs. HMO costs will be published each Open Enrollment period based on provider rates.

NYPA pays the full premium of your Dental Plan, Vision Care Plan, Life Insurance, and Short Term and Long Term Disability coverage.

You pay the full cost of coverage for any supplemental benefits you elect.

Contributions While on Unpaid Leave

If you are on an approved unpaid medical leave from NYPA, you will be required to pay the employee contribution for your Medical Plan, Flexible Spending Accounts, Cancer Plan, and the Accident Expense Plan, if applicable. You may choose one of two payment methods:

- Pay the employee contribution(s) by check on a monthly basis on or before the first day of the month. This method of payment is on a post-tax basis. If payment is not made in a timely manner, your Medical, FSA, Cancer Plan, and Accident Expense Plan coverage will be cancelled. Once the coverage is cancelled, COBRA coverage will be offered for Medical and FSA benefits. Participants must contact the Cancer and Accident Expense Plan Administrator to continue benefits.

- Pay the missed employee contribution(s) through payroll deductions upon your return to work. This method of payment is on a pre-tax basis for the Medical Plan, HMO, FSA, the Cancer Plan, and the Accident Expense Plan.

The parties agree that an employee is not liable to repay missed employee contributions in the event the employee does not return to work.

In order to continue your Medical Plan, FSA, Cancer Plan, and the Accident Expense Plan while on an unpaid leave of absence, you must select your payment method by completing a Payment of Benefit Contributions form, which you may obtain from your site HR Representative.

Benefits Provided During Long Term Disability (LTD)

If you are on LTD, your Medical and Dental Plans will be continued for you and your eligible, covered dependents during your LTD period. If you separate from employment with NYPA, all benefits will cease at that time, including medical and dental benefits.

However, if you have ten (10) or more years of service at the time you first became disabled, you are eligible to continue your Medical Plan for as long as you remain eligible for LTD benefits. You will be responsible for paying the active employee contribution in effect each year in order to continue your Medical Plan while you receive LTD benefits.

If you retire, see Section 20, *Medicare and Retiree Benefits* for information about your medical benefits.

Coordination of Benefits (COB) – Coverage Under More Than One Plan

Coordination of Benefits occurs when you and/or your dependents are covered by more than one plan. COB is designed to prevent duplicate payments, so that the total payments made by all plans do not exceed the reasonable and customary charge for a service that is covered by both plans. Coordination of benefits also determines which plan is "primary" (pays first) and which is "secondary."

Applicable Benefits

Coordination of benefits is applied to hospital, medical/surgical, major medical and dental benefits that are covered under your Medical and Dental plans. It does not apply to the prescription drug benefit.

Plans such as group health plans that are sponsored by other employers coordinate with your plan. COB also applies to government or tax-supported programs (except Medicare or Medicaid) or benefits provided under No-Fault Automobile Insurance Law.

Processing Claims

One of the plans involved will pay benefits first (primary). The other plan (secondary) will then consider the balance of reasonable and customary Covered Charges. No plan will pay more than it would have paid without this provision.

A plan will pay benefits first if it meets one of the following conditions:

- The plan has no coordination of benefits feature.
- The plan covers the person as an employee.
- The plan for a dependent covered under both parents' plans (when parents are not separated or divorced) is that of the parent whose birthday (month and day only) is earlier in the year. If both parents have the same birthday, the plan of the parent who has been in his or her plan the longest is primary. If the other plan does not have the birthday rule, the rule of that plan determines which will be primary.

COB for Dependent Children if you are Divorced or Separated

- The plan of the parent with custody will pay benefits first.
- If the parent with custody has remarried the order of payments will be as follows:
  - The plan of the parent with custody will pay first.
  - The plan of the stepparent with custody will pay benefits next.
  - The plan of the parent without custody will pay benefits next.
  - A court decree may give one parent financial responsibility for the medical, dental or other health expenses of the dependent children. If there is a court decree, the rules stated above will not apply. Instead, the plan of the parent with financial responsibility will pay benefits first.
  - The plan covering the person for the longest time applies when none of the rules above apply.

You will have to give information about any other plans when you file a claim.

Spouse Who Also is a Power Authority Employee

If your spouse is also an employee of the Power Authority only one of you may cover your dependent children under the Medical and Dental plans. This means for each plan, one of you will elect family coverage and the other can choose to either be covered under that family plan and elect to waive their coverage or elect their own individual coverage. In the case of Medical, if waiving coverage the employee will receive the opt-out stipend. There is no coordination of benefits between your coverage and your spouse's coverage.

If You Experience a Change in Status

In accordance with IRS regulations, you can only change your benefits during Open Enrollment or if you experience a qualified change in family status (i.e., an event that

cause you, your spouse or domestic partner, or your dependent to gain or lose eligibility for coverage).

Qualified changes in status are defined by the IRS as changes in:

- Legal marital status (marriage, divorce, death of a spouse, legal separation, or annulment)
- Number of dependents (birth, adoption, death)
- Employment status (of the employee or spouse)
- Dependent's status (over the age of eligibility for coverage)
- Residence (moving out of an HMO service area)
- Worksite location and work schedule (e.g., reduction in hours or during a strike or lockout)
- Eligibility for Medicare or Medicaid

To change your coverage, you must file paperwork with Human Resources within 30 days of the qualifying event. You may only make a coverage change if it is consistent with the change in status (for example, if you marry, you may add a dependent, but you may not change your Medical Plan choice.) Documentation of eligibility is required to add a new dependent to coverage.

If you do not make the change within 30 days, you will be required to wait until the next Open Enrollment period to do so. Any changes in your benefits as a result of a qualifying event will be effective as of the date of the qualifying event.

There are certain family status changes that allow you 60 days to notify Human Resources:

- Divorce
- Legal separation
- A child's ceasing to be an eligible covered dependent

You are responsible for informing Human Resources about all circumstances affecting eligibility for benefits for yourself and your dependents, including changes causing loss of eligibility. Benefit changes must be made within the appropriate timeframe, as listed above.

Changing Your Benefit Elections During the Year

Special Enrollment Rights

Federal law gives you special enrollment rights that are broader than your right to make election changes for events listed above. In a special enrollment, your election change doesn't have to be consistent with your qualifying life event. Those special enrollment rights are described here.

- If you opt out of medical coverage for yourself or your dependents (including your spouse) because you have other health insurance or group health plan coverage, and then you or your dependents lose eligibility for that other coverage (or if the plan sponsor stops contributing toward your or your dependents' other coverage), you may be able to enroll yourself and your dependents in a Power Authority Medical Plan. You must request enrollment within 30 days of the date your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

- You also have a special enrollment opportunity if you or your eligible dependents either:
  - Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
  - Become eligible for a state's premium assistance program under Medicaid or CHIP.

  For these enrollment opportunities, you will have 60 days — instead of 30 days — from the date of the Medicaid/CHIP eligibility change to request enrollment in the Medical Plan. Note that this 60-day window doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

Also, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you can enroll yourself and your dependents in a Medical option. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or to learn more, contact your site HR Representative.

Medical Privacy Rights

The privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply to the health care provisions of the Plan but not to those provisions addressing non-health benefits, such as disability or life insurance. The Power Authority will provide you with a Notice of Privacy Practices describing the manner in which the Company and the Plan use and disclose protected health information (PHI), your rights to inspect, copy and correct medical records concerning you, and the procedure for filing complaints if you think your privacy rights have been violated. Contact your site HR Representative for a copy.

SECTION 3 – HOW THE MEDICAL PLAN WORKS

New York Power Authority makes medical benefits available to you and your eligible dependents. You can elect the NYPA Medical Plan (a PPO), and in certain geographic areas, HMO options are available. You may also elect to waive coverage.

All Medical Plans include hospital, medical and prescription drug benefits, but the level of coverage and types of services they offer may vary.

Contributions

Annual health care contributions follow a two-tier cost structure. Deductions are based on the plan you choose and the level of coverage you elect. Contributions are deducted in equal increments over 26 pay periods on a pre-tax basis.

Annual Contributions

The annual employee health care contributions in effect from July 1, 2015 to January 1, 2022 are listed in the table below.

Effective Date	Annual Health Care Contributions *	
	Individual	Family
January 1, 2018	$1,400	$3,500
January 1, 2022	$1,400	$3,800

*If you enroll in an Health Maintenance Organization (HMO) and the HMO costs more than the NYPA Medical Plan, you pay the annual employee health care contribution based on your election of individual or family coverage (above) plus the cost of the difference between the two plans. If the HMO plan costs do not exceed NYPA plan costs, you pay the annual employee health care contribution above. HMO plan costs are published during each open enrollment period based on the HMO providers rates. Deductions are taken over 26 pay periods on a pre-tax basis.

Opt-Out Stipend

If you are a member of another health care plan, you may waive NYPA medical coverage. Employees who waive coverage will receive an annual stipend of $1,500. The stipend is distributed in equal increments over 26 pay period and is paid on an after-tax basis.

To waive coverage, you must complete a NYPA Medical Waiver form. The form is available from your site HR Representative and must be returned to Human Resources within the timeframe indicated.

Keep in mind that you may not re-enroll for NYPA medical coverage until the next Open Enrollment period, unless you experience a qualified change in family status.

NYPA Medical Plan

Accessing Benefits

As a participant in the NYPA Medical Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for the Network level of Benefits under the Medical Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with the Medical Plan Claims Administrator to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of a Network.

Non-Network Benefits apply to Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider, or Covered Health Services that are provided at a Non-Network facility.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the NYPA Medical Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a Non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Medical Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Network Out-of-Pocket Maximum. You may want to ask the Non-Network provider about their billed charges before you receive care.

Network Providers

The NYPA Medical Plan offers two provider networks and a behavioral health network. Each has an extensive list of providers. For more information about the networks and provider directories, go to:

- Options PPO Network: www.myuhc.com
- Empire Plan: www.empireplanproviders.com/provider.htm
- Behavioral Health Network: www.myuhc.com

The Medical Plan Claims Administrator or its affiliates arrange for health care providers to participate in a Network. At your request, the Medical Plan Claims Administrator will send you a directory of Network providers free of charge. Before obtaining services, you should always verify the Network status of a provider. Keep in mind a provider's Network status may change. It is your responsibility to verify a provider's Network status before services are performed.

It is your responsibility to ensure that the provider you select is in the network, that his or her agreement with the Medial Plan Claims Administrator covers the particular services you are seeking, and that he or she is accepting new patients. The network of providers is subject to change. If any of the preceding conditions are not met, you must choose another Network provider to get Network Benefits.

If you are new to the NYPA Medical Plan (i.e. recently enrolled in the NYPA Medical Plan for first time), and are currently undergoing a course of treatment utilizing a Non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the number on your ID card.

Network Gap Exception

Under specific circumstances, the NYPA Medical Plan allows a member to receive the network level of benefits from an out of network provider. This is called a network gap exception.

- A Geographic Network Gap Exception occurs when there is no participating provider within a 30 mile radius of the member's home zip code.
- A Clinical Gap Exception occurs when there is no network provider available to provide a specific service or to treat the member's specific diagnosis.

Gap exceptions must be requested and approved by the Medical Plan Claims Administrator prior to the date of service. To initiate a gap exception, call the number on the back of your ID card and choose the prompt for notification. The Medical Plan Claims Administrator's coordinators will collect all necessary information and will review the exception request. Members will receive a letter notifying them of the decision. If the gap exception is denied, the Medical Plan Claims Administrator will advise the member of the available alternatives.

Eligible Expenses

New York Power Authority retains the authority to determine whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the NYPA Medical Plan [see Grievance clause in front of book]

The cost for Covered Services from a Network provider is negotiated between the provider and the Medical Plan Claims Administrator. A Network provider cannot charge you more than the negotiated amount for a Covered Service. For benefits for Covered Health Services provided by a Non-Network provider, other than services arranged by the Medical Plan Claims Administrator, you will be responsible to the Non-Network provider for any amount billed that is greater than the amount the Medical Plan Claims Administrator determines to be an Eligible Expense.

Eligible Expenses are the amount the Medical Plan Claims Administrator determines will be paid for Benefits.

The cost for Covered Services from a Non-Network provider may not be negotiated. A Non-Network provider may bill you for any difference between the provider's billed charges and the Eligible Expense described here. You are responsible for paying, directly to the Non-Network provider, any difference between the amount the provider bills you and the amount the Medical Plan Claims Administrator will pay for Eligible Expenses.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The Annual Deductible applies only to Non-Network Benefits for the NYPA Medical Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the In-Network Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible or the Out-of-Network Out-of-Pocket Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Benefits for outpatient surgery from a Non-Network provider. Since the plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and Non-Network Out-of-Pocket Maximums for the NYPA Medical Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the NYPA Medical Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Network and Non-Network Out-of-Pocket Maximums:

NYPA Medical Plan Features	Applies to the Network Out-of-Pocket Maximum	Applies to the Non-Network Out-of-Pocket Maximum
Copays	Yes	N/A
Payments toward the Network Annual Home Health Care Deductible	Yes	Yes
Payments toward the Non-Network Annual Deductible	N/A	No
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not receiving pre-certification	No	No
Charges that exceed Eligible Expenses	No	No

HMO Options

Health Maintenance Organization (HMO) options are available if you live in an area served by an HMO that contracts with the Authority. HMO benefit booklets and Summaries of Benefits & Coverage (SBCs) are available from your site HR Representative.

Covered Services

The HMO options provide comprehensive medical services with an emphasis on preventive medicine, including routine physical examinations and some wellness benefits.

HMOs contract with doctors, hospitals, and clinics to provide health care within specific geographic areas. To enroll in a particular HMO, you must live in its service area. You must use doctors in your HMO's network and within the service area. Some HMOs also provide out-of-network benefits, but you will need to check with the individual HMO.

Coverage varies among HMOs, so you should carefully examine the plan provisions for HMOs you are eligible to enroll in. You need to review each plan separately when you are trying to decide if a particular plan is right for you and your family's needs. One of the

first things you'll do when you join an HMO is choose a primary care physician (PCP) from a list of doctors in the HMO's network. Your HMO can provide you with a list of doctors to choose from. Your PCP will oversee all of your medical care. If you need to see a specialist or another doctor, you usually need a referral from your PCP.

All of the HMOs that the Authority contracts with provide hospital benefits, medical services, mental health benefits and substance abuse benefits, and prescription drug benefits. The fees and copays for these services vary for each HMO and are outlined in the HMO benefit booklets and (SBCs). The HMO vendors, plans, plan features, copays, and costs are subject to change in the future.

It is your responsibility review the HMO documents carefully to understand the terms and conditions of the plan, and use it to make well-informed benefits decisions for you and your family.

HMO Plans

The following HMOs are available at NYPA's sites:

HMO Plans	NYPA Site
Capital District Physicians Health Plan (CDPHP)	B-G, CEC STL (1/1/2021)
Independent Health	BUF, NIA

Filing a Claim

The HMOs have agreed to file claims on your behalf. If the HMO offers out-of-network benefits, and you obtain services from an out-of-network provider, you will need to file a claim with the HMO yourself.

SECTION 4 – NYPA MEDICAL PLAN PRE-CERTIFICATION

United Healthcare's (UHC) ***Care Coordination*** program is focused on minimizing gaps in care and helping you obtain pre-certification before receiving certain types of medical care. A nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

Requirements for Receiving Pre-Certification

Network providers are generally responsible for obtaining pre-certification before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining pre-certification by notifying the Medical Plan Claims Administrator.

When you choose to receive certain Covered Health Services from Non-Network providers, you are responsible obtaining pre-certification before you receive these Covered Health Services.

If you do not comply with the notification requirement, you must pay a $250 penalty for each confinement that is not pre-certified. Further reductions or denials may apply in accordance with the plan provisions. In addition, any penalty you pay or amounts that are not reimbursed because of your non-compliance will not count toward your deductible, co-insurance, or out-of-pocket maximum.

Examples of services that require pre-certification include, but are not limited to:

- Inpatient Hospital stays - all scheduled admissions, and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Inpatient Mental Health or Substance Use Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility).
- Skilled Nursing Facility / Hospice program.
- Surgery.

Notification is required within 48 hours or two business days of admission.

SECTION 5 – NYPA MEDICAL PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply to the NYPA Medical Plan when you receive certain Covered Health Services, and outlines the NYPA Medical Plan's Annual Deductible and Out-of-Pocket Maximums.

NYPA Medical Plan Features	Network Amount		Non-Network Amount
	1/1/2020	1/1/2022	
	Copays apply toward the Network Out-of-Pocket Maximum		
Acupuncture Services	$30	$35	Not Applicable
Emergency Room Services	$45		Not Applicable
Virtual Visits	$15 (waived through 12/31/2020)	$15	Not Applicable
Physician's Office Services	$30	$35	Not Applicable
Rehabilitation Services	$30	$35	Not Applicable
Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy	$30	$35	Not Applicable
Surgery – Outpatient	$30	$35	Not Applicable
Urgent Care Center Services	$30	$35	Not Applicable

NYPA Medical Plan Features	Network Amount	Non-Network Amount
Annual Deductible		
■ Individual	Not Applicable	2018 - $700
■ Family	Not Applicable	2018 - $2,100
The Annual Deductible does not apply toward the Non-Network Out-of-Pocket Maximum for all Covered Health Services.		
Annual Out-of-Pocket Maximum		
■ Individual.	2017 - $7,150*	2017 - $900
■ Family (not to exceed the applicable Individual amount per Covered Person).	2017 - $14,300*	2017 - $2,400
*The Network Annual Out-of-Pocket Maximum is the IRS maximum, as indexed annually. The Annual Deductible does not apply toward the Out-of-Pocket Maximum for Non-Network Covered Health Services.		
Lifetime Maximum Benefit There is no dollar limit to the amount the plan will pay for Benefits during the entire period you are enrolled in this plan.	Unlimited	

NYPA Medical Plan Schedule of Benefits

This table provides an overview of the NYPA Medical Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Benefit Descriptions*. All covered services must meet medical necessity requirements.

Covered Health Services[1]	Benefit *(The Amount Payable by the NYPA Medical Plan based on Eligible Expenses)*		
	Network		Non-Network[2]
	1/1/2020	1/1/2022	
Acupuncture Services	$30 Copay per visit	$35 Copay per visit	80% after you meet the Annual Deductible
Ambulance Services	*Ground and/or Air Transportation:* $50 Copay per transport		*Same as in-network*
Autism Spectrum Disorder Services (Includes, but not limited to: behavioral health treatment; psychiatric care; psychological care; therapeutic care including non-restorative therapy provided by licensed or certified speech therapists, occupational therapists, social workers, or physical therapists; augmentative communication devices)	$30 Copay per visit	$35 Copay per visit	80% after you meet the Annual Deductible
Cancer Services	Benefits will be the same as those stated under each Covered Health Service category in this section.		Benefits will be the same as those stated under each Covered Health Service category in this section.
Chiropractic Care See Section 6, *Benefit Descriptions*, for limits.	$30 Copay per visit	$35 Copay per visit	80% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the NYPA Medical Plan based on Eligible Expenses)*		
	Network		Non-Network[2]
	1/1/2020	1/1/2022	
Dental Services - Accident Only	$30 Copay per visit	$35 Copay per visit	80% after you meet the Annual Deductible
Dental Services – Other Covered Services	$30 Copay per visit	$35 Copay per visit	80% after you meet the Annual Deductible
Durable Medical Equipment (DME) (Includes, but not limited to: equipment to assist mobility, such as a standard wheelchair; standard Hospital-type bed; oxygen concentrator units and the rental of equipment to administer oxygen; Delivery pumps for tube feedings; braces (non-dental), including necessary adjustments to shoes to accommodate braces and back braces for the diagnosis of Scoliosis; mechanical equipment necessary for the treatment of chronic or acute respiratory failure; shoe/foot orthotics; CPAP equipment)	100%		80% after you meet the Annual Deductible
Emergency Room Services	$45 Copay, Waived if admitted		No charge up to benefit maximum of $1,500 per year; then 80%
Foot Care	$30 Copay	$35 Copay	80% after you meet the Annual Deductible
Home Health Care	A $50 Annual Deductible applies, then 75%		75% after you meet the Annual Deductible
Hospice Care	100%		100%

Covered Health Services[1]	Benefit *(The Amount Payable by the NYPA Medical Plan based on Eligible Expenses)*		
	Network		Non-Network[2]
	1/1/2020	1/1/2022	
Hospital - Inpatient Stay	100%		100%
Injections received in a Physician's Office	$30 Copay	$35 Copay	80% after you meet the Annual Deductible
	$0 Copay for preventive immunizations[3]		
Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.		Benefits will be the same as those stated under each Covered Health Service category in this section.
Mental Health Services			
■ Inpatient	100%		100%
■ Outpatient	$30 Copay per visit	$35 Copay per visit	80% after you meet the Annual Deductible
Multiple Surgical Procedures	Benefits will be the same as those stated under each Covered Health Service category in this section		Benefits will be the same as those stated under each Covered Health Service category in this section.
Nutrition	$30 Copay	$30 Copay	80% after you meet the Annual Deductible

<table>
<tr><th rowspan="3">Covered Health Services[1]</th><th colspan="3">Benefit
(The Amount Payable by the NYPA Medical Plan based on Eligible Expenses)</th></tr>
<tr><th colspan="2">Network</th><th rowspan="2">Non-Network[2]</th></tr>
<tr><th>1/1/2020</th><th>1/1/2022</th></tr>
<tr><td>Obesity Surgery</td><td colspan="2">Benefits will be the same as those stated under each Covered Health Service category in this section.

See Section 4, NYPA Medical Plan Pre-Certification and Section 6, Benefit Descriptions, for further information on medical necessity and pre-certification requirements.</td><td>Benefits will be the same as those stated under each Covered Health Service category in this section.

See Section 4, NYPA Medical Plan Pre-Certification and Section 6, Benefit Descriptions, for further information on medical necessity and pre-certification requirements.</td></tr>
<tr><td>Outpatient Surgery, Diagnostic and Therapeutic Services</td><td colspan="2"></td><td></td></tr>
<tr><td>■ Outpatient Surgery</td><td colspan="2">100%</td><td>100%</td></tr>
<tr><td>■ Lab and radiology/X-ray</td><td>$30 Copay</td><td>$35 Copay</td><td>100% up to $1,500 per calendar year then 80% after you meet the Annual Deductible</td></tr>
<tr><td rowspan="2">■ Mammography testing.</td><td>$30 Copay</td><td>$35 Copay</td><td rowspan="2">100% up to $1,500 per calendar year then 80% after you meet the Annual Deductible</td></tr>
<tr><td colspan="2">$0 Copay for preventive services[3]</td></tr>
</table>

Covered Health Services[1]	Benefit *(The Amount Payable by the NYPA Medical Plan based on Eligible Expenses)*		
	Network		Non-Network[2]
	1/1/2020	1/1/2022	
■ PAP smear	$30 Copay	$35 Copay	100% up to $1,500 per calendar year then 80% after you meet the Annual deductible
	$0 Copay for preventive services[3]		
■ Sickness and Injury related diagnostic services	$30 Copay	$35 Copay	100% up to $1,500 per calendar year then 80% after you meet the Annual deductible
■ CT Scans, PET Scans, MRI and Nuclear Medicine	$30 Copay	$35 Copay	100% up to $1,500 per calendar year then 80% after you meet the Annual deductible
■ Outpatient Therapeutic Treatments	$30 Copay	$35 Copay	100% up to $1,500 per calendar year then 80% after you meet the Annual deductible
Physician Fees for Surgical and Medical Services – Inpatient Surgery	100%		No charge up to benefit maximum of $1,800 per calendar year then 80% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the NYPA Medical Plan based on Eligible Expenses)*		
	Network		Non-Network[2]
	1/1/2020	1/1/2022	
Physician Fees for Surgical and Medical Services – Outpatient Surgery	$30 Copay	$35 Copay	100%
Physician's Office Services - Sickness and Injury	$30 Copay	$35 Copay	80% after you meet the Annual Deductible
Preventive Care Services[3]			
■ Physician Office Services	$0 Copay		Not Covered
■ Outpatient Diagnostic Services	$0 Copay		Not Covered
■ Breast Pumps	$0 Copay		Not Covered
■ Immunizations	$0 Copay		80% after you meet the Annual Deductible
■ Routine Well Baby Care	$0 Copay		80% after you meet the Annual Deductible
Prosthetic Devices	$30 per device	$35 per device	80% after you meet the Annual Deductible
Reconstructive Procedures	Benefits will be the same as those stated under each Covered Health Service category in this section.		Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the NYPA Medical Plan based on Eligible Expenses)*		
	Network		Non-Network[2]
	1/1/2020	1/1/2022	
Rehabilitation and Habilitative Services - Outpatient Therapy	$30 Copay per visit	$35 Copay per visit	80% after you meet the Annual Deductible
Second Opinions Allowed, but not required	$30 Copay per visit	$35 Copay per visit	80% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	100%		100%
Substance Use Disorder Services			
■ Inpatient	100%		100%
■ Outpatient	$30 Copay for the first visit only	$35 Copay for the first visit only	100%
Temporomandibular Joint (TMJ) Services – Orthognathic Surgery	100%		80% after you meet the Annual Deductible
Urgent Care Center Services	$30 Copay per visit	$35 Copay per visit	Same as in-network Urgent Care Co-pay
Virtual Visits	$15 copay (waived through 12/31/2020)		Not Covered
Wigs	100%		80% after you meet the Annual Deductible

[1]You must notify the Medical Plan Claims Administrator, as described in Section 4, *NYPA Medica*l *Plan Pre-Certification* to receive full Benefits for certain Covered Health Services. See Section 6, *Benefit Descriptions,* for further information.

[2] Non-Network services that exceed Eligible Expenses are not covered under the plan.

[3]Per ACA guidelines - Network preventive care services have $0 Copay.

SECTION 6 – BENEFIT DESCRIPTIONS

This section supplements the Schedule of Benefits table in Section 5, *NYPA Medical Plan Highlights*.

While Section 5, *NYPA Medical Plan Highlights*, provides you with Copayment, Coinsurance, and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits provided by the NYPA Medical Plan. All covered services must meet medical necessity requirements.

Acupuncture Services

Acupuncture services are covered up to 30 visits.

Ambulance Services

Round trip Emergency transportation (limited to only the first trip to hospital for any one illness or injury) by a licensed ambulance service, including ground and/or air transportation, to a hospital or medical facility where Emergency health services can be performed and are equipped to provide treatment for the particular illness or injury. See Section 21, *Glossary* for the definition of Emergency.

The following are examples of ambulance copays, but it is not an exhaustive list:

Scenario 1: A participant is in an accident and is transferred via ambulance to the nearest hospital. The hospital determines that it is medically necessary to transfer the participant to a second hospital for treatment. Both ambulance transports would be covered. The participant would only pay one $50 copay.

Scenario 2: A participant is in an accident and is transferred via ambulance to the nearest hospital and is admitted to the hospital. A few days later, the hospital determines that it is medically necessary to transfer the participant to a second hospital for treatment. Both ambulance transports would be covered. The participant would pay a $50 copay for each ambulance transport.

Chiropractic Care

Chiropractic care is covered up to 30 visits. After that, the care you are receiving must be considered active treatment. This means the provider must certify that the treatment will result in a medical improvement in your diagnosed condition. Care that is provided solely for relief of pain or that will not result in a demonstrated or expected improvement of the diagnosed condition is considered maintenance care, and will not be covered after the time period stated above. The Medical Plan Claims Administrator will make the final determination concerning whether care is active treatment or maintenance treatment. Chiropractic care coverage is generally limited to treatment of the back. If a chiropractor treats another part of the body, that claim is evaluated on a case-by-case basis. See Grievance clause in front of book.

Dental Services - Accident Only

Dental services and surgical extractions are covered by the NYPA Medical Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

Benefits are available only for treatment of a natural tooth.

Dental services for final treatment to repair the damage must be completed within 12 months of the accident.

Dental – Other Covered Services

Dental services are generally provided under Section 11, *Dental Benefits*. However, the following procedures are covered under the NYPA Medical Plan:

- Oral surgery to remove an impacted tooth.
- Cutting procedures on gums or mouth tissues needed to treat a disease.

These procedures are only covered for participants enrolled in the NYPA Medical Plan. Participants enrolled in an HMO that NYPA contracts with, should refer to the HMO and/or Section 11, *Dental Benefits*, for coverage information. If you waived NYPA's medical coverage, you should carefully review the provisions of your medical plan for coverage information.

Emergency Room Services

Emergency room treatment must be medically necessary and if due to an accidental injury, treatment has to be given within 72 hours after the accident. Emergency treatment must be given within 24 hours after a sickness or pregnancy-related condition begins.

Home Health Care

Covered Health Services are services received from a Home Health Agency that are both of the following:

- ordered in writing by a Physician; and
- provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. The aides' only duties must be caring for the patient.

Home Health Care Benefits are available for up to 40 visits per calendar year. Four hours of services provided by a home health aide will count as one visit. Each visit by any other member of the home health care team will count as one visit.

Not Covered:

- Services not included in the home health care plan ordered by the agency.
- Services provided by a member of your immediate family or a person who ordinarily resides in your home. Immediate family means your spouse, children, parents, grandparents, siblings and their spouses.
- Custodial Care
- Transportation services.

Hospice Care

Hospice care refers to medical care for a terminally ill person provided in the home, hospice unit or hospital. If the hospice is located in New York State it must be certified pursuant to Article 40 of the New York Public Health Law, or the hospice is located outside of New York State, certified by the state in which the hospice organization is located. The NYPA Medical Plan provides benefits for a hospice care, hospital, home care or hospital outpatient care program for a covered individual if the patient's doctor confirms that the patient is expected to live for less than six months. The following expenses are covered by the Plan:

- Inpatient care in a hospice unit or regular hospital bed.
- Day care services furnished by a hospice agency.
- Intermittent care by an R.N., L.P.N., or Home Health Aide.
- Physical, speech, occupational or respiratory therapy.
- Medical social and nutritional services.
- X-rays, laboratory examinations, chemotherapy and radiation therapy when required for control of symptoms.
- Medical supplies and rental of durable medical equipment.
- Drugs and medicines prescribed by a physician and that are considered approved for the patient's condition. Benefits are not payable if the drugs or medications are of an Experimental nature.
- Medical care provided by the hospice physician.
- Bereavement counseling for the patient's family either before or up to one year after the patient's death.
- Transportation between home and hospital or hospice organization when medically necessary.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during the Inpatient Stay.
- Room and board in a Semi-private Room. Charges for a private room, up to the hospital's regular daily charge for a private room, will only be considered if medically necessary and approved by the Medical Plan Claims Administrator on

a case by case basis (For example, a private room may be deemed medically necessary if the patient had a communicable disease).
- Blood and blood plasma

Benefits for other Hospital-based Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described in Section 5, *NYPA Medical Plan Highlights.*

Benefits for Emergency admissions and admissions of less than 24 hours are described in this Section under *Emergency Room Services* and *Outpatient Surgery, Diagnostic and Therapeutic Services*, respectively.

Inpatient room and board benefits can be paid for up to 365 days for each cause.

Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications, rendered by a physician or a licensed certified nurse-midwife. The nurse-midwife must be licensed or certified to practice nurse midwifery, and permitted to perform the service under the law of the state where the services are rendered.

The plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; and
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to the NYPA Medical Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include, but are not limited to the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.

- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

United Behavioral Health (UBH) is the Mental Health/Substance Use Disorder (MH/SUD) Administrator. You are encouraged to contact UBH for referrals to Network Providers and coordination of care. You can contact the MH/SUB Administrator by calling the number on the back of your ID card.

All inpatient hospitalizations must be pre-certified by the MH/SUB Administrator to avoid a $250 penalty.

Multiple Surgical Procedures

If surgeries are performed *bilaterally,* which means that *two incisions* are made, the first surgery is paid at 100% and the second surgery is paid at 50%. An example of this type of surgery would be a bunion surgery. The reason the payment for the second surgery is reduced is there is no additional preparation time associated with the second surgery since the *same procedure* is being done on each foot.

There are instances when two surgeries are performed on the same day. One surgery is identified as primary or major surgery. The *second surgery,* while an important part of the overall surgery *does not require the same skill or expertise* as *the major surgery.* In this case, the major surgery is payable at 100% and the secondary surgery is paid at 50%. An example of a primary or major, and a secondary surgery would be a tonsillectomy (primary/major) with a myringotomy (ear surgery - tubes) (secondary/minor).

Incidental surgery is different from the surgeries described above. No payment will be made for incidental surgery. An example of this type of surgery would be a doctor doing an appendectomy that is *not medically necessary* while performing abdominal surgery.

Nutrition

The Plan covers the following nutrition services:

- Enteral feedings and other nutritional and electrolyte formulas when medically necessary
- Nutritional education when required for a disease in which patient self-management is an important component of treatment; and would require intervention of a trained health professional in the absence of such training.

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

The NYPA Medical Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon

fees related to outpatient surgery are described in Section 5, *NYPA Medical Plan Highlights.*

When these services are performed in a Physician's office, Benefits are described in Section 5, *NYPA Medical Plan Highlights.*

Outpatient Diagnostic Services

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment. Benefits for facility-based Physician's fees related to these services are covered under Section 5, *NYPA Medical Plan Highlights.*

The plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Lab and radiology/X-ray.
- Mammography testing. Preventive mammography is covered. However, if a physician orders a mammography because disease is suspected, the benefit will be subject to Copays or Deductible/Co-Insurance as described under Section 5*, NYPA Medical Plan Highlights.*
- PAP smear. Preventive PAP smear is covered. However, if a physician orders a PAP smear because disease is suspected, the benefit will be subject to Copays or Deductible/Co-Insurance as described under Section 5*, NYPA Medical Plan Highlights.*

Preventive Care Services

The NYPA Medical Plan pays Benefits for preventive care services.

The following services are covered consistent with the Patient Protection and Affordable Care Act (ACA) regulations.

- Bacteria screening, urine, pregnant women 12-16 weeks
- Abdominal aortic aneurysm screen
- Basic metabolism test “general health panel”
- Bone mineral density tests
- Chlamydia screening
- Cholesterol test
- Colonoscopy and sigmoidoscopy
- Fecal blood testing
- Gonorrhea screening
- Hemoglobin and hematocrit testing
- HIV screening
- HPV screening
- Immunizations
- Lead screening
- Mammograms
- PAP smear
- Physical exam
- Birth control

- Prenatal and postpartum visits
- Prostate test “PSA” testing
- Rh screen
- Rubella screening
- Syphilis infection screening
- Type 2 diabetes screening
- Well child visits
- Diet counseling
- Obesity screening and counseling
- Osteoporosis screening
- Cervical cancer screening
- Congenital hypothyroidism screening for newborns
- Routine obstetrical / gynecological exam
- Tobacco screening, counseling, cessation interventions and addition prescription
- Vision coverage (screening for children)
- Counseling for women with breast cancer
- Phenylketonuria
- Screen for inherited enzyme disease
- Kids depression
- Sickle cell testing
- Fluoride, chemoprevention supplement
- Breast feeding instruction

If the PPACA is repealed, or the forgoing list of preventive care items is changed by law to add to, delete from, or modify such list, upon written request, either party may request to meet and negotiate a change in cost.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to the Medical Plan Claims Administrators website or by calling the telephone number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost-effective pump. The Medical Plan Administrator will determine the following:

- Which pump is the most cost-effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.

For questions about your preventive care Benefits under this plan call the number on the back of your ID card.

Prosthetic Devices

- Only the initial charge for the first appliance is covered. An appliance which replaces a lost body organ or part or helps an impaired organ or part to work.

- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras and lymphedema stockings for the arm.
-
- The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to the initial, single purchase of each type of prosthetic device. ***Note:*** Prosthetic devices are different from DME - see *Durable Medical Equipment (DME).*

Reconstructive Procedures

Reconstructive procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact the Medical Plan Claims Administrator at the number on your ID card for more information about Benefits for mastectomy-related services.

Second Opinions

Second opinions are allowed, but are not required, for surgical and medical procedures.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Services and supplies received during the Inpatient Stay.
- Room and board in a Semi-private Room.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include but are not limited to the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

United Behavioral Health (UBH) is the Mental Health/Substance Use Disorder Administrator. You are encouraged to contact the MH/SUD Administrator for referrals to Network Providers and coordination of care. You can contact the MH/SUD Administrator by calling the number on the back of your ID card. All inpatient hospitalizations must be pre-certified by the MH/SUB Administrator to avoid a $250 penalty.

Temporomandibular Joint (TMJ) Services – Orthognathic Surgery

- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ*).*

Payment for the TMJ diagnosis (office visit) are covered under *Physician's Office Services - Sickness and Injury*. X-rays are covered under Section 11, *Dental Benefits*. If surgery is recommended, it is payable under Hospital or Outpatient Surgery. Crowns and bridgework to treat TMJ are covered under the Dental Plan.

Virtual Visits

Virtual visits give you access to care 24/7 for minor health issues. You can see a doctor from your mobile device or computer. The virtual visit benefit is available to participants through the following apps: Teledoc, American Well and Doctor on Demand.

SECTION 7- MEDICAL EXCLUSIONS & LIMITATIONS

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Benefit Descriptions*

The NYPA Medical Plan does not pay Benefits for certain services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition. Please review all limits carefully, as the NYPA Medical Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

- Services performed by a provider with your same legal residence.

Other Exclusions

- Charges for medical exams or tests not necessary for the treatment of a covered injury, sickness or pregnancy.

- Charges in excess of what is reasonable and customary for particular services or supplies.

- Custodial care.

- Eye glasses, eye refractions and hearing aids, unless required because of an accident which happens while covered. For more information regarding Vision Care and Hearing Aid(s) Coverage, See Section 12, *Vision Care* and Section 13, *Hearing Aids*, respectively.

- Private duty nursing.

SECTION 8 – MEDICAL CLAIMS PROCEDURES

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Medical Plan Claims Administrator will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call the Medical Plan Claims Administrator at the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network provider, you (or the provider if they prefer) must send the bill to the Medical Plan Claims Administrator for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Medical Plan Claims Administrator at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting the Medical Plan Claims Administrator's website, calling the toll-free number on ID card or contacting your site HR Representative. Be sure the claim form and bill contains the following information:

- Your name and address
- The patient's name, age and relationship to the Participant.
- The group number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - Information indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

Once the Medical Plan Claims Administrator has processed your claim, you will receive payment for Benefits that the plan allows. It is your responsibility to pay the Non-Network provider the charges you incurred, including any difference between what you were billed and what the plan paid.

Explanation of Benefits (EOB)

You may request that the Medical Plan Claims Administrator send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at the Medical Plan Claims Administrators website.

Important - Timely Filing of Non-Network Claims
All claim forms for Non-Network services must be submitted within one year from the end of the calendar year after the date of service. Otherwise, the plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by the Medical Plan Claims Administrator. This requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Timely Filing of Network Claims
It is the **Physicians and Hospitals responsibility** to submit Network claims within 60 days after the date of service. Otherwise, the plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by the Medical Plan Claims Administrator.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call the Medical Plan Claims Administrator at the number on your ID card before requesting a formal appeal. If the Medical Plan Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740816
Atlanta, Georgia 30374-0816

For urgent care requests for Benefits that have been denied, you or your provider can call the Medical Plan Claims Administrator at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

The Medical Plan Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the Medical Plan Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. See Grievance Provisions in front of booklet.

Filing a Second Appeal

Your plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Medical Plan Claims Administrator within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Medical Plan Claims Administrator will review all claims in accordance with the rules established by the *U.S. Department of Labor*.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Medical Plan Claims Administrator, or if the Medical Plan Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Medical Plan Claims Administrator's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).

- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received the Medical Plan Claims Administrator's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Medical Plan Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by the Medical Plan Claims Administrator of the request.
- A referral of the request by the Medical Plan Claims Administrator to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, the Medical Plan Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that the Medical Plan Claims Administrator may process the request.

After the Medical Plan Claims Administrator completes the preliminary review, the Medical Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Medical Plan Claims Administrator will assign an IRO to conduct such review. The Medical Plan Claims Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Medical Plan Claims Administrator will provide to the assigned IRO the documents and information considered in making the Medical Plan Claims Administrator's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Medical Plan Claims Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and the Medical Plan Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Medical Plan Claims Administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Medical Plan Claims Administrator, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the Medical Plan Claims Administrator's determination, the plan will immediately 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 Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant 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 either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an

admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Medical Plan Claims Administrator will determine whether the individual meets both of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the Medical Plan Claims Administrator may process the request.

After the Medical Plan Claims Administrator completes the review, the Medical Plan Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Medical Plan Claims Administrator will assign an IRO in the same manner it utilizes to assign standard external reviews to IROs. The Medical Plan Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Medical Plan Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's 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, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Medical Plan Claims Administrator.

You may contact the Medical Plan Claims Administrator at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the plan must approve or in which you must notify the Medical Plan Claims Administrator before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Medical Plan Claims Administrator's decision letter to you.

The following tables describe the time frames which you and the Medical Plan Claims Administrator are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Medical Plan Claims Administrator must notify you within:	**24 hours**
You must then provide completed request for Benefits to the Medical Plan Claims Administrator within:	**48 hours** after receiving notice of additional information required
The Medical Plan Claims Administrator must notify you of the benefit determination within:	**72 hours**
If the Medical Plan Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
the Medical Plan Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Medical Plan Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Medical Plan Claims Administrator must notify you within:	**5 days**
If your request for Benefits is incomplete, the Medical Plan Claims Administrator must notify you within:	**15 days**
You must then provide completed request for Benefits information to the Medical Plan Claims Administrator within:	**45 days**
The Medical Plan Claims Administrator must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Medical Plan Claims Administrator must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Medical Plan Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Medical Plan Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Medical Plan Claims Administrator within:	**45 days**
The Medical Plan Claims Administrator must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Medical Plan Claims Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Medical Plan Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

SECTION 9 - SUBROGATION AND REIMBURSEMENT

The NYPA Medical Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the plan. The plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the plan to treat your injuries. Under subrogation, the plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

You agree to cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner.

Your failure to cooperate with the plan is considered a breach of contract. As such, the plan has the right to take legal action against you, and/or set off from any future Benefits the value of Benefits the plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan. If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.

Right of Recovery

The NYPA Medical Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also 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 and reduce future benefit payment for you or your Dependent by the amount of the overpayment.

If the plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The plan has the right to recover Benefits it has advanced by submitting reminder letters or conducting courtesy calls to you or a covered Dependent that details any outstanding balance owed to the plan.

SECTION 10 - OUTPATIENT PRESCRIPTION DRUGS

Prescription Drug Product Coverage Highlights

The Prescription Drug Plan is part of the NYPA Medical Plan. This benefit does not apply to participants enrolled in an HMO or that have waived NYPA's medical coverage.

Prescription Drug Products will be dispensed if they are medically necessary, meet the Prescription Drug Plan Claims Administrator's approved guidelines, and meet the following:

- It meets the definition of a Covered Health Service as defined by the plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 21, *Glossary*.
- The following Schedule of Benefits provides an overview of the plan's coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Prescription Drug Benefits – Schedule of Benefits		
Covered Health Services[1]	**Network Amount**	**Non-Network Amount**
Retail - up to a 34-day supply		
■ Tier-1	1/1/2020 $10 Copay	1/1/2020 $10 Copay
■ Tier-2	1/1/2020 $30 Copay	1/1/2020 $30 Copay
■ Tier-3	1/1/2016 $45 Copay 1/1/2022 $50 Copay	1/1/2016 $45 Copay 1/1/2022 $50 Copay
Mail order - up to a 90-day supply		
■ Tier-1	1/1/2020 $25 Copay	N/A
■ Tier-2	$62.50 Copay 1/1/2020 $75 Copay	N/A
■ Tier-3	1/1/2016 $112.50 Copay 1/1/2022 $125 Copay	N/A

[1]You are not responsible for paying a Copayment for Preventive Care Medications as defined in Section 21, *Glossary* under Preventive Care Medications.

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

All Prescription Drug Products covered by the plan are categorized into these three tiers on the Prescription Drug List (PDL), or formulary. The plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products. The Prescription Drug Plan Claims Administrator also refers to the tiers as generic, preferred brand, and non-preferred brand.

The Prescription Drug Plan Claims Administrator develops a PDL, which is reviewed by a group of expert health professionals. The evaluation is based on a number of factors, including clinical, safety, efficacy, and economic factors. As new drugs become available, the Prescription Drug Plan Claims Administrator updates the formulary to get safer and more effective medications to its members. Medications may be added, change tiers, and some may be removed and no longer covered under the plan. When that occurs, the amount of money you are obligated to pay for that prescription drug will change.

Since the PDL may change periodically, you can obtain information about the formulary through the Prescription Drug Plan Claims Administrator's website or by calling them at the number on your prescription drug ID card.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details.

You are responsible for paying the lower of:

- The applicable Copay.
- The Prescription Drug Charge for that particular Prescription Drug.

Identification Card (ID Card) - Network Pharmacy

Your prescription drug ID card is separate from your medical ID card. You must either show your prescription drug ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Prescription Drug Plan Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy or use a Non-Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the plan as described later in this Section under the heading, *How to File a Claim*. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copay that applies.

Retail Pharmacies

The plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies through the Prescription Drug Plan Claims Administrator's website or by calling them at the number on your prescription drug ID card.

To obtain your prescription from a Network Pharmacy, simply present your prescription drug ID card and pay the Copay. The plan pays Benefits for certain covered Prescription Drug Products:

- As written by a Physician.
- The greater of a consecutive 34-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, but not to exceed a 100 unit dose. Effective April 1, 2019, the 100 pill provision will be eliminated, and the maximum supply will be limited to a 34-day supply in retail pharmacies.
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 34-day supply, the Copay that applies will reflect the number of days dispensed.

Mail Order Services

The mail order service may allow you to purchase up to a 90-day supply of a covered drug through the mail from a Network Pharmacy.

To use the mail order service, all you need to do is submit a patient profile form and have your physician submit your prescription directly to the Prescription Drug Plan Claims Administrator. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach the Prescription Drug Plan Claims Administrator at the number on your prescription drug ID card.

The plan pays mail order Benefits for certain covered Prescription Drug Products:

- As written by a Physician.
- Up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Diabetic Medications and Supplies

Effective April 1, 2019, all diabetic medications and supplies will require a copay based on the associated prescription Tier as listed in the *Prescription Drug Benefits – Schedule*

of Benefits chart. If you purchase test strips/supplies at the same time as your medication, then there will be no additional copay for the test strips/supplies**.**

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the Prescription Drug Plan Claims Administrator's website or by calling them at the number on your prescription drug ID card.

Benefits for ED Medications

Benefits under the Prescription Drug Plan include erectile dysfunction (ED) medications, provided they are medically necessary. Your physician must contact the Prescription Drug Plan Claims Administrator for a prior approval, which is valid for one year.

How to File Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the plan should have paid for it.
- You pay a Copay and you believe that the amount of the Copay was incorrect.

Contact the Prescription Drug Plan Claims Administrator or your site HR Representative for a Prescription Drug Reimbursement Form.

In order for your request to be processed, all receipts must contain the information listed on the reimbursement form. Your pharmacist can provide the necessary information if your claim or bill is not itemized. Once the form is completed, you can mail or fax the form to the Prescription Drug Plan Claims Administrator. After the claim has been processed, you will receive payment for Benefits that the plan allows.

Exclusions and Limitations

When an exclusion applies to a Prescription Drug Product, you can access information on excluded medications through the Prescription Drug Plan Claims Administrator's website or by calling the number on your prescription drug ID. The general exclusions listed in Section 19, *Additional Information About your Benefits,* also apply to Prescription Drug Benefits.

- Available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed.

- The amount dispensed is in excess of the supply needed for 34 days, or in excess of 100 unit doses, whichever is greater, as to each prescription refill unless ordered through the Bulk Order/Mail Service benefit.

- Refills in excess of the allowable number or dispensed one year after the date of the initial prescription.

- Prescription Drug Products dispensed by an individual not licensed to dispense drugs.

Claims Appeals

Coverage review description

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Prescription Drug Plan Administrator reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the plan's benefit design.

How to request an initial coverage review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at www.expressscripts.com/PA.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, is obtained by calling the Customer Service phone number on the back of your prescription card. Complete the form and mail or fax it to Express Scripts Attn: Benefit Coverage Review Department PO Box 66587 St Louis, MO 63166-6587. Fax 877 328-9660.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1-800-753-2851.

How a coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to the Prescription Drug

Plan Claim Administrator for review. For an administrative coverage review request, the member must submit information to Prescription Drug Plan Claim Administrator to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (Home delivery)	Patient: Automated call (letter if call is not successful) Prescriber: Electronic or fax (letter if fax not successful)	Patient: Letter Prescriber: Electronic or fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours**	Patient: Automated call and letter Prescriber: Electronic or fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Electronic or fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

**Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an

appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: phone 1 800-753-2851 fax 1 877- 852-4070

Administrative appeal requests: phone 1 800-946-3979 fax 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 appeal or urgent appeal is processed

Prescription Drug Plan Claim Administrator completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days	Patient: Automated call (letter if call is not successful) Prescriber: Electronic or fax (letter if fax not successful)	Patient: Letter Prescriber: Electronic or fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours	Patient: Automated call and letter Prescriber: Electronic or fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Electronic or fax (letter if fax not successful)

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to request a level 2 appeal after a level 1 appeal has been denied

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number

- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St Louis, MO 63166-6587 Fax 1 877-328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: phone 1 800-753-2851 fax 1 877- 852-4070

Administrative appeal requests: phone 1 800-946-3979 fax 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a Pharmacist, Physician, panel of clinicians or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days	Patient: Automated call (letter if call is not successful) Prescriber: Electronic or fax (letter if fax not successful)	Patient: Letter Prescriber: Electronic or fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours	Patient: Automated call and letter Prescriber: Electronic or fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Electronic or fax (letter if fax not successful)

New York Power Authority retains the authority to determine Covered Health Services and how the Eligible Expenses are reimbursed under the NYPA Medical Plan. [see Grievance Process in front of book]

SECTION 11 – DENTAL BENEFITS

Dental benefits are offered through Delta Dental, herein referred to as the Dental Plan Claims Administrator. You may elect either individual or family coverage, or choose not to participate in the Dental Plan. The dental benefits are provided to promote good dental health. Your dental benefits cover a wide range of services, and will help pay a large portion of your covered dental expenses.

Cost

NYPA pays the full cost of your dental coverage.

Annual Deductible

The deductible is the amount you pay each year before the Dental Plan pays any benefits. Each covered person must meet a calendar year deductible (up to the per family limit), which applies to all covered dental expenses incurred during the year, except diagnostic and preventive benefits. If you incur dental expenses that are not covered expenses under the Dental Plan, these expenses will not count toward your deductible.

Coinsurance

Coinsurance is the percentage of covered services that you pay as your share of the bill, after you have met the annual deductible. For example, if the Dental Plan pays 80% of covered expenses after you meet the deductible, then 20% would be your coinsurance. If you use an in-network dentist, you will only be responsible for the coinsurance of the agreed upon contracted rate.

Annual Maximum Dental Plan Benefit

The Dental Plan will pay a maximum of $2,000 in benefits per covered person, per calendar year, for covered dental services rendered by participating and non-participating providers. Orthodontic benefits do not count toward this annual maximum. Any charges incurred in excess of the annual $2,000 maximum plan benefit will be your responsibility.

Lifetime Benefit Maximums

There is a separate lifetime maximum benefit of $3,000 per covered person for orthodontic treatment.

Common Accident Feature

If two or more covered family members are hurt in the same accident, only one plan deductible will have to be paid each year. This common accident feature applies to the combined family expenses due to that accident during the year.

Schedule of Dental Benefits

Eligibility	Employee, spouse or domestic partner, and eligible dependent children to age 23	
Deductibles (waived for Diagnostic and Preventive Services)	$50 per person / $100 per family each calendar year	
Maximums	$2,000 per person each calendar year	
Benefits and Covered Services	**Network Amount**	**Non-Network Amount**
Diagnostic & Preventive Services Exams, cleanings, x-rays, sealants and fluoride	100%	100%
Basic Services, Endodontics, Periodontics Fillings, simple tooth extractions, posterior composite restorations and injectable antibiotics	80%	80%
Oral Surgery NYPA Medical Plan HMO that NYPA offers	0% (see Medical) 80%	0% (see Medical) 80%
Major Services, Prosthodontics Crowns, inlays, onlays, cast restorations, bridges and dentures	50%	50%
Orthodontic Benefits Adult and dependent children	75%	75%
Orthodontic Maximums	$3,000 lifetime	$3,000 lifetime

Selecting a Dentist

You are free to go to any licensed dentist for covered services. This includes both in-network and out-of-network providers. When you use an in-network dentist, however, your out-of-pocket costs are typically lower than those you would incur if you received services from an out-of-network dentist.

In-Network Providers: The Dental Plan Claims Administrator has a network of dentists who have agreed to accept reduced fees for the covered services they provide to plan participants. You maximize the value you derive from the plan and will usually pay the

least when you visit a network dentist. In-network dentists file claim forms with The Dental Plan Claims Administrator, receive reimbursement directly from the Dental Plan Claims Administrator, and accept what the Dental Plan pays (less any deductibles or co-insurance or amounts over the benefit maximum) as payment in full. A list of participating dentists is available from the Dental Plan Claims Administrator's website.

Out-of-Network Providers: Out-of-network dentists are those who have not entered into an agreement with the Dental Plan Claims Administrator to provide services at a discounted price. If you receive dental services from an out-of-network dentist during the year, the covered charges are subject to a deductible and co-insurance and the benefit maximum. You will also be responsible for paying any charges over the Reasonable & Customary Charges, in addition to the applicable deductible and coinsurance amounts. Your dentist may or may not file claim forms for you.

Covered Services

Covered dental charges are a Dentist or physician's charges for the services and supplies listed below required for dental care and treatment of any disease, defect or accidental injury, or for preventive dental care.

You can also access Dental Plan benefit information, print ID cards, and view your claims at the Dental Plan Claims Administrator's website.

Diagnostic and Preventive Care

Diagnostic and preventive care services are reimbursed at 100% (with no deductible applied.) These services include:

- Cleaning and Scaling teeth (Prophylaxis) once every 6 months. The six-month period begins with the date the services are first provided. For example, if you had a cleaning on March 9, you're eligible for your next cleaning on or after September 9.
- Fluoride treatments once every six months.
- Charges for space maintainers and their fittings.
- Routine oral exam once every six months.
- Full mouth and Bitewing X-rays once every six months.
- Emergency treatment for dental pain when no other treatment but X-rays is given. If other treatment is given, the benefit payment for the other treatment is payable according to the type of service provided.
- Sealants (on posterior teeth) for children up to age 14.

Major Services

The plan pays 50%, after you meet the annual deductible, for reconstructive care procedures. These include but are not limited to the following:

- Charge for a crown or gold Filling that is needed to restore the structure of teeth broken down by decay or injury.

    - You will only be paid the amount for silver, porcelain or other fillings unless the work can only be done with gold.

    - The charge to replace a gold filling is only covered if the filling is over five years old.

- Charges for Dentures (full, partial or adding teeth to an existing denture), or fixed Bridges are covered if required because of loss of natural teeth while covered under the Dental Plan.

    - Replacement of an existing bridge or denture is only covered if the existing piece is at least five years old.

  Charges for adjustments to new dentures or bridgework or specialized techniques involving precision attachments (to strengthen a bridge or place a crown) are considered to be included in the cost of the new piece and would not be covered during the first 6 months after installation.

- Special work that you ask to have done (i.e., diamond studs, initialing, etc.), is not covered.

Other Services

Charges for the following services are paid at 80%, after you meet the annual deductible:

- Silver (Amalgam), Silicate, Plastic, Porcelain, and Composite Fillings.

- Root Canal Therapy (endodontic treatment).

- Treatment of gums and mouth tissues (Periodontic Treatment).

- General Anesthetics in connection with oral surgery, fractures, dislocations and treatment of gums. Local anesthetics are considered to be included in the charge for treatment. Extra charges for local anesthetics are not covered.

- Treatment of jaw fractures and dislocations.

- Charges for injectable Antibiotics.

Cutting Procedures

Expenses for pulling teeth (extractions) and cutting procedures in the mouth (oral surgery) are covered as follows:

- If you are enrolled in the NYPA Medical Plan, expenses for cutting procedures and extraction of tooth performed by an oral surgeon are covered under the Medical Benefits provisions – See Section 6*, Benefit Descriptions*.

- If you are enrolled in an HMO that NYPA offers, expenses for cutting procedures and extraction of tooth performed by an oral surgeon are covered under the NYPA Dental Plan.

- Simple extractions (no cutting procedures) are also covered under the NYPA Dental Plan. These procedures are payable at 80% of reasonable and customary charges, or contracted rate if a preferred provider is used, after you meet your deductible. These procedures are included in the yearly dental plan maximum of $2,000.

If you are enrolled in the NYPA Medical Plan, and it is recommended by an oral surgeon to have a dental procedure performed in a hospital outpatient setting, a letter of medical necessity and a predetermination form is to be sent to the NYPA Medical Plan Claims Administrator for a review of dental procedure. A decision will be made whether the charges are covered expenses in accordance with the plan. If approved, the hospital outpatient setting, along with any other charges that apply to medical, will be considered for payment under the NYPA Medical Plan – See Section 6, *Benefit Descriptions*. Charges for treatment or services provided or related to teeth will be considered for payment under the dental plan as administered by the Dental Plan Claims Administrator. This applies to both employees and dependents.

Orthodontia

The plan pays 75% of the reasonable and customary costs for treatment needed to properly align teeth for covered adults and children. Benefits are subject to a $50 per person $100 per family) annual deductible and a lifetime maximum of $3,000 per person. Orthodontic benefits do not affect your dental maximum for other covered services.

- The plan covers most orthodontic treatment (other than work done because of extractions or space maintainers) to correct malposed teeth, provided the first active orthodontic appliance was inserted while you or your dependent were covered under the Dental Plan. Coverage includes the initial exam, diagnostic tests and x-rays, initial and subsequent installation of appliances and all orthodontic adjustments. A predetermination estimate is recommended.

- One of the following conditions must be diagnosed by the dentist in order for the charges to be covered:

    - The upper teeth protrude over the lower teeth by 4 or more millimeters.

    - There is an open bite (front upper and lower teeth do not meet) of four or more millimeters.

    - The gum area is more than four millimeters too large or small for the teeth (arch length discrepancy of four or more millimeters).

    - Teeth are in a crossbite (extreme bucco-lingual version of teeth).

Orthodontic Benefit Payments

Orthodontic benefit payments will be divided into equal, quarterly (90 day) portions (or payments), with the first portion beginning on the date an active appliance is first inserted. The last portion will be deemed incurred 90 days before the earlier of:

- the date the course of treatment is estimated to be completed,
- or 2 years from the date the first portion is deemed incurred.

Benefit payments for orthodontic services stop when your coverage stops. There are no benefits available for charges incurred after coverage stops.

Incurred Dental Charges

A charge will be considered incurred as of the date the service or supplies are provided except in the following situations:

- the first date of preparation of the tooth or teeth involved for fixed bridgework, crowns, inlays, onlays or gold restorations,
- the date the impression was taken for full or partial dentures,
- the date the tooth was opened for root canal therapy (endodontic therapy).

Exclusions

The general exclusions listed in Section 19, *Additional Information About your Benefits,* also apply to Dental Benefits. Some of the dental services, supplies or treatments that are not covered by the plan include, but are not limited to the following:

- Treatment by someone other than a dentist or physician except where performed by a qualified technician under the direction of a dentist or physician.
- Services and supplies which are partially or wholly cosmetic in nature.
- Training in or supplies used in dietary counseling, oral hygiene or plaque control; procedures, restorations and appliances to increase vertical dimension or to restore dental "bite."
- Facings or veneers on molar crowns or molar false teeth.
- Training or supplies used to educate people on care of their teeth.
- Charges for crowns and fillings not shown in this section under *Covered Services Categories.*
- Preventative Appliances (e.g. bite guards).

HMO Considerations

If you are given a prescription by a dentist, it may not be covered by your HMO. Only prescriptions written by your primary care physician (or another physician to whom you were referred) may be covered. Coverage under each HMO varies, so you need to examine the plan provisions of the HMO you are enrolled in to see what is covered. (See also Cutting Procedures above for consideration).

Claims Procedures

If you have a question about the payment or denial of a claim, call the Dental Plan Claims Administrator. To be eligible for payment, claims must be submitted no later than the end of the year following the year in which the service was incurred.

Predetermination of Benefits

A predetermination of benefits is a claim that is filed prior to dental care being received. Filing a predetermination with the Dental Plan Claims Administrator before you receive services allows them to review the treatment plan and let you and your dentist know, in advance, how much the plan will cover and what you may have to pay.

Predeterminations are recommended, but not required. In other words, you do not need to receive an approval of the benefit in advance of obtaining dental care in order for the claim to be considered for payment. The payment amount may change if your course of treatment changes. If this occurs, have your dentist complete a new claim form.

Filing a Claim

You do not have to file a claim form when using an in-network dentist. If you use an out-of-network dentist who chooses not to submit a claim to the Dental Plan Claims Administrator, you will have to file your own claim. You must submit a separate claim for each covered person. Complete a Dental Claim Form and send it with appropriate bills or receipts to the address shown on the form. Benefits will be paid as soon as the necessary documentation is received. Claim forms are available from your site HR Representative.

Here are some guidelines to follow when filing your claim:

- Send the original claim, not a copy. Keep the copy for your records.
- Fully complete the form. Missing information can delay processing of your claim.
- Sign the form.
- If the dentist office will not complete the form, request an itemized bill that contains all the necessary information for processing your claim, such as:
    - The name and address of the provider;
    - The date and type of service;

- The dental code or description of service (your dentist will provide this).
- Individual charge for each service.

Claims must be submitted no later than the end of the year following the year in which the expense was incurred.

Claims Appeals

Delta Dental
If your claim is denied in whole or in part, the Dental Plan Claims Administrator will notify you and your dentist in writing within thirty (30) days after the claim is filed. The notice of denial will explain the specific reason(s) why the claim was denied. The notice of denial will also contain an explanation of the Dental Plan Claims Administrator's claim review and appeal process and the time limits applicable to the process.

If you or the dentist wants the denial of benefits reviewed, you or your dentist must write to the Dental Plan Claims Administrator within one hundred eighty (180) days of the date on the denial letter. In the letter, you or your dentist should state whey the claim should not have been denied. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. If after review, the Dental Plan Claims Administrator continues to deny the claim, they shall notify you and your dentist in writing of its decision on the request for review within thirty (30) days of the date the request is received.

If you or your dentist believes the matter warrants further consideration, you must advise the Dental Plan Claims Administrator in writing as soon as possible. The matter will be referred to the Dental Plan Claims Administrator's Dental Affairs Committee, which will render a decision within thirty (30) days of the request for further consideration.

Dental Plan Administrator
If your claim was denied in whole or in part by Delta Dental, you can appeal to White Plains Employee Benefits (the Dental Plan Administrator). To appeal a claim, you can call the Benefits Hotline at 718-3114 and speak with an Employee Benefits representative. Please include the date and a description of the services provided.

You must file an appeal within 60 days of the date your claim was denied. White Plains Employee Benefits will respond in writing to your appeal within 30 calendar days.

Employee Benefits Review Committee: If you submitted an appeal to Delta Dental and White Plains Employee Benefits (the Dental Plan Administrator) and believe that the matter has not been resolved appropriately, you may submit an appeal to the Employee Benefits Review Committee via the Director of Compensation and Benefits. The appeal must be in writing. You may also request a meeting with the Committee. The Committee will review the appeal on the facts of the case, the applicable Plan Document, benefits handbook, and relevant precedents. You will receive a written decision from the Committee.

SECTION 12 – VISION CARE

The Vision Care Plan is provided by New York Power Authority (NYPA) and is available to employees only at no cost. It is provided to encourage you to have regular eye exams.

Eligibility

Active, regular and probationary full-time employees are eligible for this benefit. You will be automatically enrolled in the Vision benefit.

Family members are not covered under this benefit.

Covered Services

The vision benefit provides reimbursement up to $75 during a 12-month period (from the last date you received service) for an eye exam.

Filing a Claim

To receive reimbursement for your eye exam, you must submit a reimbursement request.

All Vision claims must be filed no later than December 31st of the year following the calendar year in which the expense was incurred.

SECTION 13 – HEARING AIDS

NYPA provides reimbursement for hearing aids, up to maximum of $1,500 every three years through a health reimbursement account. This is available at no cost to employees. You may elect to enroll in this benefit or choose not to participate.

Eligibility

Active, regular and probationary full-time employees are eligible for this benefit. Family members are not covered under this benefit.

Covered Services

NYPA provides reimbursement up to $1,500 for the purchase of one pair of hearing aids once every three years (on a collective bargaining year basis). For example, if you are reimbursed for a hearing aid on June 15, 2015, you will be eligible to be reimbursed again after July 1, 2018.

Filing a Claim

To receive reimbursement for your hearing aids, you must submit a reimbursement request.

All claims must be filed no later than December 31st of the year following the calendar year in which the expense was incurred.

SECTION 14 – FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) provide a way for you to pay eligible out-of-pocket health care or dependent care expenses with pre-tax dollars. There are two types of Flexible Spending Accounts:

- A health care reimbursement account, for your and your dependents' out-of-pocket health care expenses
- A dependent care reimbursement account, for costs related to the care of eligible dependents (child care or elder care) while you and your spouse are at work

The NYPA flexible spending account plan, allows you to set aside pre-tax dollars from your paycheck to pay for certain out-of-pocket health care and dependent care expenses. Using pre-tax dollars to cover these costs lowers your Social Security, federal, and, in some cases, state and local taxes. You may elect to contribute to a health care FSA, a dependent care FSA, or both. Money set aside for health care expenses cannot be used to pay for dependent care expenses, or vice versa.

Your participation in either or both accounts is voluntary. Enrollment is not automatic — you must re-enroll in the FSAs each year during Open Enrollment if you wish to participate in the upcoming year.

Considerations Before Enrolling

Since there is a tax advantage to using the reimbursement accounts, under federal regulations governing flexible spending accounts, you forfeit any unused balance left in your account at the end of the year. This rule is referred to as "use-it-or-lose-it". Your unused balance cannot be carried over into the next year. Nor can you transfer money between the accounts. To avoid this, you should consider:

- Last year's medical, dental, and/or dependent care expenses.
- Medical, dental, or vision care costs you forsee that might not be covered under your healthcare plans (e.g., deductibles, copays)
- Changes in your family status that might have an impact on your medical/dental or dependent care expenses (e.g., dependent child turns age 13)

Your flexible spending account contributions are subject to the IRS "use-it-or-lose-it" rule. Any unused funds that remain in your account(s) at the end of the plan year will be forfeited. Account balances do not roll over to the following year. Estimate the amount you want to contribute to your flexible spending account(s) carefully.

FSA Rollover

NYPA introduced an FSA rollover feature. If you participate in the FSA Healthcare Account, you can roll over up to $550 (effective 2021; as periodically adjusted by IRS) of your unused healthcare contributions from the previous year. This does not apply to the Dependent Care Account. Any unused amount remaining in an employee's Health Care FSA that exceeds the rollover limit will be forfeited. If an employee terminates, any unused amounts are also forfeited.

Your FSA Contribution

Each year, you decide how much to set aside from your pay to cover your estimated out-of-pocket health care and dependent care expenses for the year. Your total health care and/or dependent care account election amount(s) is deducted from your paycheck on a pre-tax basis in equal amounts throughout the year.

The availability of your contributed funds differs between the accounts. With a health care FSA, your election amount is available in its entirety on the first day of the plan year. Your dependent care FSA funds, however, are available only as the money is deducted from your paycheck.

Health Care Account

You may set aside a minimum of $260 up to the IRS maximum of $2,700 and $2,750 a year for 2020 and 2021, respectively (as periodically adjusted by IRS.)

Dependent Care Reimbursement Account

You may set aside a minimum of $260 up to the IRS maximum of $5,000 a year (as periodically adjusted by IRS.) To be eligible for reimbursement, dependent care expenses must be incurred for the purpose of allowing you and, if married, your spouse, to be employed.

By IRS rules, married individuals who file separate tax returns are each limited to a $2,500 contribution annually. You may contribute up to $5,000 if you are married and file a joint tax return, provided both you and your spouse each earn more than $5,000 annually. If one of you earns less than $5,000 during the year, you are limited to a maximum spending account contribution equal to the salary of the lowest-earning spouse. If your spouse is a full-time student for at least five months of the year, or if your spouse is incapable of self-care, you can set aside up to $200 per month for one dependent or $400 per month for two or more dependents, even if your spouse has no earned income.

If both you and your spouse work, you must coordinate your dependent care enrollments so that the two of you together stay within the $5,000 annual maximum.

In order to prevent the dependent care FSA from being characterized as discriminatory by the Internal Revenue Service and therefore ineligible for favorable tax treatment, NYPA may reject any elections or reduce contributions or benefits during the plan year. This means payroll deductions may be reduced or stopped as needed to satisfy the nondiscrimination requirements.

Eligible Health Care Expenses

You can use the health care account to pay medically necessary out-of-pocket health care expenses for you and your eligible dependents that have not been reimbursed by any other health plan or another flexible spending account.

You can generally include medical expenses for yourself, as well as those expenses you pay for someone who was your spouse or your dependent either when the services were provided or when you paid for them. There are different rules for dependents and for individuals who are the subject of multiple support agreements. A list of these

dependents can be found in IRS Publication 502, Medical and Dental Expenses, at http://www.irs.gov/pub/irs-pdf/p502.pdf.

Covered Services

Generally, you can be reimbursed for qualified medical, pharmacy, dental, or vision benefit expenses, as defined in Section 213(d) of the Internal Revenue Code. Some common reimbursable expenses are listed below. You can find a more complete and detailed list of eligible and ineligible health care expenses in IRS Publication 502, Medical and Dental Expenses.

Eligible Health Care Expenses

Eligible health care expenses include, but are not limited to:

- Acupuncture
- Alcohol or drug dependency treatment
- Ambulance
- Artificial limbs
- Bandages
- Birth control pills
- Braille books and magazines
- Chiropractic services
- Christian Science practitioner services
- Co-insurance, copay amounts and deductibles
- Contact lenses and solution
- Crutches
- Dental expenses (exam, cleaning, X-rays, root canal, etc.)
- Eyeglasses, including examination fees
- Fertility treatments
- Guide dogs
- Hearing aids and batteries
- Hospital services
- Laboratory fees
- Lasik surgery
- Learning disability treatment
- Nursing home expenses for medical treatment
- Optometry services
- Organ transplants
- Orthodontia, except for cosmetic purposes
- Osteopathic services
- Prescribed medicines
- Psychiatric care
- Psychological treatment

- Psychotherapy
- Smoking-cessation programs
- Special Education
- Sterilization fees
- Surgical fees
- Transportation to receive medical treatment
- Vaccinations and immunizations
- Vasectomy
- Wheelchair
- X-rays

Ineligible Health Care Expenses

You cannot be reimbursed from your health care account for expenses which are not eligible to be deducted on your federal income tax return or which have been reimbursed elsewhere.

Examples of such ineligible expenses include, but are not limited to:

- Insurance premiums, including those for health insurance, dental and/or vision insurance, life insurance, long term care insurance, and temporary continuation of coverage
- Athletic/fitness club dues, or other expenses to keep fit
- Contact lens insurance
- Cosmetic surgery, unless needed to correct a congenital deformity
- Dance lessons, even if recommended by a doctor as physical/mental therapy
- Domestic help, even if recommended by a doctor
- Illegal operations or drugs
- Maternity clothes
- Medications and Drugs from other countries
- Nonprescription drugs and medicines
- Nutritional Supplements
- Personal care items (e.g. cosmetics, toothpaste, soaps, lotions, shampoo)
- Veterinary bills
- Weight loss programs undertaken for general health and not for specific ailments

Eligible Dependent Care Expenses

You can use your FSA dependent care account to cover expenses for child care or elder care while you work. You can be reimbursed only if the expenses are for a qualifying dependent's care and are incurred to enable you (and your spouse if you are married) to work or look for work.

Qualifying person is:

- Your qualifying child who is your dependent and who was under age 13 when the care was provided
- Your spouse who wasn't physically or mentally able to care for himself or herself and lived with you for more than half the year, or
- A person who wasn't physically or mentally able to care for himself or herself, lived with you for more than half the year, and either:
    - Was your dependent, or
    - Would have been your dependent except that:
        - He or she received gross income of $4,050 or more,
        - He or she filed a joint return, or
        - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's return.

Dependent defined. A dependent is a person, other than you or your spouse, for whom you can claim an exemption. To be your dependent, a person must be your qualifying child (or your qualifying *relative).*

Qualifying child. To be your qualifying child, a child must live with you for more than half the year and meet other requirements.

Note: If you are divorced and you are the custodial parent, your child is a qualifying individual even if you do not claim the child as a tax dependent. A divorced, non-custodial parent cannot be reimbursed under a dependent care FSA, even if the divorced non-custodial parent claims the child as a tax dependent.

More information. For more information about who is a dependent or a qualifying child, see IRS Publication 501.

Eligible Expenses

Eligible dependent care expenses include, but are not limited to:

- Licensed preschool/nursery school
- Qualified child care center
- Adult day care facilities
- Before school and after school programs
- Babysitter (in or out of the home) while you work, as long as the individual is not your child under age 19, or anyone you or your spouse can claim as a dependent for federal income tax purposes.
- Summer day camp for your qualifying child under age 13

Ineligible Dependent Care Expenses

Ineligible expenses include, but are not limited to:

- Overnight or sleep-away camp
- Tuition fees for private or boarding school
- 24-hour nursing home care
- Weekend or evening baby-sitting that is not necessary for you (and your spouse) to work
- Care provided by your child under the age of 19 or by someone you claim as a dependent on your income tax return.
- Transportation between your home and the place care is provided
- Finder's fees for placement of an au pair or nanny
- Expenses for which you can claim a tax credit on your federal income tax returns.

You can find a more complete and detailed list of eligible and ineligible dependent care expenses in IRS Publication 503, Child and Dependent Care Expenses.

FSA vs. Federal Tax Credit

If you choose to participate in the FSA, you cannot claim medical expenses for which you were reimbursed from your health care account as a deduction on your tax return.

Federal tax laws allow you to reduce your income taxes if you pay someone to care for your child or other dependent so that you may work. You may reduce your taxes by:

- Participating in the FSA dependent care reimbursement account,
- Using the federal tax credit, or
- Using a combination of both methods.

The amount you save on taxes will vary depending on the method you use, your salary, your expenses, and your tax status. Different tax-savings methods affect your cash flow, financial flexibility, and federal income tax return preparation in different ways. For more information about how the Dependent Care Tax Credit works, see IRS Publication 503, Child and Dependent Care Expenses available at www.irs.gov. You should see your tax advisor for help in determining what is best for you.

Change in Status Events

Your Flexible Spending Account(s) election cannot be changed during the plan year, unless you experience a qualifying change in status event, such as:

- A change in legal marital status (marriage, divorce, or death of your spouse)
- A change in the number of your dependents (birth or adoption of a child, or death of a dependent)
- A change in employment status of you, your spouse, or a dependent
- An event causing your dependent to satisfy or cease to satisfy an eligibility requirement for benefits

Your requested change must be due to and consistent with the event. You may change or terminate your dependent care FSA election only if:

- The change or termination is due to and corresponds with a change in status that affects eligibility for coverage under the FSA plan.
- Your election is due to and corresponds with a change in status that affects the eligibility of dependent care expenses for the available tax exclusion.

How to Keep Track of Your Account Balances

The FSA Claim Administrator maintains a website where you can check your account balances and view your claims information. Simply log into their website and follow the registration instructions. You can view your annual election, year-to-date contributions, claims paid to date, your remaining FSA account balance, and claim information for the current and previous year. See the Section 22, *Directory of Providers* for the FSA Claim Administrator contact information and website.

FSA Healthcare Spending Card

Effective January 1, 2017, NYPA introduced the FSA Healthcare Spending Card. If you participate in the Flexible Spending Account, you will receive a FSA Healthcare Spending Card (debit card) to pay for eligible expenses, such as medical, pharmacy, dental, and vision copays at any eligible provider or merchant. This card provides you with immediate access to your FSA account. The card can only be used for IRS approved eligible healthcare expenses or Dependent Care expenses. Be sure to keep your receipts in case they are requested and for tax purposes. Contact your site HR Representative for more information, or the FSA Claim Administrator to request a new FSA Healthcare Spending Card.

Filing a Claim

You can only be reimbursed for expenses incurred during the calendar year you are enrolled. If you are a new hire, or if you enroll in the plan during the year due to a qualifying change of status, you can only be reimbursed for expenses incurred once your coverage begins.

You can submit your reimbursement requests in the following ways:

- Pay your provider using your FSA Reimbursement Card (debit card), Note: Provider must have technology to use card.
- Online Claims Submission: Submit your claims and copies of your supporting documentation online at FSA Claim Administrator's website.
- Fax: Submit your completed reimbursement form and supporting documentation using the fax number listed on the reimbursement form.
- Mail: Send in your completed reimbursement form and copies of your supporting documentation using the address on the form.

If you have a question about your claim, you can call the FSA Claim Administrator. Reimbursement checks are only made payable to you — they cannot be made payable to your provider.

Remember, you must submit FSA reimbursement claims for a given plan year by March 31 of the following year. Claims filed after March 31 will not be reimbursed. Reimbursement checks must be cashed within one year from the date of the check.

Health Care FSA Claims

If you submit a claim for more than you have accumulated in your health care account, you may be reimbursed up to your total annual contribution. Say, for example, that your annual contribution is $500. By March you would have about $125 in your account. If you were to pay out-of-pocket expenses of $400 in March, you could submit that claim for full reimbursement. Your payroll deductions would continue through the rest of the year, and you would have $100 left to cover later expenses.

Automatic Rollover

If you are enrolled in the NYPA Medical Plan and have no other health care coverage, your NYPA Medical Plan major medical and prescription drug claims will automatically roll over for payment to your health care account. Your NYPA Dental Plan claims also automatically roll over for payment to your health care account. You may choose to turn off the automatic rollover option or arrange to have your reimbursement deposited directly into your checking or savings account by going online at the FSA Claim Administrator's website

Coordination of Benefits

If you or your dependents are also covered by another plan — such as your spouse's medical or dental plan — the coordination of benefits provision will apply. When NYPA's plan is the primary plan, you should send the Explanation of Benefits statement you receive (the statement of benefits the plan has paid) to the other plan. Once the other plan has processed the claim, you can request reimbursement from your health care account for any unpaid balance by filing a Flexible Spending Account Withdrawal Request.

Dependent Care Account Claims

A Dependent Care FSA Claim Form is used to submit a reimbursement claim. Unlike a health care account, you may not submit a claim for more than you have in your dependent care account.

All dependent care reimbursement requests must include a completed and signed provider certification. This is noted on the reimbursement form. If you do not have provider certification, complete the reimbursement form and submit an itemized statement from the dependent care provider that includes:

- Start and end dates of service
- Dependent's name and date of birth
- Itemization of charges
- Provider's name, address, and tax ID or Social Security Number.

Credit card receipts, canceled checks, and balance forward statements do not meet the requirements for acceptable documentation.

SECTION 15 DISABILITY BENEFITS

NYPA offers two types of disability coverage:

- The Short Term Disability (STD) Plan provides continuing income for up to thirteen weeks when you are unable to work due to short term illness or injury.
- The Long Term Disability (LTD) Plan provides continuing income after you have been unable to work due to illness or injury for more than three consecutive months.

Eligibility

If you become sick or injured due to a job-related incident, you may be entitled to submit a claim under the New York State Workers' Compensation Law. Benefits outlined in the Short Term Disability section apply to disabilities that *are not* due to a job-related accident or illness. Long Term Disability benefits may coordinate with Workers' Compensation claims. There are a few eligibility guidelines that you should know about:

- Disability benefits are available only to you and not to your spouse or dependents.
- You are eligible for these plans if you are a full-time employee covered by a collective bargaining agreement between the Power Authority and Locals 2032 and 2104 of the International Brotherhood of Electrical Workers. Temporary, seasonal or part-time employees are not covered under these plans. Probationary and provisional employees are covered by the Short Term Disability Plan, but not the Long Term Disability Plan.
- You must be under a licensed physician's care if you are disabled because of sickness or pregnancy.

Disability benefits are based on your basic wage which will be determined on the day before you stop work due to your disability. Basic wages do not include overtime, bonus pay and other extra pay. If you are not at work due to disability at the time a wage change is made, your disability benefit amount under these plans will not be affected by the change.

Paying for Coverage

The Short Term and Long Term Disability Benefits are provided by the New York Power Authority (NYPA).

Short Term Disability (STD) Plan

The STD Plan provides a weekly benefit to help you and your family meet your day-to-day living expenses in the event that you are unable to work due to a disability. Under this plan, you are considered totally disabled if you become injured due to an accident, or you are unable to work because you are sick, or as a result of pregnancy, childbirth or a related medical condition.

Short Term Disability Benefit

The weekly STD benefit payment will equal 50% of your basic weekly wage. *The maximum weekly benefit is $500.*

To determine the daily benefit you would receive, divide the weekly benefit you would be eligible for by five (normal number of workdays in the week).

Short Term Disability Plan Features

Elimination Period

STD benefits start on the 8th day (consecutive calendar days) that you are not at work due to your disability. However, if you have any sick leave credits accrued, *you must use your sick time first before you can receive an STD benefit.* Your STD benefit will begin once your sick leave is exhausted.

Coverage Ends

Your combination of sick leave and STD cannot exceed 13 weeks.

Recurrent Disability

If you return to work after receiving a STD benefit and become disabled again within one week of your return to work, this will be considered as one period of disability. This means that the second eight-day waiting period before STD benefits begin would be waived. Long Term Disability benefits may be available after the STD benefit ends.

If your physician determines that the later disability is entirely unrelated to the cause of the earlier disability, it will be regarded as a separate disability period.

If you have successive disability periods due to injuries received in one accident, this will be considered as one period.

Exclusions

Disabilities not covered would be those resulting from injuries or sickness sustained while engaged in any occupation for pay, when benefits are payable in accordance with the provisions of any workers' compensation or similar law.

Filing A STD Claim

You should contact your site HR Representative to apply for STD. The Disability Plan Administrator reviews your STD claim to determine if you are eligible for benefits. If you are eligible, your weekly benefit payment is calculated and the check is sent to you.

Taxability of Benefit

STD benefit payments are subject to social security (FICA) withholding. The appropriate amount of tax will be withheld from your check and remitted to the government. If you have received STD benefits, you will receive a W2 Form from the plan administrator showing the amount of benefit paid. STD benefits are subject to Federal and New York State income taxes, but these taxes are not withheld from your benefit.

Long Term Disability (LTD) Plan

In the event that your disability continues and you are totally disabled, you may be eligible for LTD benefits. Under this plan you are totally disabled if during the Qualifying Disability Period (see below), and the following 24 months of absence from work, you are unable to perform the normal duties of your occupation for any employer. After the 27th month of absence, you must be completely unable to engage in any occupation or employment for pay or profit.

LTD benefits are paid to you if you are totally disabled as a result of an accidental injury or sickness or as a result of pregnancy, childbirth or a related condition.

Long Term Disability Benefit

LTD benefits are paid monthly and are equal to 50% of your basic monthly wages. The monthly benefit payment cannot exceed $3,000.

You may get or be entitled to income or benefits from sources other than LTD when you are disabled. Your LTD benefit payment will be reduced by the amount of Other Income Benefit. In no case will your monthly LTD benefit be less than $100.

If you qualify, payment of the LTD benefit begins at the end of the qualifying disability period.

Other Income Benefits That Reduce LTD Benefits

- **Federal Social Security Act, Railroad Retirement Act ("the Acts")** - Benefits that you receive or are entitled to receive because of your disability or retirement will be counted. Benefits paid or available to your dependents because of your disability or retirement will also be counted. Benefits from any of the Acts may increase from time to time due to cost-of-living increases or other increases because of changes in the Acts. If you are being paid benefits under this plan at the time any of these increases goes into effect, the increase will not be counted as other income benefit for you. This means that after the date benefits become payable to you under this LTD Plan, The Hartford will not further reduce your payments because you are receiving higher benefits due to increases in the Acts. All other changes in the Acts which affect your benefits or your dependents' benefits will be counted whether or not benefits are payable to you under this LTD Plan at the time the change is made.

- **No-Fault Auto Laws** - Only the basic reparations portion for loss of income of a law providing for payments without determining fault in connection with automobile accidents will be counted. Supplemental disability benefits you buy under a no-fault auto law will not be counted.

- **Overtime, Bonus Pay and Extra Pay** - Compensation from the Authority including payout of accrued sick leave, overtime, bonus pay or other extra pay arrangements of any kind.

- **Workers' Compensation or a Similar Law** - For loss of earnings.

- **New York State and Local Retirement Systems** - Disability benefit, unless you qualify for normal retirement under the plan, in accordance with the New York State Retirement System.

In some cases, you might receive Workers' Compensation or other similar benefits in one lump sum instead of monthly payments. Since other income benefits are computed on a monthly basis, The Hartford will figure a monthly amount out of the lump sum you received. The monthly amount will be equal to the amount that you would have been able to receive each month under the law if you had not gotten a lump sum payment. All of the monthly amounts added together will not be more than your lump sum payment.

The LTD Benefit will not be reduced by any Accident Expense/Cancer Plan benefits you receive that are outlined in Section 17, *Supplemental Benefits*.

Long Term Disability Plan Features

Elimination Period

The LTD Plan has a qualifying disability period of three consecutive months. This means that you must be totally disabled and not working for that period before benefits will begin.

Coverage Ends

The length of time depends on your age on the date that you became totally disabled. The chart below shows how long your payments could continue:

Your Age on the Date That Total Disability Starts is:	**Your Benefit Payments Will Continue During Total Disability:**
Under Age 60	Until the 1st Day of the Month Immediately Following your 65th birthday
Age 60 But Under Age 65	For 57 Months
Age 65 But Under Age 70	For 33 Months
Age 70 But Under Age 75	For 21 Months
Age 75 Or Older	For 15 Months

The period in which benefit payments are due to continue starts from and includes the first day you are not at work due to your disability.

Benefit payments will stop before the time shown above if you are no longer totally disabled.

Total Disability Due to a Mental or Nervous Disorder

If you become totally disabled due to a mental or nervous disorder (defined as neurosis, psycho-neurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind), your benefit payments can continue for the first two years of your disability. At the end of the two years, benefits can only continue if you are confined in a hospital or other institution that is qualified to provide care and treatment for the mental or nervous

disorder. The care and treatment must be considered as active treatment, demonstrated by medical progress of the mental or nervous condition. Custodial care is not considered active treatment.

If you are confined in the hospital or institution for more than 14 consecutive days, you can receive benefit payments for an additional 90 days after your discharge from the hospital or institution.

Recurrent Disability
If within three consecutive months following the end of your total disability, you become totally disabled again by an injury, illness or pregnancy related to the cause of your earlier disability, the later disability which starts during the three month period will be considered as a continuation of the earlier disability.

If the cause of a later disability is unrelated to the earlier one, or you become totally disabled again but not within three consecutive months of the end of the earlier disability, you must complete a new qualifying disability period.

Exclusions
Disabilities not covered are those resulting from injury or sickness:

- caused by your involvement in illegal activity;
- due to war or any act of war, whether declared or not, or due to any act of international armed conflict, or the conflict involving the armed forces of any international authority;
- incurred by you during service to the armed forces of any country;
- caused by intentional self-injury.

Filing An LTD Claim
Since LTD claims cannot be handled as quickly as STD claims, as soon as you and your doctor think you will be absent from work for more than three months, contact your site HR Representative to begin the process of applying for LTD. The Disability Plan Administrator reviews the LTD applications, and if approved, will send the benefit payments directly to you.

Taxability of LTD Claims
The LTD benefit payments, like STD benefit payments, are subject to social security (FICA) withholding for the first 26 weeks of disability. The appropriate amount of tax will be withheld from your check and remitted to the government. If you have received LTD benefits, you will receive a Form W2 from the Disability Plan Administrator showing the amount of benefits paid. LTD benefits are also subject to Federal and New York State income taxes, but these taxes are not withheld from your benefit.

SECTION 16 – LIFE INSURANCE BENEFITS

NYPA provides a life insurance benefit for active full-time employees and offers retirees the option to purchase continued coverage. Life insurance benefits are provided under a group life insurance policy.

Life Insurance Plan

The Life Insurance Plan provides a source of income for your family members in the event of your death, helping cover immediate or long-term expenses. The life insurance amount is known as a death benefit.

Cost

NYPA pays the full cost of life insurance for active employees.

Imputed Income

Under federal tax rules, life insurance coverage in excess of $50,000 is considered a benefit that is taxable income (i.e. "imputed" income). NYPA calculates the imputed income, and adds it to your taxable income each pay period. The imputed income will be included on your W-2 form and reported to the IRS.

Coverage

If you die while actively employed by NYPA, your beneficiary is entitled to your life insurance amount, 150% of your basic straight-time annual equivalent salary, computed to the highest multiple of $500 which is equal to or less than 150% of your salary. For example, if your annual salary was $45,800, your life insurance would equal $68,500.

Beneficiary

Your designated beneficiary is the person or persons who will receive any benefit payable under the Life Insurance Plan. You completed a life insurance beneficiary form, naming a Beneficiary for your life insurance benefit. If your beneficiary dies before all insurance is paid out (method of payment is discussed later), the unpaid balance will be paid to the beneficiary's estate, unless you make a different request in your beneficiary designation (Contingent Beneficiary). A contingent beneficiary will receive benefits only if no primary beneficiary(ies) survives you.

Payment of any part of the benefit for which there is no beneficiary named or still living at the time of your death will be made to your estate. Instead of your estate, the Life Insurance Company may make payment to:

- your surviving husband or wife, if any,
- your surviving children equally, if there is no surviving husband or wife, or,
- your surviving parents, if there is no surviving husband or wife or child.

If you name more than one beneficiary, they will share in the benefits equally, unless you specify otherwise.

Change Your Beneficiary

You may change the beneficiary at any time by filing a new form with your site HR Representative. A life insurance (death benefit) amount will only be paid to the beneficiary that you designated on the life insurance form. No other legal designation, including a bona fide will, can serve to provide a beneficiary for this death benefit. Therefore, *it is very important that you periodically check your records and update your beneficiary designation, if needed, by completing and submitting a Change of Beneficiary Form.* A person authorized as your "Power of Attorney" cannot change your beneficiary. Change of Beneficiary forms are available from your site HR Representative. You can request a copy of the change for your records.

Filing a Claim

If you die while covered under the Life Insurance Plan, your beneficiary must notify NYPA. Your beneficiary is required to provide NYPA with a certified copy of your death certificate, which will be submitted to the Life Insurance Plan Administrator for processing. Once the claim has been reviewed, and it has been determined that a beneficiary is eligible for the death benefit, the Life Insurance Plan Administrator notifies the Life Insurance Company. The Life Insurance Company will pay the life insurance proceeds to your beneficiary.

Payment of Death Benefit

When a life insurance benefit is payable, the Life Insurance Company sends a lump sum check directly to the beneficiary(ies).

Payment of Death Benefit to a Minor Child

The Life Insurance Company has the option to pay up to $50 each month on behalf of a minor child, to an adult who has assumed custody and chief support of the child. These payments will stop when the Life Insurance Company gets notice from the Life Insurance Plan Administrator that a legal guardian has been appointed. Any remaining balance will then be paid to the legal guardian.

Life Insurance if Totally Disabled

If you are an active employee and you become totally disabled before your 60th birthday, your life insurance will continue for one year, as long as you remain totally disabled. There will be no cost to you. Total disability under this plan means that you are completely unable to engage in any occupation or employment for which you are, or become qualified for by reason of education, training or experience; and you are in fact not engaged in any occupation or employment for pay or profit.

After your first nine months of disability the Power Authority will apply to the Life Insurance Company for a waiver of life insurance premium for you. If this waiver is approved, your life insurance will continue at no cost to you or the Authority from year to year as long as the following conditions are met:

- You are totally disabled for at least nine months (pertains to your first nine months not at work due to your disability).
- Medical evidence shows that your disability will be permanent.
- Written proof of disability is given to the Life Insurance Company when requested, who will not ask for proof more than once a year. If you do not give

the Life Insurance Company proof of your continuing disability when it is requested, your insurance will be terminated on the annual anniversary of the date you first gave proof.

If the waiver of premium application is not approved by the Life Insurance Company, you will be given the option to convert to an individual life insurance policy. See "Converting Your Life Insurance" for more information on converting to an individual policy.

In addition, and not related to any other cause of disability, total disability under this plan will also include the following:

- Loss of the use of both hands,
- loss of the use one hand and one foot,
- loss of the use of both feet,
- total loss of sight in both eyes which cannot be recovered.

Loss of a hand means removal at or above the wrist joint.
Loss of a foot means removal at or above the ankle joint.
Loss of an eye means total loss of sight which cannot be recovered.

If you are age 60 or over when you become totally disabled, you are eligible to convert to an individual policy. Conversion to an individual policy is discussed at the end of this section.

Total Disability Ends

If you are no longer disabled, your life insurance will end 31 days after the date your disability stops unless you return to work at the Power Authority.

Converting Your Coverage

If your life insurance coverage ends due to your termination of employment, or your benefit amount is reduced due to retirement, you may purchase an individual life insurance conversion policy issued by the Life Insurance Company. *You must apply for this individual life insurance conversion within 31 days after termination.* Evidence of insurability, including a medical examination, will not be required to convert your policy.

An individual life insurance policy can be issued if one of the following occurs:

- your group life insurance stops (due to termination of employment or if you become totally disabled on, or after you attain age 60). You may convert up to the amount of your insurance under the group life policy.
- the amount of your group life insurance is reduced (due to retirement). You may convert the difference between your active and retiree life insurance benefit amounts.

Your site HR Representative or the Life Insurance Company can provide you with a life insurance conversion application which will show the cost. The first premium must be paid before the policy can be put in force.

You will have the option to convert to any one of the individual policies offered by the Life Insurance Company. Individual Term Life Insurance policies can be provided for up to one year. After the term insurance stops, the policy will continue, but will not provide term insurance. The policy will not have disability benefits or other extra benefits.

Your group life insurance is payable if you die within the 31-day period allowed for conversion, whether or not you have applied for an individual policy and regardless of your employment status when you left the Authority (e.g. resignation or retirement). The Life Insurance Company will calculate and pay the highest benefits allowed under the plan.

SECTION 17 – SUPPLEMENTAL BENEFITS

You may elect certain voluntary benefits in addition to the benefits described elsewhere in this document. These plans are designed to supplement your other coverages, not to replace them. Supplemental benefits include:

- Accident Expense Plan, which pays a cash benefit in the event of a Covered Person's accidental injury, dismemberment, or death.
- Cancer Plan, which pays cash benefits directly to you to help with unexpected expenses if cancer occurs.

You may choose to be covered under one or both of the plans, or choose not to enroll.

Accident Expense Plan

The Accident Expense Plan is a supplemental policy that provides cash benefits directly to you to help with unexpected expenses if an accident occurs. You will be paid certain benefits if a covered person's accidental death, dismemberment, or injury is caused by a covered accident, independent of sickness that occurs on or off the job. Some of the benefits include: Accident Emergency Treatment, Accident Follow-Up Treatment, Initial Accident Hospitalization, Accident Hospital Confinement, Physical Therapy, and an Accidental Death and Dismemberment Benefit. Contact your site HR representative for more information.

Coverage Options

The policy itself, which you receive from the Accident Expense Plan Administrator, sets forth, in detail, the rights and obligations of both you and the Accident Expense Plan Administrator. The policy should be consulted to determine governing contractual provisions. It is, therefore, important that you read your policy carefully.

New enrollees may only participate in the newest Accident Expense Plan offered. Employees currently enrolled in an Accident Expense Plan that is closed to new participants may remain in that plan or choose to opt into the newest plan during open enrollment. If you choose to enroll in the newest plan, you cannot opt back into the closed Plan. An Accident Plan representative will contact you to complete your enrollment.

The newest Accident Expense Plan coverage options are: Individual, Employee/Spouse, One Parent Family, or Two Parent Family.

This benefit will not reduce any LTD benefits you receive that are outlined in Section 15, *Disability Benefits*.

Cost

The cost for this plan is based on the plan and coverage option you choose. You pay the full cost of the Accident Expense Plan you elect with before-tax dollars.

Converting Your Coverage
You may continue coverage upon termination or retirement from NYPA. You must notify the Accident Expense Plan Administrator within 31 days of your separation or retirement to make arrangements for premium payment.

Cancer Plan

The Cancer Plan is designed to supplement your existing health insurance coverage when certain losses occur as a result of the diagnosis of cancer and other diseases and conditions caused, complicated or aggravated by or resulting from cancer or cancer treatment. The plan pays benefits directly to you to help with unexpected expenses if cancer occurs. Contact your site HR Representative for more information.

Coverage Options
The policy itself, which you receive from the vendor, sets forth, in detail, the rights and obligations of both you and the Cancer Plan Administrator. The policy should be consulted to determine governing contractual provisions. It is, therefore, important that you read your policy carefully.

New enrollees may only participate in the newest Cancer Plan offered. Employees currently enrolled in a Cancer Plan that is closed to new participants may remain in that plan or choose to opt into the newest plan during open enrollment. If you choose to enroll in the newest plan, you cannot opt back into the closed Plan. A Cancer Plan representative will contact you to complete your enrollment.

The newest Cancer Plan coverage options are: Individual, One Parent Family, or Two Parent Family.

This benefit will not reduce any LTD benefits you receive that are outlined in Section 15, *Disability Benefits*.

Cost
The cost for this plan is based on the plan and coverage option you choose. You pay the full cost of the Cancer Plan you elect with before-tax dollars.

Converting Your Coverage
You may continue coverage upon termination or retirement from NYPA. You must notify the Cancer Plan Administrator within 31 days of your separation or retirement to make arrangements for premium payment.

SECTION 18 – EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is a free, confidential assessment and referral service to help you and your family members cope with personal or professional problems. Regular and probationary full-time employees and their families are eligible for this benefit.

To maintain confidentiality, an independent consulting group, provides professional assistance on a confidential basis to employees and their dependents. A counselor will assess your problem and, if needed, make a referral to other outside resources for treatment or help in resolving the problem, monitor treatment progress and, where necessary, design a follow-up program.

Services Provided

Counseling Services

You and your family members can receive counseling for a wide range of personal problems, including, but not limited to:

- Mental and emotional stress
- Family and marital problems
- Care of a child
- Care of an elderly relative
- Drug and alcohol dependencies
- Dealing with disabilities
- Legal or financial matters of concern

Cost of Services

The Authority pays the cost for utilizing this service. If the counselor later refers you to another source, the cost for additional counseling is your responsibility, and charges will be considered as any other claim submitted under your health care benefits plan. *Remember if you are covered under an HMO, benefits vary*.

How to Contact an EAP Counselor

You and/or a family member may arrange to see a counselor near your home or work area to discuss problems and develop an approach to solutions. Referrals for outside treatment are made to local sources.

You may also call a counselor. For non-emergency calls, counselors are available every workday between the hours of 8:00 a.m. and 6:00 p.m. In an emergency, help is available 24 hours a day, 7 days a week. Counselors will want to know if the caller is an employee or a family member. If you are calling because of an emergency, clearly state so.

When using the EAP helpline:

- Dial the toll-free number, 1-800-833-8707.
- Identify your relationship to NYPA (employee/family member).
- If it's an emergency, clearly state so.
- Be honest—remember, your call will be handled in the strictest of confidence.

The EAP Consultant is an independent organization. If you self-refer, no one will know you called unless you choose to tell them.

Childcare Resource and Referral Services

The EAP provides you with access to trained childcare specialists who can help you assess your childcare needs. Specialists are available to discuss your concerns, answer your questions, and provide pre-screened referrals for specific childcare resources. Specialists can assist with the entire spectrum of childcare concerns, from planning stages through managing care on an ongoing basis. Depending on your needs and the type of child care you are looking for (e.g. family day care in a provider's home vs. a day care center), the specialist can refer you to child care resources in your work or home area.

There is no charge for using the childcare resource and referral services provided by the EAP, although you are responsible for any costs charged by the childcare provider you eventually select.

To access this service, call the EAP, and let the counselor know that you would like to speak to a childcare specialist.

Eldercare Services

EAP counselors can provide counseling and information to help you:

- Evaluate the needs of your elderly relative,
- Develop a plan to assist you in providing the needed care,
- Determine eligibility for benefits such as Medicare, Medicaid, Social Security, etc.
- Locate and evaluate local resources that provide eldercare services, and
- Understand and deal with the stress often associated with the aging of older relatives.

There is no cost to you to use the eldercare counseling and referral services. If you wish to have your elderly relative examined by a geriatric specialist, either at home or in the office, there will be no charge for the first visit. Charges for any subsequent visits, or for the use of any eldercare services outside of EAP services (whether referred to you by an EAP counselor or not), will be your responsibility.

To access this service, call the EAP and indicate that you would like to speak to a counselor about Eldercare.

Note: While the EAP counselors will research your childcare and eldercare options, you make the final decision. The services you select as the result of a referral are not guaranteed or endorsed by NYPA or the EAP Consultant.

EAP Website

The EAP website, is an important resource center that gives you access to information and tools to help you better manage your life, your work, and all your responsibilities. The website also provides a wealth of articles, tips, databases, self-assessments, and other resources—all a mouse click away.

Materials are organized in an easy to use menu:

- Parenting
- Aging
- Balancing
- Thriving
- Working
- Living

SECTION 19 – ADDITIONAL INFORMATION ABOUT YOUR BENEFITS

General Exclusions and Limitations

No payment will be made under the Medical, Prescription Drug, or Dental Plans for:

- Charges in connection with
  - injuries sustained while doing any act or thing pertaining to any occupation or employment for pay or profit, or
  - disease for which benefits are payable in accordance with the provisions of any workers' compensation or similar law.
- Charges incurred while you or a covered dependent are confined in a hospital operated by the United States of America or an agency thereof, or charges which you would not be required to pay if there were no health/dental coverage.
- Charges incurred by a dependent for any expense for which he or she is entitled to benefits as an employee or former employee of the Authority. For example, the dependent retired from the Authority and was therefore eligible for retiree coverage, and if that dependent was married to an active Authority employee, that dependent would file for coverage under the retiree program only, not as a dependent under the NYPA Medical Plan for active employees.
- Charges for you or a dependent for any medical expense incurred during or in connection with a hospital confinement which began prior to the date you or your dependent became covered under the plan.
- Charges for education, training and room and board while you or your dependent are confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Charges for services and supplies in connection with injury caused by war whether declared or not, or by international armed conflict.
- Charges for services provided by any person who is a member of your family or ordinarily resides in your home.

COBRA Continuation of Coverage

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents may be entitled to the opportunity to elect a temporary extension of health coverage called “COBRA continuation coverage” if

- you cease employment with the Power Authority, or
- your hours are reduced to the point that you are no longer covered by these benefit plans, or

- if your covered dependents lose their NYPA coverage.

Your Dependents

- Your spouse/domestic partner and covered dependents may be eligible for COBRA continuation coverage if you become divorced or legally separated, or if you die. Your covered dependent(s) may be eligible for COBRA if they cease to be an eligible dependent under the Medical and/or Dental Plans.

NOTE: Medical Plan benefits are continued for the spouse and dependent(s) of active employees who have 10 or more years of service with the Power Authority at the time of their death.

Benefits Offered Under COBRA

If you choose continuation of coverage, you are entitled to the same coverage that was provided while you were in active service. The following benefits are offered under COBRA:

- NYPA Medical Plan or an Health Maintenance Organization offered by NYPA
- Dental Plan
- Vision Care Plan
- Flexible Spending Account(s)
- Hearing Aids
- Employee Assistance Program

Notification Requirements

New York Power Authority must inform you and any eligible dependent of your rights to continued coverage under COBRA following the end of your employment, reduction in hours, or death.

You or your dependent must notify New York Power Authority if coverage for a dependent ends as a result of a

- divorce or dissolution of domestic partnership
- Medicare eligibility, or
- A child losing his or her dependent status.

To provide notification of a COBRA-qualifying event, you must contact Human Resources within 60 days of the qualifying event. Otherwise, COBRA coverage will not be made available. After you (or your dependent) have notified New York Power

Authority, you will receive a COBRA information packet and election form from our COBRA Administrator.

Making a COBRA Election

To elect COBRA continuation coverage an eligible individual must contact the COBRA Administrator within 60 days of:

- Coverage ending as a result of a qualifying event, or
- Receiving notice from New York Power Authority or the COBRA Administrator that coverage has ended and that COBRA continuation coverage is available.

If a notice is sent to a spouse/domestic partner, that notice also applies for all other covered dependents residing with the spouse/domestic partner. However, each dependent has an independent right to elect continued coverage.

Your right to elect COBRA will not be affected by other coverage you may have at the time you elect COBRA coverage (for example, if you have coverage under your spouse's plan at the time your coverage under the NYPA Medical Plan ends). However, your COBRA coverage will end if you obtain Medicare or other group coverage after electing COBRA.

How Long COBRA Coverage Lasts

You may be entitled to purchase up to 18 months of COBRA coverage under Federal Laws. If you lose COBRA coverage, you may be eligible for a supplemental continuation of coverage under New York State law. Additionally, as the result of a change in the NYS Insurance Law (Chapter 236 of the Laws of 2009), which became effective January 1, 2010, unmarried young adults through the age of 29 are eligible for NYPA medical coverage under the "Young Adult Option."

Your dependents may be entitled to continue coverage for up to 18 months, or 36 months in some instances. Employees dismissed for gross misconduct may be entitled for up to six months of extended coverage.

The table below shows how long COBRA coverage will continue based on various events.

Event	COBRA Coverage Will End
Your termination or a reduction in work hours	The last day of the 18-month period following the date group coverage ended
Disabled dependent	The last day of the 29-month period following the date group coverage ended, or on the date New York Power Authority stops providing any group health coverage

For your dependents, if you become divorced or legally separated, or if you die. This also applies to dependents losing eligibility due to age limitations.	The last day of the 36-month period following the date group coverage ended, or on the date New York Power Authority stops providing any group health coverage
Non-payment of premium by the end of the grace period	Retroactive to the last month for which coverage was paid

Cost of COBRA Coverage

You (or your covered dependents) must pay the full cost of coverage, plus a 2% administrative fee. The premium rate will be determined at the beginning of the plan year and will apply to anyone who elects to continue coverage during that period. The premium rate will not change during the plan year, unless NYPA revises the group health care program for all participants.

Coverage during the continuation period will terminate if the enrollee fails to make timely premium payments, becomes enrolled in another group health plan, or NYPA stops providing any group health coverage.

For More Information

Additional information about COBRA coverage will be provided to you (or your dependents) when you (or your dependents) become eligible. You may contact your site HR Representative with questions about COBRA.

New York State Mini-COBRA

As a result of New York State legislation that became effective January 1, 2010, enrollees who have exhausted their federal COBRA coverage may extend NYPA Medical Plan coverage for an additional 18 months under the state's continuation of coverage law. Under the legislation, if you lose COBRA coverage because you have reached the end of your 18- or 29-month continuation period, you may request additional coverage that will extend coverage until the earlier of:

- 36 months (combined length of COBRA and New York State coverage);
- The end of the period in which premiums were last paid;
- The date the enrollee becomes entitled to Medicare benefits; or
- The date NYPA no longer provides group health care coverage to any of its enrollees.

The enrollee will pay the full premium cost plus a two (2) percent administrative fee for this coverage continuation.

Young Adult Option

As a result of a change in New York State Insurance Law, effective January 1, 2010, unmarried young adults through age 29 are eligible for NYPA medical insurance coverage under the "Young Adult Option."

The Young Adult Option does not change NYPA's maximum age criteria for dependent coverage available to eligible employees, but allows the adult child of an employee who meets the established criteria to purchase individual medical coverage through NYPA when the Young Adult does not otherwise qualify as a dependent under the NYPA medical plan options. Either the young adult or his/her parent may enroll the Young Adult in the Young Adult Option, and either may elect to be billed for the NYPA medical plan premium.

Eligibility Criteria

A Young Adult is entitled to the same medical plan coverage as his/her parent provided the Young Adult meets all of the following eligibility requirements:

- be a child of a NYPA medical plan enrollee (including those enrolled under COBRA);
- be age 29 or younger;
- be unmarried;
- not be insured by or eligible for coverage through the young adult's own employer-sponsored health plan, whether insured or self-funded, provided that the health plan includes both hospital and medical benefits;
- live, work or reside in New York State or the medical plan's service area within New York;
- not be covered under Medicare.

In addition, the Young Adult does not need to live with the parent, be financially dependent upon the parent, or be a student. A Young Adult's eligibility for medical coverage through a former employer under federal COBRA or New York State continuation coverage does not disqualify the Young Adult from electing this option from NYPA. The Young Adult's parent does not need to have family coverage, nor is the Young Adult required to have been previously covered as a dependent under a NYPA medical plan, to be eligible to enroll in this option.

When Young Adult Children May Enroll

A Young Adult or his/her parent may enroll the Young Adult in the Young Adult Option and either may pay the cost of the coverage. A Young Adult may enroll:

- within 60 days of when the Young Adult would otherwise lose coverage due to age or loss of dependent status under the parent's policy; or
- within 60 days of when the Young Adult becomes eligible due to a loss of his/her employer coverage; relocation of residence or employment to New York State or the health care plan's service area; or otherwise becomes newly eligible due to a change in circumstances (such as a divorce).

How to Enroll

To enroll a Young Adult in the Young Adult Option, either the parent or the young adult must complete the Young Adult Option enrollment application, which you can obtain

from your site HR Representative. Proof of the parent/child relationship also must be provided with the application, e.g., birth certificate. The application and documentation must be submitted to your site HR Representative for approval.

Pre-Existing Condition Limitations and Certificates of Creditable Coverage

Group health plans may not impose a limitation or exclusion for pre-existing conditions. If you terminate your employment and become covered under another employer's plan, or if your dependents become covered under another plan that has a pre-existing condition limitation or exclusion, coverage under this Plan may reduce any pre-existing condition waiting period imposed by the new plan.

New York Power Authority will provide each person covered under the plan's medical benefits with a certificate of coverage under this Plan at the following times: (1) if the individual is a qualified beneficiary for COBRA purposes, upon the occurrence of a qualifying event, (2) at the time the individual ceases to be covered under the plan, and/or (3) if an individual elects COBRA, when COBRA coverage ceases. New York Power Authority may contract with the insurer or third party administrator to provide this certificate. You may also request a certificate of coverage within 24 months of loss of coverage by making a written request for such certification to your site HR Representative.

SECTION 20 – MEDICARE AND RETIREE BENEFITS

Medicare and your Medical Benefits

There are three parts to Medicare. Part A covers hospital expenses, Part B covers medical charges (e.g. physician office visits) and Part D covers the prescription drug costs. The NYPA Medical Plan assumes that every retiree and spouse who is eligible for Medicare is covered for Part B. Even if someone has not enrolled in Part B, the amount payable under Part B will be deducted.

When a retiree becomes eligible for Medicare, Medicare will pay for some of the same hospital and medical expenses which are covered under the NYPA Medical Plan. Medicare will pay first.

The Authority Plan "carves out" benefits paid by Medicare. If a doctor accepts Medicare assignment, the NYPA Medical Plan will not pay in excess of the Medicare approved amount. If the doctor does not, the NYPA Medical Plan would look at the amount that Medicare allows compared to what Medicare pays and pay the difference up to the reasonable and customary charge. You will not be reimbursed more for the same expenses under both this Plan and Medicare than what this Plan would have paid alone.

Employees who retire on or after July 1, 1991 must use the 60-day Medicare lifetime reserve of hospital days before the hospitalization portion of the NYPA Medical Plan becomes primary.

Medicare Part B – Active Employees Who are Medicare Eligible

The Medicare carve out provision does not apply to active employees and their dependents who are over age 65. Employees who work past age 65 are subject to the "Working Aged" provision. Individuals affected by the Working Aged provision may reject their NYPA Medical Plan coverage and elect in writing to take Medicare. If you elect to take Medicare while you are actively employed, the Authority will not reimburse you for the cost of Medicare. If you reject NYPA Medical Plan coverage, you will not be eligible for any health benefits under this plan.

If you change your mind and later want to rejoin the NYPA Medical Plan, contact the Benefits Department in White Plains.

Medicare Part D – Active Employees Who are Medicare Eligible

Medicare prescription drug coverage (Medicare Part D) became available in 2006 to everyone with Medicare. If you are an active employee who is age 65 or older, or if you have a spouse or eligible dependent who is age 65 or older, or otherwise eligible for Medicare you should read NYPA's "Notice of Creditable Coverage for Persons with Medicare or Who are Eligible for Medicare and Who are Covered by The New York Power Authority Health Insurance Program." You can request a printed copy of the notice from your site HR Representative or the Benefits Department in White Plains.

The prescription drug benefits provided by NYPA, in most cases, provides you with better coverage than the coverage offered under Medicare Part D, which means that

NYPA provides you with "creditable prescription drug coverage." Therefore, you should not sign up for any Medicare Part D plans being offered to you.

Retiree Eligibility

If you meet NYPA's Retirement Eligibility (on chart on next page), retire from the New York Power Authority, and you immediately receive retirement benefits from the New York State Retirement System, the Authority will provide the following benefits:

- **Medical** – You and your dependents are eligible for medical benefits (including major medical, pharmacy, and hospitalization) as described in the following chart. Coverage is modified when you or your dependent become eligible for Medicare. Dental benefits are not continued into retirement, but you may elect COBRA coverage.

  If you die post-retirement, medical benefits will be continued for your spouse (as long as he or she remains unmarried). Covered dependents can continue coverage up to age 26.

- **Medicare Part B Reimbursement** - Retirees are eligible for Medicare Part B reimbursement, up to $100 per month. This reimbursement amount applies only to the retiree (not to any dependents). To be reimbursed, you must submit your Social Security statement or voucher verifying Medicare Part B payment. Each year you will receive a voucher which must be signed and returned to the Power Authority.

- **Life Insurance** - Retirees are eligible for a life insurance benefit.

- **Employee Assistance Program (EAP)** – Retirees are also eligible for the EAP.

If you leave the Authority with a vested retirement benefit and you do not immediately collect a pension, you will not be eligible for Medical coverage, Medicare Part B Reimbursement, Life Insurance, or the Employee Assistance Program.

	IBEW Employees Hired Before 05/19/2015			IBEW Employee Hired On or After 05/19/2015
	Employee Retires Prior to 05/19/2015	Employee Retires 05/19/2015 - 1/1/2019	Employee Retires after 1/1/2019	
Retirement Eligibility (for employees, spouse, eligible dependents)	10 Years of service	10 Years of service	10 Years of service	15 Years of service
Retiree Contribution to Medical Coverage	No contribution to any medical plan	No contribution to any medical plan	No contribution if enrolled in the NYPA Medical Plan If enrolled in another plan, your contribution is 50% of the difference between the NYPA Medical Plan and the plan you enrolled in	Retiree contribution is fifty percent of the active employee contribution
Retiree Medical Coverage	NYPA Medical Plan - Same 2015 plan terms in effect at time of retirement	NYPA Medical Plan - Same plan terms in effect at time of retirement	NYPA Medical Plan - Retirees are subject to the same changes affecting active employees in 2019 and forward (copays, deductibles, RX copays etc.)	NYPA Medical Plan - Plan terms (copays, deductibles, RX copays etc.) are subject to the same changes affecting active employees
New Dependents	Retire 05/19/2015 to 12/31/2017 – Retiree can add dependents to retiree medical plan	Retire 05/19/2015 to 12/31/2017 – Retiree can add dependents to retiree medical plan Retire on or after 01/01/2018 – Retiree can add dependents one time, and will be required to pay the difference between the family and single contribution	Retiree can add dependents one time, and will be required to pay the difference between the family and single contribution	May not add new dependents after retirement
Domestic Partner Benefits (All Domestic Partner Benefits are Subject to Imputed Income)	After 5/19/2015, domestic partner covered at the time of retirement can continue coverage during retirement	Domestic partner covered at time of retirement can continue coverage during retirement	Domestic partner covered at time of retirement can continue coverage during retirement	Domestic partner covered at time of retirement can continue coverage during retirement

Notes: New Hires refer to staff hired May 19, 2015 and thereafter. The one time, post retirement option of adding new dependent(s) and related cost applies to any medical plan.

Retiree Life Insurance

If you meet NYPA's retirement edibility criteria, your life insurance coverage can be continued. The benefit will equal 150% times the annual equivalent salary in effect at the time of retirement, computed to the highest multiple of $500, if it is not already a multiple of $500, to a maximum of $25,000. You will be required to pay one-half of the cost of the annual premium for your life insurance.

If you decline retiree life insurance, you will be covered by a $3,500 lump sum benefit. This lump sum benefit is paid by the Authority and is provided at no cost to you.

If you fail to pay the premium for your retiree life insurance in a timely manner, as determined by the White Plains Benefits Department, your life insurance will revert to the $3,500 lump sum benefit. Your retiree life insurance benefit will end and cannot be reinstated.

Employee Assistance Program

The EAP described in Section 18, *Employee Assistance Program* is continued for retirees and their family at no cost to the retiree.

SECTION 21 – GLOSSARY

Nothing contained in the glossary is meant to limit benefits set forth in other sections of this Handbook. This section defines many terms used throughout this Benefits Handbook.

ACA – Affordable Care Act, also known as the Patient Protection and Affordable Care Act. Healthcare reform legislation signed into law in March 2010.

Accident Expense Plan Administrator – AFLAC insures the Accident Expense Plan

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Annual Deductible (or Deductible) - A designated amount that you are responsible to pay each calendar year for covered charges before benefits are payable under the NYPA Medical and Dental Plans. Certain expenses, e.g., diagnostic and preventive dental work, are not subject to the annual deductible. Copays do not apply to the annual deductible.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests, or activities.

Basic Wages - The amount of money you earn, but not including any overtime, bonus pay and other extra pay.

Beneficiary - A person whom you designate to receive the plan benefit.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the plan

Bitewing - Dental X-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Body Mass Index (BMI) - a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Bridges - A dental appliance replacing missing teeth that can be attached to adjacent teeth for support (fixed) or held by clasps (removable).

Calendar Year - A period of one year beginning with a January 1.

Cancer Plan Administrator – AFLAC insures the Cancer Plan

Cancer Resource Services (CRS) - a program administered by the Medical Plan Claims Administrator or its affiliates made available to you by New York Power Authority. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care Coordination℠ - programs provided by the Medical Plan Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

COBRA Administrator – TASC administers the COBRA program.

Coinsurance - The portion of a medical or dental expense that you are responsible for, in addition to the annual deductible. For example, if the NYPA Medical Plan covers an expense at 80% of the reasonable and customary charge, the remaining 20% is your coinsurance amount.

Common Accident Feature - If two or more of your covered family members are hurt in the same accident, only one annual deductible will be applied in the year the accident occurred and during the succeeding calendar year against all the expenses incurred as a result of the accident. The Common Accident Feature applies to the NYPA Medical and Dental Plans.

Company - New York Power Authority.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - Federal law giving employees and covered dependents the option to pay for continued coverage under a plan in the event coverage would otherwise have ceased as a result of a Qualifying Event (e.g. employee's termination).

Contingent Beneficiary - Person who is designated to receive a plan benefit if your primary beneficiary (first choice) is deceased.

Copayment (or Copay) - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services. Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Medical Plan Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Charges - The actual expenses incurred for the services and supplies that are allowed for covered services under the NYPA Medical and Dental Plans.

Covered Family Members or Covered Person - You, your spouse or domestic partner, or and dependent children who are covered under the plan.

Covered Health Services - those health services, including services or supplies, which the Medical Plan Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, substance-related and addictive disorders, or their symptoms.
- Included in Section 5, NYPA Medical Plan Highlights and Section 6, Benefit Descriptions.
- Provided to a Covered Person who meets the plan's eligibility requirements, as described in Section 2, *Benefits Overview*.
- Not identified in Section 7, Medical Exclusions and Limitations.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dental Plan Administrator – Delta Dental is the administrator for the Dental Plan.

Dentist - A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.

Dentures - A partial or complete set of artificial teeth set in plastic material to substitute for the natural teeth and related tissues.

Dependent - an individual who meets the eligibility requirements specified in the plan, as described under Section 2, *Benefits Overview*. A Dependent does not include anyone who is also enrolled as a Participant.

Disability Plan Administrator – The Hartford is the administrator for the Short Term and Long Term Disability Plans

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership – relationship between two individuals who are single, in a long-term committed relationship, have been in the relationship for at least one year, reside in the same household, and are financially interdependent.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Each Cause - You or a covered family member may be confined in a hospital more than one time. More than one surgical procedure may be performed. The Medical Plan Claims Administrator will consider all hospital confinements and all surgical procedures to occur because of the same cause unless the person recovers completely from the injury or sickness which caused the first hospital confinement or procedure, or in the case of pregnancy, the later hospital confinement or surgical procedure is caused by a different pregnancy, or

You return to work for one full day before having another hospital confinement or surgical procedure, or in the case of hospital confinement only, one confinement is due to accidental injury and the other is due to sickness. For a covered family member, the disability which causes the later hospital confinement or surgical procedure is completely different from the disability which caused the first hospital confinement or surgical procedure, or when your dependent engages in normal activities for at least 90 days before having another hospital confinement or surgical procedure.

Sickness will include any sickness resulting from a complication of pregnancy for the purpose of determining each cause

EAP Consultant – Corporate Counselling Associates, Inc. provide Employee Assistance Program services.

Eligible Expenses - for Covered Health Services, incurred while the plan is in effect, Eligible Expenses are determined by the Medical Plan Claims Administrator as stated below and as detailed in Section 3, *How the Medical Plan Works*.

Eligible Expenses are determined solely in accordance with the Medical Plan Claims Administrator reimbursement policy guidelines. The Medical Plan Claims Administrator develops the reimbursement policy guidelines, in its own discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Medical Plan Claims Administrator accepts.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Employer - New York Power Authority.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Medical Plan Claims Administrator or Prescription Drug Plan Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

Explanation of Benefits (EOB) - a statement provided by the Medical Plan Claims Administrator to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the plan.
- The reason(s) why the service or supply was not covered by the plan.

Filling – Silver Amalgam - Material used to fill cavities that is usually placed on the tooth surface that is used for chewing because is a particularly durable material. Porcelain, Silicate, Acrylic, Plastic or Composite Filings - Materials used to fill cavities, which have less durability thus they are placed on non-stress bearing surfaces of front teeth because the color more closely resembles the natural tooth than does the color of Silver Amalgam.

Fluoride - A solution of Fluorine which is applied topically to the teeth for the purpose of preventing dental decay.

FSA Claim Administrator – UnitedHealthcare is the claim administrator for the Flexible Spending Accounts.

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

Hospice Care Plan - Hospice Care is a plan of terminal patient care that is established and conducted by a certified Hospice Agency and supervised by a physician. Hospice services typically provided include, but are not limited to, inpatient care in a Hospice Unit or other licensed facility, home care and family counseling during the bereavement period.

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

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.

- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Life Insurance Company - Aetna Life Insurance Company insures the Life Insurance Plan.

Life Insurance Plan Administrator – AXA Equitable Life Insurance Company administers the Life Insurance Plan.

Maintenance Care - Care and treatment that is solely provided for the relief of pain or to maintain a bodily function and prevent worsening of a condition. Maintenance care will not result in a demonstrated or expected improvement of the diagnosed condition.

Managed Care - The primary goal of a “managed care” program is to deliver cost effective health care and to ensure quality and access of care to the plan participants.

Maintenance Medication – a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication by contacting the Prescription Drug Plan Administrator by calling the telephone number on your ID card or logging onto their website.

Medical Plan Claims Administrator – UnitedHealthcare is the administrator for the NYPA Medical Plan

Medicare - The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental or Nervous Disorder - Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

No-Fault Automobile Insurance Law – The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medical Necessity - accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator - the organization or individual designated by New York Power Authority who provides or arranges Mental Health and Substance Use Disorder Services under the Plan. United Behavioral Health (UBH) provides these services. A list of Network providers is available at www.myuhc.com or by calling the number on the back of your ID card.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Medical Exclusions and Limitations.*

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Medical Plan Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Medical Plan Claims Administrator's affiliates are those entities affiliated with the Medical Plan Claims Administrator through common ownership or control with the Medical Plan Claims Administrator or with the Medical Plan Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a Non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers.

Non-Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Non-Network providers.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with the Prescription Drug Plan Claims Administrator or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Prescription Drug Plan Claims Administrator as a Network Pharmacy.

Open Enrollment - the period of time, determined by New York Power Authority, during which eligible Participants may enroll themselves and their Dependents under the plan. New York Power Authority determines the period of time that is the Open Enrollment period.

Other Income Benefits - This refers to the reduction of your disability benefit by the amount of other income benefit sources that you may receive, e.g., Social Security benefits, Workers' Compensation.

Out-of-Pocket Maximum - this is the maximum amount you pay every calendar year. Refer to Section 5, *NYPA Medical Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Medical Plan Works* for a description of how the Out-of-Pocket Maximum works.

For Network Benefits, the Out-of-Pocket Maximum includes all Network Copays, Co-Insurance, Annual Deductibles that you pay for any Network Services (i.e. Physicians, Hospitals, and Prescriptions).

For Non-Network Benefits, the Out-of-Pocket Maximum only includes Non-Network Co-Insurance that you pay for Non-Network Services (i.e.. Physicians, Hospitals, Prescriptions).

The out-of-pocket maximum does not include amounts determined to be above the reasonable and customary charge for the service. Once you have met the out-of-pocket maximum, the plan will pay excess covered charges at 100% (R&C).

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant - a Participant of the Employer who meets the eligibility requirements specified in the plan, as described in Section 2, *Benefits Overview.*

Periodontal Treatment - Treatment of the gums and mouth tissues for periodontal disease. This disease weakens and destroys the gums, bone and membrane

surrounding the teeth. Periodontal Disease is the principal cause of tooth loss in people over age 30. This disease is sometimes called Vincent's Disease, Gingivitis or Pyorrhea.

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan Administrator - New York Power Authority or its designee.

Pre-Determination of Benefits - If your dental care provider recommends a course of treatment for you or a covered family member, the provider can request a Pre-Determination of Benefits. A Pre-Determination of Benefits gives the employee and the provider information on what charges will be covered and what benefits would be paid, before the treatment is initiated

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Prescription Drug Charge - the rate the Prescription Drug Plan Claim Administrator has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to the Prescription Drug Plan Claims Administrator's periodic review. As a result, some Prescription Drug Products may move to a different tier (up or down), and some may no longer be covered under the plan. You may determine to which tier a particular Prescription Drug Product has been assigned by contacting the Prescription Drug Plan Claims Administrator at the number on your ID card.

Prescription Drug Plan Administrator – Express Scripts (ESI) is the pharmacy benefit manager for the Prescription Drug Plan.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, only be dispensed pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this plan, this definition includes:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:

- insulin syringes with needles;
- blood testing strips - glucose;
- urine testing strips - glucose;
- ketone testing strips and tablets;
- lancets and lancet devices;
- insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
- glucose monitors; and
- allergy serum.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge, without application of any Copay, as required by applicable law.

You may determine whether a drug is a Preventive Care Medication by calling the Prescription Drug Plan Claims Administrator at the number on your prescription drug ID card or logging onto their website.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Prophylaxis - The removal of tartar and stains from the teeth. The cleaning of the teeth by a dentist or dental hygienist.

Qualifying Disability Period - The specified amount of time that you must be absent from work due to your disability before benefits will begin.

Reasonable and Customary Charge (non-participating providers)

Medical - The reasonable and customary charge is the amount paid for a medical service and/or supply in a geographic area based on what providers in the area usually charge for the same or similar medical service/supply. In determining whether charges are reasonable and customary, consideration is given by the Medical Plan Claims Administrator to the nature and severity of the condition being treated and any circumstances which require additional time, skill, or experience. The plan may use resources such as data managed by the University of Syracuse (equivalent to 90th percentile of FAIR Health rates), MultiPlan, or Medicare reimbursements as guides for

reasonable & customary. Reasonable and customary charges are reviewed and updated, semi-annually and may be subject to change. Reasonable and customary amounts may increase, decrease, or remain the same.

Dental - The term reasonable and customary charges, as determined by dental carrier, means the usual charge most other dentists or other providers of similar training or experience in the same or similar geographic area for the same or similar services or supplies. The guide is the actual charges submitted by providers to dental carrier. Reasonable and customary charges are reviewed on an annual basis and may or may not be subject to change. As such, reimbursements could increase, decrease or remain the same.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retired Employees - New York Power Authority employees that meet the retiree eligibility service requirements and who retire and receive retirement income from the New York State and Local Retirement Systems. See Section 20, *Medicare and Retiree Benefits* for more information.

Room and Board - Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

Root Canal Therapy (Endodontic Therapy) - Treatment of a tooth having a damaged pulp. Usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals and filling the spaces with sealing material.

Scaling - To remove calculus (tartar) and stains from teeth with special instruments.

Sealants - A type of resin that will bond to the enamel of a tooth and form a protective coating resistant to chemical or physical breakdown.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefits Handbook includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the plan.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in Section 2, *Benefits Overview*.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Term Life Insurance - life insurance payable to a beneficiary only when an insured person dies within a specified period.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Totally Disabled - You would be considered totally disabled (with respect to Long Term Disability) under this plan if during the first 27 months of your disability you are unable to perform the normal duties of your occupation for any employer. After the 27th month of absence, you must be completely unable to engage in any occupation or employment for pay or profit.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

The Medical Plan Claims Administrators and Prescription Drug Plan Claims Administrators have processes by which they compile and review clinical evidence with respect to certain health services. From time to time, they issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

Urgent Care - treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center - a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- Do not require an appointment.
- Are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends.
- Provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 22 – DIRECTORY OF PROVIDERS

Contact information for each vendor for the NYPA IBEW Benefits Plans are listed in the following directory.

Health & Welfare Plans	Claims Administrator or Insurance Carrier
NYPA HR Services	914-287-3114 Business Hours: Monday to Friday 7 am to 5 pm EST
NYPA Medical Plan **Medical and Hospitalization Benefits**	**UnitedHealthcare** Group #: 193266 Medical Claims: PO Box 740800, Atlanta, GA 30374-0800 • Website: www.myuhc.com • Phone: 866-351-6831 • Business Hours: Monday to Friday 8 am to 8 pm EST UnitedHealthcare Options PPO Network • Website: www.myuhc.com • Phone: 866-633-2446 • Business Hours: Monday to Friday 8 am to 8 pm EST UnitedHealthcare Empire Network: • Website: www.empireplanproviders.com/provider.htm • Phone: 877-769-7447 • Business Hours: Monday to Friday 8 am to 5 pm EST United Behavioral Health Network • Website: www.myuhc.com • Phone: 866-374-6060 • Business Hours: Monday to Friday 8 am to 8 pm EST Crisis Management 24 x 7

NYPA Medical Plan **Prescription Drug Benefits**	**Express Scripts** Group #: NYPARXX Claims: ESI, ATTN: Commercial Claims, PO Box 2872, Clinton, IA 52733-2872 • Website: express-scripts.com • Express Scripts Phone: 1-855-778-1494 • Business Hours: Monday to Friday 6 am – 12 am EST Sat. & Sun 6 am - 10 pm EST Accredo (Specialty Pharmacy) • Website: accredo.com • Phone: 800-803-2523 • Business Hours: Monday to Friday 8 am – 11 pm EST Saturday 8 am - 5 pm EST
HMO	**Capital District Physicians Health Plan (CDPHP)** Group #: 10005854 Claims: CDPHP, 500 Patroon Creek Blvd, Albany, NY 12206-1057 • Website: www.cdphp.com • Phone: 518-641-3700 or 800-777-2273 • Business Hours: Monday to Friday 8 am to 8 pm EST
HMO	**Independent Health** Group #: 22637 Claims: Independent Health Claims, PO Box 9066, Buffalo, NY 14231 • Website: www.independenthealth.com • Phone: 800-501-3439 • Business Hours: Monday to Friday 8 am to 8 pm EST

Dental Plan	**Delta Dental** Group #: 02478 Claims: Delta Dental of New York, P.O. Box 2105, Mechanicsburg, PA 17055-6999 • Website: www.deltadentalins.com/nypa • Phone: 800-932-0783 • Business Hours: Monday to Friday 9 am to 9 pm EST
Vision Care	**New York Power Authority** 123 Main Street, White Plains, NY 10601 Attn: Benefits Group • Phone: 914-287-3114 • Business Hours: Monday to Friday 7 am to 5 pm EST
Hearing Aids	**New York Power Authority** 123 Main Street, White Plains, NY 10601 Attn: Benefits Group • Phone: 914-287-3114 • Business Hours: Monday to Friday 7 am to 5 pm EST
Short Term Disability	**Hartford Life and Accident Insurance Company** Claims: The Hartford, PO Box 14301, Lexington, KY 40512-4301, Attn: Group STD Claims • Phone: 866-945-7781 • Fax: 866-411-5613 • Business Hours: Monday to Friday 8 am to 8 pm EST

Long Term Disability	**Hartford Life and Accident Insurance Company** Claims: The Hartford, PO Box 14302, Lexington, KY 40512-4302, Attn: Group LTD Claims • Phone: 800-549-6514 • Fax: 866-411-5613 • Business Hours: Monday to Friday 8 am to 9 pm EST
Life Insurance	**AXA Equitable Life Insurance Company** AXA's Employee Benefits Group 8501 IBM Dr., Ste. 150-B Charlotte, NC 28262 • Phone: 866-274-9887 • Fax: 469-417-1973 • Business Hours: Monday to Friday 7 am to 7 pm CST
Health Care & Dependent Care FSA	**UnitedHealthcare** Group #: 193265 Claims: Health Care Account Service Center, P.O. Box 981506, El Paso, TX 79998-1506 • Website: www.myuhc.com • Phone: 866-755-2648 or 800-331-0480 • Fax: 915-231-1709 • Business Hours: Monday to Friday 9 am to 11 pm EST
Supplemental Benefits – Cancer and Accident Expense Plans	**AFLAC** • Phone 1-800-366-3436 • Business Hours: Monday to Friday 8 am to 8 pm EST
Employee Assistance Program (EAP)	**Corporate Counseling Associates** • Website: myccaonline.com company code: nypa • Phone: 800-833-8707 • Business Hours: 24 x 7

COBRA	**TASC** Address: TASC, PO Box 14015, Madison, WI 53078-0015 • Phone: 800-422-4661 • Fax: 608-663-2753 • Business Hours: Monday to Friday 8 am to 5 pm EST

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