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The New York State Health Insurance Program (NYSHIP)
for Employees of Participating Agencies

Welcome to the New York State Health Insurance Program (NYSHIP). As a new employee, or an employee newly eligible for health insurance, there are some important things you should know:

- Your employer may offer coverage under either The Empire Plan or the Excelsior Plan. Both plans provide medical, hospital, mental health and substance abuse and prescription drug benefits.
- Federal Health Care Reform requires that a *Summary of Benefits and Coverage* be available for The Empire Plan and The Excelsior Plan. You may view a copy of the *Summary of Benefits and Coverage* for the NYSHIP plan you are eligible for or enrolled in at https://www.cs.ny.gov/sbc/index.cfm. Or, if you do not have internet access, you may call 1-877-7-NYSHIP (1-877-769-7447) and choose the Medical Program to request a copy.
- Your Health Benefits Administrator (HBA) – usually located in your agency's personnel office – is the person you should contact to make any changes to your health insurance coverage. For example, if you need to add or remove a dependent, update your address, change your health insurance option, or if you have any questions about your coverage, contact your HBA.
- Check https://www.cs.ny.gov/ebd, the New York State Department of Civil Service web site, for updates and information, including new publications, your prescription drug list, benefit changes and to find a participating provider.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://www.cs.ny.gov/ebd or by calling 1-877-7-NYSHIP (1-877-769-7447).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1000** (**$500** for enrollees in or equated to Grade 6 and below or earning less than $34,318 for UUP; not available to PAs or PEs) per enrollee, per spouse/domestic partner and per all dependent children combined. Does not apply to care rendered by a participating provider or by a network facility, hearing aids, prosthetic wigs, external mastectomy prostheses, emergency ambulance services, Managed Physical Medicine Program or prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$250** per enrollee, per spouse/domestic partner and per all dependent children combined for non-network Managed Physical Medicine Program. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network Max: Individual **$6,350**/Family **$12,700**. Co-insurance Max: **$3000** (**$1500** for enrollees in or equated to Grade 6 and below or earning less than $34,318 for UUP; not available to PAs or PEs) per enrollee, per spouse/domestic partner and per all dependent children combined.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan does not cover do not count toward either out-of-pocket limit. In-Network Max excludes prescription drug costs, non-network expenses and ancillary charges. Co-insurance Max excludes hospital co-pays, penalties and expenses incurred under the Prescription Drug Program, Managed Physical Medicine Program or Home Care Advocacy Program (HCAP).	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See https://www.cs.ny.gov/ebd **or call 1-877-7-NYSHIP** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating and network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-payment/visit plus $20 co-payment for radiology/lab services	20% co-insurance	none
	Specialist visit	$20 co-payment/visit plus $20 co-payment for radiology/lab services	20% co-insurance	none
	Other practitioner office visit	$20 co-payment/visit plus $20 co-payment for radiology/lab services	20% co-insurance; 50% co-insurance for Managed Physical Medicine Program	none
	Preventive care/ screening/ immunization	No charge	20% co-insurance	No charge for certain preventive care services in accordance with Patient Protection and Affordable Care Act (PPACA).
If you have a test	Diagnostic test (x-ray, blood work)	$20 co-payment/office visit; $40 ($30 for NYS CSEA and UCS) co-payment/ hospital outpatient setting	20% co-insurance in an office; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	none
	Imaging (CT/PET scans, MRIs)	$20 co-payment/office visit; $40 ($30 for NYS CSEA and UCS) co-payment/ hospital outpatient setting	20% co-insurance in an office; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	Precertification required or benefits will be reduced up to the out-of-pocket maximum.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cs.ny.gov.	Level 1 or for most Generic Drugs	30-day supply: $5; network pharmacy 31-90 day supply: $10; Mail Service or Specialty Pharmacy 31-90 day supply: $5	Claims for your out-of-pocket costs may be eligible for partial reimbursement.	Medicare primary enrollees are covered under the same co-payment structure for up to a 31-day supply or 32-90 day supply. Certain medications require prior authorization for coverage. Most Level 1 contraceptives are covered with no co-payment.
	Level 2, Preferred Drugs or Compound Drugs	30-day supply: $25; network pharmacy 31-90 day supply: $50; Mail Service or Specialty Pharmacy 31-90 day supply: $50		
	Level 3 or Non-preferred Drugs	30-day supply: $45; network pharmacy 31-90 day supply: $90; Mail Service or Specialty Pharmacy 31-90 day supply: $90		
	Specialty drugs	Applicable co-payment based on the drug co-payment level		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 co-payment/office surgery; $30 co-payment/non-hospital outpatient surgery; $60 ($40 for NYS CSEA and UCS) co-payment/outpatient hospital surgery	20% co-insurance in an office setting; 10% co-insurance or $75 (whichever is greater)	Physician/surgeon fee in addition to facility fee applies only if the physician/surgeon bills separately from the facility.
	Physician/ surgeon fees	$20 co-payment/surgery	20% co-insurance in an office setting	
If you need immediate medical attention	Emergency room services	$70 ($60 for NYS CSEA and UCS) co-payment/visit	$70 ($60 for NYS CSEA and UCS) co-payment/visit	Co-payment waived if admitted.
	Emergency medical transportation	$35 co-payment/trip	$35 co-payment/trip	Not subject to deductible or co-insurance. No charge for Mental Health and Substance Abuse ambulance services.
	Urgent care	$20 co-payment/office visit; $40 ($30 for NYS CSEA and UCS) co-payment/outpatient hospital visit; Additional $20 co-payment for radiology/lab services	20% co-insurance in an office; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	——————none——————

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% co-insurance	Precertification required; $200 penalty if hospitalization is not precertified.
	Physician/surgeon fee	No charge	20% co-insurance	Physician/surgeon fee in addition to facility fee applies only if the physician/surgeon bills separately from the facility.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-payment/visit	20% co-insurance	Psychological testing must be reviewed for medical necessity.
	Mental/Behavioral health inpatient services	No charge	10% co-insurance	No coverage for non-network Residential Treatment Facilities, Halfway Houses or Group Homes.
	Substance use disorder outpatient services	$20 co-payment/visit	20% co-insurance	Psychological testing must be reviewed for medical necessity.
	Substance use disorder inpatient services	No charge	10% co-insurance	No coverage for non-network Residential Treatment Facilities, Halfway Houses or Group Homes.
If you are pregnant	Prenatal and postnatal care	No charge for routine pre and post natal care	20% co-insurance	none
	Delivery and all inpatient services	No charge	10% co-insurance; 20% co-insurance for provider services not billed by hospital	Precertification required; $200 penalty if hospitalization is not precertified.
If you need help recovering or have other special health needs	Home health care	No charge	50% co-insurance	Precertification required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home nursing.
	Rehabilitation services	$20 co-payment/visit	50% co-insurance for office visits under Managed Physical Medicine Program; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	Outpatient hospital rehabilitation services covered when medically necessary following a related hospitalization or surgery.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you need help recovering or have other special health needs (cont.)	Habilitation services	$20 co-payment/visit	50% co-insurance	HCAP or Managed Physical Medicine Program network allowance depending on the service. No charge when precertified if service is covered under HCAP. No co-insurance maximum for Managed Physical Medicine Program services.
	Skilled nursing care	No charge	50% co-insurance; 10% co-insurance in a skilled nursing facility	Limitations and exceptions apply to skilled nursing facility coverage. Precertification required; $200 penalty if admission is not precertified. Non-network benefits apply if skilled nursing at home is not precertified. No non-network coverage for the first 48 hours.
	Durable medical equipment	No charge	50% co-insurance	Diabetic shoes are covered up to $500 when precertified. Allowance for diabetic shoes purchased at a non-network provider is one pair up to 75% of the network allowance. Precertification required; non-network benefits apply if not precertified.
	Hospice service	No charge	10% co-insurance or $75 (whichever is greater)	Precertification required; $200 penalty if hospitalization is not precertified.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Custodial care
- Dental care (adult & child), except for the correction of damage caused by an accident
- Long-term care
- Non-network Residential Treatment Facilities, Halfway Houses or Group Homes
- Routine eye care (adult & child)
- Routine foot care
- Services that are not medically necessary
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
• Acupuncture (provided by a doctor, with limitations)	• Chiropractic care	• Infertility treatment (with limitations)	• Private-duty nursing (covered under HCAP only)
• Bariatric surgery (with limitations)	• Hearing aids (with limitations)	• Non-emergency care when traveling outside the U.S.	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-7-NYSHIP. You may also contact your state insurance department, the U.S. Department of Labor or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and choose the appropriate carrier
- The New York State Department of Civil Service, Employee Benefits Division at 518-457-5754 or 1-800-833-4344
- The New York State Department of Financial Services at 518-474-6600 or 1-800-342-3736
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society of New York, Community Health Advocates at 888-614-5400 or http://www.communityhealthadvocates.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al [1-877-769-7447].

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $7540
- ☐ **Plan pays** $7040
- ☐ **You pay** $500

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7540**

Patient pays:

Deductibles	$0
Co-pays	$300
Co-insurance	$0
Limits or exclusions	$200
Total	**$500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers:** $5400
- ☐ **Plan pays** $4860
- ☐ **You pay** $540

Sample care costs:

Prescriptions	$2800
Medical Equipment & Supplies	$1300
Office Visits and Procedures	$900
Education	$200
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**

Patient pays:

Deductibles	$0
Co-pays	$500
Co-insurance	$0
Limits or exclusions	$40
Total	**$540**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

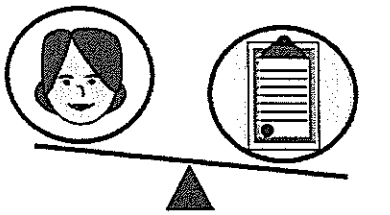
Appeal

A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may *not* balance bill you for covered services.

Co-insurance



Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

(See page 4 for a detailed example.)

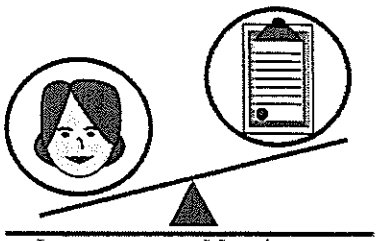
Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible



The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

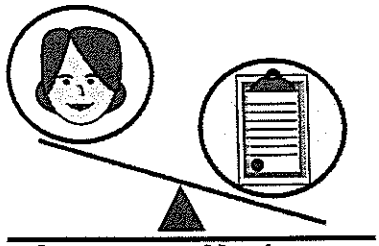
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do *not* contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do *not* contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

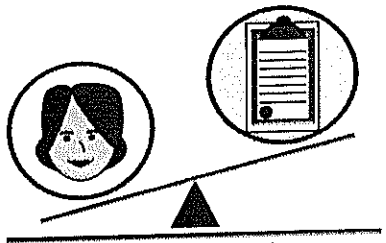
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

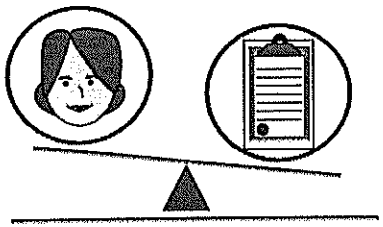


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

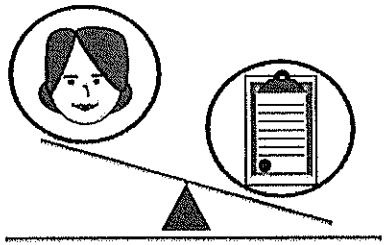


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

Group Number: 770

FITZHARRIS AND COMPANY INC.

EMPLOYEE INFORMATION SHEET

As an employee benefit, the Long Beach Public School District is happy to provide a dental care program administered by Fitzharris and Company.

HOW TO USE YOUR DENTAL PLAN

Obtain a claim form from the benefits office and fill in sections 1 through 11. Sections 1 through 11 are self-explanatory. Section 12 should be "#770". Sections 13 through 17 are to be completes since they are used to assist Fitzharris in determining whether you are entitled to dual coverage and/or coordination of benefits with another carrier. The form should then be given to the dentist of your choice at your next appointment.

YOUR DENTAL CARE BENEFIT

Your dental care program is an excellent benefit. All covered dental procedures are subject to an annual per person deductible of $50 with a family limitation of $150 regardless of the number of patients in the family. Any expenses incurred in October, November or December which are used to satisfy the deductible amount in full or in part will also be used to reduce the deductible amount for the following calendar year. There is a $1,000 annual maximum per person. The following payment schedule will illustrate the co-payment percentages involved with each covered procedure, in accordance with Fitzharris's payout level.

		Paid by Fitzharris*	Paid by Patient*
DIAGNOSTIC-	(exams & x-rays)	80%	20%
PREVENTIVE-	(fluoride treatments to age 19, teeth cleaning- children and adults & sealants to age 14)	80%	20%
BASIC RESTORATIVE-	(fillings)	80%	20%
ORAL SURGERY-	(extractions)	80%	20%
ENDODONTICS-	(root canal therapy)	80%	20%
PERIODONTICS-	(treatment of gum disorders)	60%	40%
MAJOR RESORTATIVE-	(crowns)	60%	40%
PROSTHODONTICS-	(dentures, bridgework)	60%	40%
ORTHODONTICS-	(straightening of teeth)	60%	40%

* Payments percentages refer to (1) participating dentist charges or (2) non-participating dentist's charges that are within "usual, customary and reasonable" (UCR) maximum levels as calculated by Fitzharris.

Orthodontics is a benefit for eligible employees, spouses and dependent children to age 19 and has a separate maximum of $500 per person per calendar year.

Periodontics has a separate maximum of $500 per person per calendar year.

Eligible for coverage are:

Employees
Spouses
Dependent children to age 19 unless a full-time student in which case to age 23.

DENTISTS

A number of licensed dentists in New York have entered into agreements with Fitzharris to abide by Fitzharris's policies regarding services, your portion of the charged fees and other matters pertinent to Fitzharris's obligations to its subscribers. These dentists, known as participating dentists, will send claim forms to Fitzharris and will be paid directly paid by Fitzharris. You pay only for services not covered or co-payment amounts as stated in the notification of payment form which Fitzharris will send to you with each claim. Other dentists not participating in Fitzharris also regularly perform services for Fitzharris subscribers; in such cases, payment is made directly to you. Payout by Fitzharris is the same in either case. While Fitzharris can guarantee your personal co-payment with participating dentists, you have complete freedom of choice in selection of your dentist.

LIMITATIONS AND EXCLUSIONS

There are certain limitations and exclusions which apply to your dental plan. For example, dentistry that is performed for appearance only and services rendered or devices started prior to the effective date of the program are not covered.

The contract on file at the benefit office will give a full listing of the limitations and exclusions of your dental plan.

PREDETERMINATION

If the amount of care to be rendered to any one patient will exceed $300, the dentist should submit the claim form the Fitzharris for predetermination before completing the treatment. Fitzharris dental consultants will examine the treatment plan and x-rays which may accompany the form and future benefits will be detailed. This is generally a very simple procedure that takes only a few days, but it is very important because it assures you and the dentist that you are eligible for dental benefits, and it tells both you and the dentist if certain proposed services are not covered by the contract.

BENEFITS SERVICES

If you or your dentist have any questions about claim filing procedures or the status of your claim, please feel free to contact Fitzharris Benefit Service Department at:

Fitzharris and Company
P.O. Box 9182
Farmingdale NY 11735

Phone Number:	1-516-777-2244
Toll Free:	1-800-635-5651
Website:	www.fitzharrisinc.com

NOTE – This information sheet pertains to proposed benefits and is to acceptance of the application for the dental service contract. This information sheet will not modify such contract in any way, nor shall the subscriber accrue any and additional rights because of any statement in or omission from this information sheet.