KINGSTON TRUST FUND

Group Health & Dental Plan

2025 SUMMARY PLAN DESCRIPTION – PART A

This Plan has been updated to comply with Health Care Reform (HCR) rules.
See **color copy** of this Plan with highlighted changes at www.ktftrustfund.com.

NEW plan information is in RED.
KTF, MagnaCare, and First Health Preferred Provider (PPO) Networks
Administered by: KINGSTON TRUST FUND

- This Summary Plan Description/Plan Document, along with interpretive memoranda and operational policies, will govern in all cases.
- The Summary Plan Description is organized in four (4) parts:
  - KTF Part A (Eligibility Rules, Medical Schedule of Benefits, and Exclusions)
  - KTF Part B (Appeals, Eligibility Rules, Subrogation, etc.)
  - KTF Part C (Important Employee Notices regarding Your Rights, Specific Plan Rules)
  - KTF Part D (Dental Schedule of Benefits, Covered Codes, and Exclusions)

The Grandfathered Plan status for the group health plan is NOT elected under the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010.

Grandfathered status DOES apply to the KTF Dental Plan.

Restatement Date:	**January 1, 2025**
Benefit Year/Deductible Year Ends:	December 31
Trust Plan Year Ends:	June 30
Last Amendment:	July 1, 2024
Printed:	January 2025

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INTRODUCTION AND IMPORTANT NOTICE TO MEMBERS

This document is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this document. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this document. If you are enrolled in family coverage, each eligible family member is also entitled to these benefits.

There have been several changes in this Plan due to new rules under the Patient Protection and Affordable Care Act **(PPACA)** enacted March 23, 2010**,** also known as the Affordable Care Act **(ACA)** or Health Care Reform **(HCR)**. Please take some time to review this Plan (all four parts). It is especially important to review Part C for the various disclosure notices outlining your rights and obligations under this Plan. All documents are available at www.ktftrustfund.com including a new Uniform Glossary of Terms, which explain how benefits are paid.

This Plan will continue to respond to the numerous new rules governing health care plans because of the Patient Protection and Affordable Care Act, better known as Health Care Reform. There are many new disclosure requirements that are required to be included in the Summary Plan Description. All notices regarding patient rights, including a notice of your HIPAA Privacy and Security Rights are now found in Part C.

The Summary Plan Description is organized into four separate parts as follows:

- **PART A –** This section provides specific plan rules for eligibility, coordination of benefits, prior authorization, along with the medical, behavioral health and addiction, and prescription drug benefits. The benefits are determined by the Board of Trustees. This is a self-funded, non-federal governmental plan subject to rules under the Public Health Service (PHS) Act. It is not an ERISA Plan nor is it subject to state insurance laws.
- **PART B –** This section is maintained by KTF and contains detailed information on the Plan's general rules on excluded benefits, definition of terms, eligibility, prior authorization, case management, coordination of benefits, appeals, subrogation, and Medicare coordination. It is important for members to know this Plan will be updated as needs to include operational and interpretive memorandum from time to time.
- **PART C –** This section was added for the specific purpose of maintaining the various disclosure notices required by various acts. Please refer to the Table of Contents to expedite the location of a specific notice. The notices are in alphabetical order by subject matter to make them easier to locate.
- **PART D –** The Dental Schedule of Benefits and covered codes are included in this section. The Dental Plan incorporates by reference the basic provisions for eligibility. General Plan rules are the same as for the Group Health Plan under Parts A, B, and C. Prior authorization of dental procedures is not required. Benefits will be based on whether services are provided by in-network or out-of-network providers.

To further aid you in understanding and comparing plans, please refer to the following which can be found online at www.ktftrustfund.com. You may also request a copy of these documents from the Trust Office or KTF Compliance Office.

- ***A Uniform Glossary of Terms*** – Additional Definitions that apply may be found in Part B of the Plan. You may also find this at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits.
- ***SBC (Summary of Benefits and Coverage)*** – Based on a standardized format as required by PPACA.

Changes that are new for 2025 will be noted in RED. The color coding when viewing this Plan online is to aid you in identifying clarification and PPACA modification for new rules:

1. All physical therapy must be preauthorized as medically necessary for the first six (6) visits and additional visits, in blocks of ten (10), must be preauthorized as medically necessary for a maximum of 50 visits per benefit year.
2. Rx out-of-pocket for non-Medicare members will remain $4,000 (effective 01/01/2025). Rx out-of-pocket for Medicare members will decrease to $2,000 (effective 01/01/2025).

For questions on benefits, coordination of benefits, Medicare enrollment, and subrogation rules when there is third party liability, please contact the KTF Compliance Office at 844-KTF-FUND.

PRESCRIPTION DRUG COVERAGE VS MEDICARE PART D PRESCRIPTION PLAN

This Plan, on average, is expected to pay out as much or more than the standard Medicare prescription drug coverage under Medicare Part D and is considered creditable coverage. Thus, you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment if you have maintained creditable drug coverage and do not incur a break in prescription drug coverage of 63 days or more. Please see the Medicare Creditable Coverage Notice in Part C of this Plan.

Medicare's Low-Income Benefits

Medicare has special low-income programs for people with limited income and resources, including extra help paying for Medicare prescription drugs. Information is available through the Social Security Administration online at www.socialsecurity.gov, or call (800) 772-1213 or for hearing impaired call (800) 325-0778 (TTY). See rules for prescription drugs when member is in a nursing home.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE (800-633-4227), (TTY users should call 877-486-2048).

STOP HEALTH CARE FRAUD!

Fraud increases the cost of health care for everyone! All allegations of fraud, waste, and abuse will be thoroughly investigated. A copy of the Plan's Fraud, Waste and Abuse Policy can be found in Part B of the Plan. **Protect yourself from fraud!**

1. Do not give your member identification (ID) number over the telephone or to people you do not know, except for your health care provider.
2. Let only the appropriate medical professionals review your medical record or recommend services.

3. Avoid using health care providers who say an item or service is not usually covered, but they know how to bill us to get it paid.
4. Carefully review Explanations of Benefits (EOBs) statements you receive from this Plan, Medicare, or any other provider.
5. Please review your claims history periodically for accuracy to ensure services which have never been rendered are not being billed to your account.
6. Do not ask your doctor to make false entries on certificates, bills, or records to get us to pay for an item or service.
7. If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    a. Call the provider and ask for an explanation. There may be an error.
    b. If the provider does not resolve the matter, call us via 844-KTF-FUND and explain the situation. Documentation can be faxed to (770) 874-1097.

NOTIFY THE PLAN OF CHANGES THAT AFFECT ELIGIBILITY

Do not maintain, as a family member on your policy, an ineligible individual:

- Your former spouse after a legal separation, divorce decree, or annulment is final (even if a court order stipulates otherwise – court orders cannot override plan eligibility rules); or
- Your child aged 26 or over unless they were disabled and incapable of self-support prior to age 26. Notice and proof of such disability and dependency must be provided to the Plan prior to attainment of age 26. You must elect family coverage if you wish to cover any dependent.
- If you have any questions about dependent eligibility, check with the KTF Compliance Office.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and the Trustees, on behalf of the Plan, may take action against you. Examples of fraud include: falsifying a claim to obtain benefits; trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage; or enrolling in the Plan or using your ID card when you are no longer eligible; failure to disclose other coverage; or failure to enroll in Medicare when you are first eligible by reason of age or disability when you are no longer covered as an active employee or a dependent of an active employee; or any other act that causes this Plan to pay claims it is not obligated to pay.
- If your enrollment continues after you are no longer eligible for coverage (e.g., you have separated from service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for the services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

PREVENTING MEDICAL MISTAKES

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more, and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

- Ask questions if you have doubts or concerns and make sure you understand the answers.

- Choose a doctor with whom you feel comfortable talking with.
- Take a relative or friend with you to help you ask questions and understand answers.
- Keep and bring a list of all medications you take whenever you go to a provider. We recommend you always keep a list on your cell phone or in your purse or billfold.
- Bring the actual medicines or give your doctor and pharmacist a list of all medicines you take, including non-prescription (over the counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medicine and what to avoid while taking it. Be sure to write down the information your doctor and/or pharmacist says.
- Make sure your medicine is what your doctor ordered.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Get the results of any test or procedure.
- Ask when and how you will get the results of tests or procedures.
- Do not assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.
- Talk to your doctor about which hospital is best for your health needs.
- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.
- Make sure you understand what will happen if you need surgery.
- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
    - “Exactly what will you be doing and how long will it take?"
    - "What will happen after surgery and how can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

For additional information, check out the following Patient Safety Links:

- www.ahrq.gov/consumer/ The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.ihi.org/improvement-areas/improvement-area-patitent-safety The Institute for Healthcare Improvement has information on how to ensure safer health care for you and your family.
- www.bemedwise.org The National Council on Patient Information is dedicated to helping consumers be informed and active in medication decisions.
- www.leapfroggroup.org The Leapfrog Group promotes safe practices in hospital care.
- www.ahqa.org The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

FEE-FOR-SERVICE PPO PLAN – ALLOWABLE CHARGES

This Plan is a fee-for-service plan that **does not** require a primary care physician or referrals to see specialists. You are free to choose in-network/PPO providers as well as out-of-network/NPPO providers. You can choose your own physicians, hospitals, and other health care providers. The Plan will reimburse your provider (with assignment of benefits) or you for covered services when you pay for the charges yourself. **All PPO providers are required to accept an assignment of benefits and will be reimbursed directly by the Plan.** You should not pay more than your normal copay to PPO providers at the time of service. Be sure to know your PPO networks!

- You are responsible for verifying the status of your provider prior to receiving services.
- If you go out-of-network, you will pay more for services. Benefits are based on allowable or eligible charges, and you are responsible for excess charges for out-of-network providers. Please refer to Part B for a complete explanation of how allowable charges are determined.

PPO Networks for Members Living Within the Primary Coverage Area

Members living within the primary coverage area may access the following networks. All other providers, including sister network (First Health Network) are considered out-of-network providers and will be paid according to the NPPO Schedule of Benefits except in the case of an emergency or if you are traveling outside the primary coverage area and need to see a doctor for urgent care. Go to the nearest Emergency Room or for non-emergency situations, go to the nearest Urgent Care Center. **You need to preauthorize your Urgent Care visit while traveling for it to be paid as an in-network benefit. The only in-network/PPO providers are:**

- ✓ KTF PPO Network
- ✓ KTF Dental PPO Network
- ✓ MagnaCare PPO Network
- ✓ Medicare Providers if you are Medicare Primary

Out of New York State (OOA) – Network Access

If you are residing or traveling outside of New York State, you may also access the following "sister" PPO network – see the logos on your ID Card:

- ✓ First Health PPO Network

Out-of-Network or Non-Participating Providers (NPPO) - *See Part B for Allowed Charges*

We have no contractual relationship with providers who are not preferred or participating providers; therefore, they may or may not accept our Plan allowance (allowed or eligible charges for purposes of benefit payment). We refer to them as "non-participating providers," "out-of-network," or "NPPO" providers. When you use NPPO providers, you may have to pay them directly at the time of service and then file your claims with us. We will then pay our benefits to you, and you must pay the provider.

You must pay any difference between the amount non-participating providers charge and our allowance *(except in certain circumstances – see Allowed/Eligible Charges in Part B)*. In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for non-covered services.

Important – If You Use Non-PPO Providers:

Your out-of-pocket costs may be substantially higher when you use non-participating providers than when you use preferred or participating PPO providers. All other providers other than the PPO providers listed previously, based on your coverage status, are considered as out-of-network providers. A NPPO provider may or may not accept assignment. They may require you to pay up front for services. All out-of-network claims are paid based on usual and customary rates provided by Fair Health.

Standard Claims Forms Required

All providers or members are required to submit claims on appropriate standardized forms (CMS1500, UB04 and ADA Dental Claim forms). If you go out-of-network, be sure to request these forms to document the services and charges provided. *See also section on Penalties:Untimely Filing*.

Failure to Preauthorize Required Treatment *(See KTF Prior Authorization Rules)*

Our fee-for-service Plan offers services through a PPO network of preferred providers. The primary PPOs for medical and behavioral health are the KTF PPO Network and the MagnaCare PPO Network. When you use a PPO, you will receive covered services at a reduced cost. You can also go to www.ktftrustfund.com to search for providers or you may call the PPO network directly.

Your Rights *(See Part C for various Notices Regarding Your Rights)*

You may get information about us, our networks, and our providers, as well as Plan information and summaries, important notices, and manuals by going to our web site, www.ktftrustfund.com. If you need clarification or additional information, contact the KTF Compliance Office via 844-KTF-FUND.

Your Medical and Claims Records are Confidential

We will keep your medical and claims information confidential. As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies. You may view our Notice of Privacy Practice in Part C for our HIPAA Privacy and Security Policy and for more information about how we may use and disclose member information.

Schedule of Benefits

The Schedule of Benefits is in Part A, below, of this Plan document. There is a listing of the various schedules, also included in this Part A. Also, please refer to the Table of Contents to quickly locate specific information.

MASTER KTF CONTACT INFORMATION		
PPO SPECIALTY	**KTF PPO (For All Members)**	**Other PPO (Paid as In-Network for OOA Members ONLY)**
Medical Treatment PPO Network	**KTF PPO** 844-KTF-FUND www.KTFTrustFund.com **MagnaCare PPO** 800-352-6465 www.MagnaCare.com	**First Health Network** 800-226-5116 www.FirstHealth.com
Behavioral & Addictive Treatment PPO Network	**KTF PPO** 844-KTF-FUND www.KTFTrustFund.com **MagnaCare PPO** 800-352-6465 www.MagnaCare.com	**First Health Network** 800-226-5116 www.FirstHealth.com
Member Reimbursement and Secondary Claims	**MagnaCare** 800-352-6465 PO Box 1001 Garden City, NY 11530	None – all other providers are paid as out-of-network (NPPO) providers**.**
Prescription Drugs BIN: 610568 PCN: RXS Rx Group: KTF	**Four Corners Health** (PBM) Members:www.fourcornershealth.myrxplan.com PA: https://paforms.com/four-corners-health/ **Manifest Pharmacy** (Mail Order) www.ManifestPharmacy.com **CVS Caremark Specialty Pharmacy**	**Four Corners Health (PBM)** Customer Service: 866-443-9331 Rx Prior Authorization: 855-742-2054 Rx PA Fax: 833-231-3647 **Manifest Pharmacy (Mail Order)** Customer Service: 888-770-4009 Physician Fax Line: 866-226-9133 **CVS Caremark Specialty Pharmacy** Customer Service: 800-237-2767
Kingston Trust Fund Office Mailing Address: PO BOX 4461, KINGSTON, NY 12402-4461 Do NOT submit claims or appeals to the KTF Trust Fund Office due to HIPAA privacy rules.		

KTF Prior Authorization Department	
KTF Prior Authorization (Medical, Behavioral, & Addictive): Prior authorization, Utilization Review, and Case Management for Medical. Prior authorization decisions are independent of provider approval or benefit decisions. **IN AN EMERGENCY, GO TO THE NEAREST HOSPITAL!**	MagnaCare: 888-362-4624 Inpatient Fax: 516-723-7339 Outpatient Fax: 516-723-7306 MagnaCare c/o Utilization Management Dept 1600 Stewart Ave Ste 700 Westbury, NY 11590

Claims Information
All claims must include the claim information and address for primary and secondary plans, along with the group number (this is the first three digits of your member ID) and the member's ID number.
Mail All Medical Claims including Behavioral and Medical Member Reimbursements to: **MagnaCare** **Phone: 800-352-6465** PO BOX 1001 GARDEN CITY, NY 11530 If this Plan is secondary, submit the EOB from the primary plan, including Medicare with your claim. Members are responsible for insuring providers have correct claims address and insurance information.
Electronic Claims Information: Clearinghouse: EMDEON Payor ID: 11303
KTF Compliance Office Phone: 844-KTF-FUND 416 CREEKSTONE RIDGE WOODSTOCK, GA 30188 Members contact the KTF Compliance Office for general information, enrollment/change forms, questions regarding benefits, COBRA, eligibility, coordination of benefits, etc. All claims' appeals must be timely filed per Plan rules (within 180 days of the date the claim was paid or denied or within 1-year of date of service for unpaid claims) with the KTF Compliance Office *(See Part B and C for Appeal Rules)*. Prior authorization and medical necessity appeals must be requested within 180 days. Emergency requests will be processed within 24 hours during normal business hours.

To locate specific information in this document, please refer to the Table of Contents for each section of the Plan for a comprehensive listing of all major subjects. Please review Important Notices found in Part C. Copies of the Plan can be requested from the KTF Compliance Office or by going online to www.ktftrustfund.com.

ELIGIBILITY AND DEPENDENT COVERAGE RULES	
Eligible Employees	Eligibility for both group health and dental benefits shall be governed by this Plan and the collective bargaining agreement(s) for Kingston School District employees. • There is no waiting period for Teachers. • The waiting period for ESP employees is to the first day of the month following the date of hire. • The waiting period for ESP employee's family members is 90 days.
Initial Entry or Effective Date and Initial Enrollment Period: *Retroactive coverage is not permitted except for newborn coverage or Qualified Medical Child Support Order (QMCSO).*	• Teaching/Professional Staff: Date of hire if you enroll during the first 30 days following your hire date. • ESP Staff: The first day of the month following date of hire. • Effective Date of Coverage: First day of the month on or following receipt of enrollment/change forms. You must enroll within 60 days of your initial eligibility date. • Reenrollment is required upon rehire if there has been a break in coverage of 63 days or more. • Late Enrollment: Not permitted except during open enrollment.
Late/Open Enrollment *Applies to changes not timely filed.*	Enrollment changes are permitted during open enrollment (each June) with coverage effective July 1. If you fail to enroll during your initial enrollment period or within 60 days of a Qualifying Life Event (QLE), you may not make a change until the next open enrollment period.
Qualifying Life Event (QLE)/Special Enrollment Events	For adoptions, placement of a foster or adopted child, the effective date of coverage is the date of event if the Plan is notified within 60 days of the event. *See QLE (Qualifying Life Event) Chart for permitted changes.* Mid-year changes include all permitted changes under Section 125 regulations for Cafeteria/Flexible Benefit Plans as well as special enrollment changes under HIPAA, which are incorporated by reference.
Enrollment Is Required for Special Benefit Programs	**Prenatal Program/Healthy Beginnings** - must enroll during the first trimester (14 weeks) or within 60 days of initial coverage. Members must remain active and respondent to the program throughout the pregnancy to remain enrolled. **Diabetic Program –** special benefits are provided to those members enrolled in this program, subject to verification they have a diabetic or potential diabetic condition. **Infertility Program** - must be covered under this Plan for 18 consecutive months and under the maximum age limit (45) for infertility treatment. The maximum benefit is $45,000 lifetime. **Out of Area Status –** If you live outside of New York State, you have access to the First Health Network. You must keep an updated out of New York State address on file with the KTF Compliance Office. **Weight Loss Incentive** – Healthy Lifestyle Program

ELIGIBILITY AND DEPENDENT COVERAGE RULES CONTINUED	
Child Updates to Age 26	Dependent coverage will automatically continue until enrolled dependent attains age 26. Any changes to dependents may only be made during open enrollment or if there is a Qualifying Life Event.
New Eligible Children/Dependents *"Child" includes children, stepchildren, legally adopted children, children placed with the employee for adoption, and eligible foster children. The taxable year is the employee's taxable year, which employers may assume is the calendar year.* ***See also Termination of Coverage rules.***	• Class 1 – Legally wed spouse. Unmarried domestic partner is no longer eligible after December 31, 2012. • Class 2 - Dependents to Age 26 (See Part C for Notice on Dependent Eligibility.) • Class 3 - Disabled Dependents - must be enrolled prior to maximum age 26 per Plan rules. Continued coverage after age 26 is limited to and subject to Plan rules for "disabled dependents." • Enrollment Rules: Dependents may only be added during open enrollment or within 60 days of any status change (e.g., loss of health coverage, exhaustion of their COBRA benefits). • Retroactive enrollment is not permitted. Members are responsible for notifying the Plan of any other coverage or family status change within 60 days of date of event, including change in employment status. *See Qualified Life Event Chart for changes that may be made mid-year.*
Extended COBRA Coverage for Children Aged 26 to 30	**Unmarried Dependents Age 26 through Age 29** (end of month in which age 30 is attained). The member may apply for medical and dental coverage for their dependent. The cost of such coverage is based on the current COBRA rate. Dependents over age 26 may not be added under their parent's plan but may elect and maintain separate COBRA coverage. *See Part C for Notice of COBRA Rights.*
Disabled Dependents Including Spouses *Members are required to notify Plan of any disability status awarded to any covered member by Social Security or the Railroad.*	An unmarried, dependent child is considered permanently and totally disabled if prior to the maximum age for dependents. Documentation of disability must be provided within 90 days of the disability date or the maximum age for dependent coverage under this Plan. • After age 26, dependent must be claimed on your tax return and live with you or be deemed to be a member of the household while temporarily absent for no more than 6 months for medically necessary care due to chronic disability or cognitive impairment. • Any change in disability or dependent status must be reported immediately to the Plan. • Disabled dependent coverage ends at the end of the month in which disability or dependent status changes or they become eligible for Medicare.

ELIGIBILITY AND DEPENDENT COVERAGE RULES CONTINUED	
Medicare Enrollment Required	See Medicare Primary Coverage Rules for retirees and individuals who are on Social Security or Railroad Disability. See Coordination of Benefit (COB) rules.
Grandchildren *Special rules apply – includes a child where legal custody or guardianship exists.*	A grandchild is not an eligible dependent unless the member or member's spouse has full legal custody or guardianship over such child and legal documentation is provided within 60 days of court approval. Coverage is effective as of the date legal guardianship is effective. Child must be eligible to be claimed as a dependent by reason of residence and support. These rules also apply to any other child where legal custody or guardianship has been awarded to the member or their spouse.
Extended COBRA Coverage for Surviving Spouses of Retirees *(See Part C for Initial COBRA Notice)*	The following widowed spouses may continue their medical coverage after COBRA expires under extended COBRA rates and rules. Widowed spouses of retired members; and divorced spouses aged 55 or older of a retired member who was married to the member for at least five years and covered the last five (5) years under this Plan are eligible for extended COBRA coverage.
Newborns, Adopted or Foster Children *Notice required within 60 days of birth – retroactive enrollment is not permitted.* *(See also Part B)*	Newborns of a covered dependent (grandchildren) are covered for the first 30 days only if notice of birth is provided **within 30 days of birth** per HIPAA rules (no extension of coverage to the end of the month). If timely notice is provided, COBRA is available **for the newborn after the first 30 days of coverage.** Birth certificate and Social Security number are required for the Plan to pay claims for any newborn or adopted child. • If family coverage is in effect, coverage of newborns is from birth, but documentation (birth certificate & social security number) is required. • If single coverage is in effect, newborns must be enrolled within 60 days of birth. • Adopted or foster children are eligible as of the custody date if legal documentation of custody, adoption, or placement in the home is provided to the Plan within 60 days of the event.
Termination of Coverage *COBRA is now available for 36 months for anyone losing their coverage – see COBRA Chart below.* *Members are responsible for notifying the Plan of all coverage and/or status changes within 60 days.*	Coverage ends as of the **last day of the month** in which the **EARLIEST** of the following occurs unless later coverage is specifically provided. Members who fail to immediately notify the Plan of a status change of a covered member (whether intentional or unintentional) are responsible for reimbursing the Plan the benefits paid or the COBRA premiums. • End of the month through which premiums were paid. • End of the month in which child attains age 26. • End of the month in which a legal separation or divorced is approved. The court order must be filed with the Plan within 60 days of the event. • End of the third month following the death of a primary member for covered dependents, then COBRA coverage is available. If the survivor is Medicare eligible or other coverage is in effect, Medicare or the other coverage becomes primary as of the day following death of the primary member. Member must enroll in Medicare Part A and B immediately.

ELIGIBILITY AND DEPENDENT COVERAGE RULES CONTINUED	
QLE changes must be consistent with the event.	The timeframe for requesting special enrollment change must be within 60 days after the event. You cannot request a new enrollment based on a qualifying life event (QLE) before the QLE occurs. Changes are prospective and will be based on the date the Plan is notified. Once you enroll or make a QLE change, your 60-day window ends, even if 60 calendar days have not yet elapsed. This means once you have enrolled in a plan, you cannot change or cancel that enrollment until the next open enrollment, unless you experience another QLE that allows such a change or cancellation. All other changes may only be made during the annual open enrollment period.

COVERAGE TERMINATION RULES – KTF COBRA CHART	
COBRA is available for 36 months following any COBRA event and/or loss of dependent or spousal eligibility. *See PART C for Initial COBRA Notice.*	
COBRA Events Defined	**Coverage Ends**
Loss of Dependent Status: Notice of status change required within 60 days of the event.	End of month in which dependent attains age 26 or is no longer disabled.
Employee Death: Coverage for surviving spouse and dependents – *see also Retiree Death.*	End of Month + 90 Days
Excess Employees: Layoff, loss of funding, or reduction of hours.**	End of Month + 60 Days
Failure to Return from Leave of Absence: FMLA or approved leave of absence without benefits.	End of Month through which leave was approved.
Loss of Spousal Eligibility – Active Employee: Divorce or legal separation.	End of Month during which the legal separation or divorce occurs.
Loss of Spousal Eligibility – Retired Employee: Spouse must be at least 55, married and covered under this Plan for the past 5 years, and lose coverage due to divorce or legal separation.	End of Month – Extended COBRA coverage after 36 months is available to eligible widows or widowers.
Military Service: Unless otherwise continued by the district under a military service policy.	End of Month + 30 days
Newborn of a "dependent" or a "Grandchild": Eligibility for COBRA is dependent upon timely enrollment of the newborn. Otherwise, COBRA rules do not apply as grandchildren are not eligible dependents.	30 days following birth
Resignation, Termination, or Loss of Eligibility: Loss of eligibility as an employee for coverage. **	End of Month + 30 Days
Retiree Death (90 days of Transition coverage): See also Extended COBRA coverage for certain *widowed spouse.* If Medicare eligible, Medicare coverage must be applied for within 60 days.	End of Month + 90 Days for spouse and dependents, plus extended COBRA for eligible widowed spouses.
Important Notice Concerning Failure to Notify Plan of a COBRA Event: Failure to notify the Plan of a COBRA event may result in the loss of COBRA benefits. COBRA notices are only provided following timely notice of a COBRA event.	
COBRA Premium Adjustments: As of January 1, 2013, the COBRA rate shall be the same as the Cost of Health Insurance as reported on your W-2 in accordance with IRS Rules.	

** Coverage may be "bridged" to prevent a break in coverage for employees who are rehired or reinstated within 90 days of a prior layoff or contract termination in accordance with District Policy, as approved by the District/Board of Education, or as provided by any Collective Bargaining Agreement.

QUALIFIED LIFE EVENT (QLE) – SPECIAL ENROLLMENT RULES					
Qualifying Life Event*	**From Not Enrolled to Enrolled**	**INCREASE Enrollment Type**	**DECREASE Enrollment Type**	**CANCEL**	**CHANGE from one plan to another**
Acquiring/adding a new eligible family member (birth, adoption, marriage, dependent status change)	No	Yes	No	No	No
Losing a covered family member (death, divorce, or legal separation)	No	No	Yes	No	No
Losing other medical/ dental/vision coverage (spouse or dependent loses their coverage)	Yes	Yes	No	No	No
Spouse changes or acquires other coverage due to different open enrollment or new employment	Yes	No	Yes	Yes	No
Moving out of regional plan's service area	No	No	No	No	Yes, only if no OOA change with current plan
Going on active military duty, non-pay status	No	No	Yes	Yes	No (COBRA available)
Return to pay status from active to military duty	Yes	No	No	No	No
Retirement of primary member	No	No	No	No	No, unless moving (OOA)
Loss of dependent eligibility	No	No	Yes	No	No
Domestic Partner Coverage	Is not covered after July 1, 2013.				
Enroll unmarried child Aged 26 through 29	Yes, for extended COBRA coverage only per Plan rules. Extended coverage must be applied for during open enrollment or within 60 days of any change in health coverage. Verification of continued eligibility is required monthly along with submission of the COBRA premium.				

PENALTY CHART FOR UNTIMELY FILING & FAILURE TO PREAUTHORIZE

1. Appeals must be filed with the KTF Compliance Office no later than 180 days after any denial, payment or non-payment on any claim filed with this Plan. Reasonable cause and evidence of prior filing of any claim must be clearly documented and included with the appeal. Failure to file a formal, written appeal with all the necessary documentation will not be considered a timely filed appeal by either the member or provider and no further recourse shall be available to them under the Plan.
2. Any penalties will reduce the amount that a provider is entitled to if benefits have been assigned, making the provider responsible for the timely and direct filing of claims. Providers should not balance bill members for penalties due to their failure to file claims timely, unless they have advised a member in writing that it is the member's responsibility to file claims and the provider has made reasonable and timely efforts to verify billing information and to notify the member of unpaid claims, etc. **Members are always responsible for timely filing claims they have paid for in full and for following up on unpaid claims**.
3. Benefits will be reduced for claims preauthorized retrospectively within 90 days of date of service. No benefit will be paid if the required prior authorization does not occur within one year of the date of service.
4. Prior authorization and late filing penalties will not be credited toward your out-of-pocket limit. All penalties will be determined or waived at the sole discretion of the Plan, based on all facts and circumstances.
5. Timely filing rules apply to claims filed by the member when the member is requesting reimbursement for expenses paid out-of-pocket. Penalties will reduce the amount payable to the member under the Plan.
6. Claims more than one year old or appeals filed more than one year after the date of service will not be covered absent special circumstances, at the discretion of the Plan.

Days Following Date of Service	0 to 90 Days After Date of Service (DOS) **	91 to 180 Days After Service (DOS) **	180 to 360 Days After Service (DOS) **
Failure to preauthorize benefits prior to treatment	10% benefit reduction up to $100 for outpatient services and $500 for inpatient services	20% benefit reduction up to $100 per day for outpatient and $500 for inpatient services	50% benefit reduction - maximum benefit limited to $25,000 if claim filed more than 180 days after service date.
Late filing of claims by the provider/member	No penalty if filed within 90 days from date of service (DOS)	10% penalty based on allowed charges.	20% minimum penalty or 50% penalty if sufficient cause is not documented.
Claim and prior authorization was not timely filed/obtained	10% reduction in benefits up to $100 for outpatient services and $500 for inpatient services.	30% reduction in benefits up to $200 per outpatient visit and $1,000 for any inpatient treatment.	50% benefit reduction up to maximum benefit of $25,000 if claim not timely filed.
** The above penalties are subject to appeal and review with submission of documentation for reasonable cause for delayed filings. All decisions and adjustments are final and at the sole discretion of the Plan.			
Penalties for failure to complete treatment	Detoxification benefits will be reduced to 50% if the individual fails to complete an addictive treatment program following detox. Benefits will be paid at 50% if a patient fails to complete an inpatient or partial inpatient program.		
See also General Rules/Limitations	See penalties for fraud and failure to timely report changes, Plan's right of recovery and Plan's right to subrogate claims.		

Out-of-Network providers who will not bill this Plan	If a provider will not bill this Plan, the member is responsible for timely filing all claims to this Plan for reimbursement. The member is responsible for timely submitting a CMS 1500 Claim form for all medical treatment or an ADA form for dental treatment within 90 days of service. **This Plan cannot pay claims based on a provider billing.**

BASIC COORDINATION OF BENEFITS (COB) CHART

This Plan follows the NAIC (National Association of Insurance Commissioners) COB Model 120 Rules of April 2005. Different rules apply once an individual is "ELIGIBLE" for Medicare.

Explanation	Primary Plan	Secondary Plan
If you are covered as an employee or retiree and have "dependent" coverage.	Plan covering you as an employee or retired employee is primary to dependent coverage.	Plan covering you as a dependent is secondary.

COORDINATION OF BENEFIT RULES FOR DEPENDENT CHILDREN

Children covered under more than one plan and parents are living together regardless of marital status.	Coverage is based on the Birthday Rule and the plan of the parent born earliest in the year based only on the month and day (not year).	Plan of the parent born later in the year is secondary.
If parents are divorced or were never married and there is a court order assigning responsibility for medical or dental coverage.	The parent who is responsible for coverage per the court order is primary (except if their plan is with TriCare, as TriCare always pays secondary to a private plan). If birthday is on the same day, the plan covering the dependent the longest is primary. The Plan of the other parent would be secondary. Court orders may be applicable to spousal coverage when there are stepchildren, and the responsible parent only has coverage under their spouse's plan.	
If parents are divorced, separated, or not living together and there is **NO court order** assigning responsibility and they have JOINT CUSTODY.	Primary coverage is based on the **Birthday Rule**. The parent born earliest in the year (ignoring the year of birth) is primary. Example: Mom is born 10/12/1946 and dad is born 3/15/1950, the dad's plan will be the Primary plan.	
If parents are divorced, separated, or were not living together and there is **NO court order** assigning responsibility for medical or dental coverage.	Order is based on the following order: • Plan covering the custodial parent; • Plan covering the spouse of the custodial parent; • Plan covering the non-custodial parent, and/or; • Plan covering the spouse of the non-custodial parent.	
COBRA COVERAGE	COBRA coverage is secondary to a plan covering the person as an employee, member, subscriber, or retiree EXCEPT when the person is covered under Medicare for End Stage Renal Disease. Special rules apply with immediate Medicare coverage for ALS or ESRD.	

THIS PLAN'S BENEFITS WHEN MEDICARE IS PRIMARY PLAN AND KTF SECONDARY	
Medicare Providers who accept Medicare Assignment and Medicare Pays 80%.	This Plan will pay remaining 20%.
Medicare Providers who DO NOT accept Medicare Assignment but will bill Medicare. These providers may charge 115% of the Medicare Allowed rate.	This Plan will pay up to the remaining 35%.
Contract Providers who do not accept Medicare – Medicare will pay nothing for these providers. These providers are required to advise you prior to treatment that they are a contract provider and not covered by Medicare.	This Plan's benefits are limited to maximum benefit that would be paid had you used a Medicare provider who only bills Medicare, which is 35% of allowed charges. **Members are responsible for excess charges.**
Behavioral Health and Addictive Treatment	*See Section XI – Mental Health and Addiction Benefits and the Medicare Coordination Chart.* • Medicare pays 80%, same as medical

GENERAL RULES AND CONDITIONS

Specific rules set out in any applicable Collective Bargaining Agreement are incorporated by reference. An employee or retiree may opt out of this group plan and will receive a "buy-out" payment in accordance with the collective bargaining agreement upon providing proof of other group health coverage during open enrollment unless there is a special enrollment (QLE) situation, e.g., loss of other group health coverage.

COBRA RATE CHANGES

COBRA rates are adjusted each January 1. Rates are based on fixed costs and actual claims experience for the prior year for procedures established by the Plan. Contact the KTF Compliance Office for COBRA information.

DEMINIS COPAYS

Deminis copays are fixed medical or Rx copays that are less than this Plan's deminis copay. This Plan will not reimburse or coordinate benefits unless the copay under the primary plan exceeds:

- Copay of more than $30 for medical services
- Copay of more than $15 for prescription drugs

If copays exceed the deminis amount, the portion of the cost not covered by the primary plan will be covered by this Plan at 80% as a major-medical PPO benefit. The 20% coinsurance applies to and is subject to the medical PPO out-of-pocket limit. This Plan automatically coordinates when the primary plan requires the member to pay a percentage of the charges (coinsurance).

All claims must be filed timely. Late filing penalties may apply.

EXCLUSIONS/LIMITATIONS (SEE PART B FOR DETAILED LISTING)

The Plan will not pay for non-covered benefits or benefits in excess of the stated maximums specifically covered in the benefits schedule. Charges may be excluded or limited based upon the specific definition of certain terms. Certain services may not be covered based on this Plan's policy and practices, as may be established from time-to-time in keeping with the general benefit of structure and intent of the Plan. As new procedures, tests, or treatments become available, benefits will be determined at the sole discretion of the Plan, based on comparable or similar procedures, medical necessity and all relevant facts and circumstances.

PENALTY FOR FRAUD OR FAILURE TO TIMELY REPORT DEPENDENT AND MARITAL STATUS CHANGES

Members will be responsible for reimbursing the Plan at the COBRA rate for all intervening months of coverage after a dependent or spouse no longer meets the eligibility criteria of the Plan, regardless of actual claims. The Plan reserves the right to pursue legal action against any member who commits fraud against this Plan.

LIMITED BENEFITS

Limited benefits are not subject to the Plan's deductible, unless otherwise noted under the specific benefit, or out-of-pocket limits. Only those specific benefits are provided as ancillary benefits. Limited benefits include alternative providers, acupuncture, chiropractic, holistic medicine, Lasik benefit, eye care, hearing aids, limited dental, infertility benefits, massage therapy, weight loss and wellness benefits.

PLAN'S RIGHT OF RECOVERY

The Plan is entitled to recover any benefit paid in error or due to improper usage of your ID card, such as using your ID card for a prescription when this Plan is the secondary plan or failing to timely notify the Plan of coverage/status changes.

The Plan is entitled to immediate reimbursement from the member. The Plan can also recover any amount due from future payments or benefits under this Plan. The member is responsible for requesting payment from the primary plan.

If you fail to timely enroll in Medicare when first eligible and Medicare would be the primary plan, you are responsible for what Medicare would have paid had claims been timely filed with Medicare.

Medicare will not cover claims submitted for payment more than one year after the date of service. If the error is not discovered until more than one year after the date of service, the member would be responsible for repaying the Plan benefits paid in error due to failure to enroll in Medicare or to show your Medicare card to the provider.

Benefits will always be determined based on the Plan's coordination of benefits rules and any other laws establishing priority of payment, such as Medicaid always pays last. You may not "choose" which plan to use. Failure to provide information on all coverage to this Plan and to any provider would be considered fraud.

PLAN'S RIGHT TO SUBROGATION WHEN THERE IS THIRD PARTY LIABILITY

A subrogation agreement is generally required when you have medical expenses that are attributed to an illness or injury caused by another party, including injuries as a result of a vehicular accident.

1. The Plan is entitled to be reimbursed for medical expenses paid on your behalf once your suit is

settled, whether an agreement is signed or not.

2. Failure to report an accident or injury that is the result of third-party liability for which you are or plan to bring legal action against the responsible party for damages would be considered fraud.
3. See Part B of the Plan for additional information on Subrogation and the Subrogation Notice and Plan's Right of Recovery in Part C.
4. This Plan does not cover work-related claims that are covered or should be covered under Workers' Compensation. A subrogation agreement is required subject to this provision and the agreement must also be signed by your attorney.

This Plan is not subject to New York's Anti-Subrogation Law as a self-funded plan exempt from state insurance law. This Plan is subject to the Public Health Service Act as a non-federal governmental plan.

MEMBER AND PROVIDER RESPONSIBILITIES

The following responsibilities apply to both providers and members except when the responsibility is specifically identified as belonging to the provider or member:

- Enrollment in Plan: Members are required to enroll via the KTF Medical and Dental Enrollment Form. You may call the KTF Compliance Office for a copy of the enrollment form or visit www.ktftrustfund.com.
- Changes: Members must notify the Plan of any family or coverage status changes, including Social Security Disability eligibility and Medicare entitlement due to disability or age and spousal employment, health coverage, or address/contact changes.
- Failure to notify the Plan of changes may constitute fraud if an otherwise ineligible spouse or dependent's coverage is continued when it should have been terminated.
- Medicare Enrollment: Enrollment in Medicare Part A and B is required when first eligible due to disability or age and no longer eligible for coverage as or under an active at work family member. Special rules apply for End Stage Renal or ALS (Lou Gehrig) patients.
- Opt-Out: If you elect health coverage other than this Plan, opt out, or have dual coverage, you are required to disclose this information when you enroll or when the event occurs. Coverage of a dependent may be suspended if you fail to respond to requests for information or to provide an updated enrollment form.
- ID Cards: Members must give providers their current ID card(s) and update providers on any change in the claims address or your mailing address. Providers are responsible for verifying current coverage at the time of service and should keep a copy of the member's ID on file.
- Coverage under More than One Plan: Members and providers are responsible for ascertaining the primary and secondary plan. Members must provide copies of all ID cards to providers.
- Behavioral Providers: Members are responsible for contacting the KTF or MagnaCare Network for available PPO mental health providers. All other providers are considered out-of-network providers and members will be responsible for the NPPO deductible, coinsurance and excess usual, customary charges (UCR) whenever a NPPO provider is used.
- Claims Submission: Providers must submit all claims on a current CMS-1500 or ADA form. This applies to all types of providers including behavioral health providers. Handwritten claims will not be accepted. All claims must be typed or printed even if the provider is not billing the Plan directly. All claims must include the member ID and complete information on both primary and secondary insurance. Call the KTF Compliance Office if you have any questions.
- Medical providers must submit medical and dental claims directly to the medical claims' office *(address is on ID Card)* within 90 days of the date of service or payment by the primary plan. Penalties apply to late filed claims. Bills that are more than one-year-old will not be considered for payment, except where there are extenuating circumstances, subject to approval by the KTF Compliance Office.
- Balance Billing: PPO providers may not balance bill members and are responsible for timely filing claims with the Plan. Providers are requested to write off any excess charges over the allowed or eligible charge noted on the Explanation of Benefits (EOB) in the interest of billing members "reasonable" amounts for their service.
- NPPO providers may not balance bill members if this is prohibited under state insurance law or if they sign a separate agreement with the Plan. Please check with your state of residence for current rules.

MEMBER AND PROVIDER RESPONSIBILITES CONTINUED

- Members are responsible for negotiating with providers for the payment of any excess charges over what is determined to be "reasonable" and "eligible" under Plan rules. Members are advised to use PPO providers to minimize their out-of-pocket expenses.
- The Plan reserves the right to review and audit claims, including claims from PPO providers in accordance with our Waste, Fraud and Abuse Policy to protect against abusive, excessive, or inappropriate billing practices.
- Electronic Filing of Claims: Electronic claims must include the Plan's payor ID *(See Claims Information and Important Contacts and information)*. Providers should check with their clearing house to arrange a crossover to forward electronic claims to the Plan's clearing house (EMDEON). If not, claims will need to be dropped to a paper claim and mailed.

KTF PRIOR AUTHORIZATION RULES

The following services must be preauthorized when this Plan is primary, or primary benefits have been exhausted. (*See Part B and Part C for Notices on Medical Necessity and Preventive Care.)*

- Alternative Treatment *(See Any Other Benefit in the Schedule of Benefits)* requires authorization prior to treatment. Clinical information and medical history from your provider will be required.
- Bariatric surgery or alternative stomach bypass procedures require 12 months of participation in a weight loss program and counseling prior to authorization of this procedure. Please contact the prior authorization department if you anticipate having this type of surgery.
- BRCA genetic testing – any genetic testing not approved in advance will not be covered.
- Chemotherapy, radiation, and infusion drug treatment must be preauthorized prior to commencing the treatment program. All drugs must be provided per Plan rules through the Specialty Pharmacy.
- Clinical Trials – Experimental Treatment – generally, experimental treatment is not covered. Certain Clinical Trials may be covered in accordance with PPACA.
- Compression Stockings coverage is aligned with Medicare guidelines for treatment and diagnosis of open venous stasis ulcers. Durable medical equipment providers are required to obtain prior authorization for gradient compression stockings. Stockings are limited to a frequency of two pairs per year. The Plan will only cover graduated compression stockings worn below the knee.
- Diabetic Shoes
- Diagnostic or Lab Tests costing over $2,500. (See MRI's, Other Diagnostic and Sleep Apnea.)
- Durable medical equipment (DME) expected to cost over $500 must be preauthorized in advance, including but not limited to electric or motorized wheelchairs, electric scooters, electric beds, and customized braces or other DME items covered by the Plan. Requests for authorization of an exception for a DME item not specifically listed must be made in advance. Such DME, if approved, will be paid at the NPPO coinsurance rate. *Please see the Definition Section for additional details on covered and non-covered DME. See also Prosthetics.* Certain DME may be covered as major-medical. Medicare Primary members must order certain DME from Medicare approved providers only. If you do not use a Medicare approved provider, the benefit will be limited as though you used a contract provider.
- Home Health Care
- Hospice Care (both inpatient and in-home hospice)
- Infertility treatment once enrolled in the infertility program, subject to program rules.
- Injectable drugs must be preauthorized, including but not limited to botulinum toxin, alpha-1-proteinase inhibitor, palivizumab (Synagis), erythropoietin therapy, intravenous immunoglobulin, growth hormones, blood clotting factors and interferon when used for Hepatitis C.
- Inpatient confinement for medical, surgery, behavioral health, or addictive treatment, except for the first 48 hours of a vaginal delivery or 96 hours of a caesarian delivery. Extended maternity stays due to medical necessity must be preauthorized.
- MRI's, CT scans, echo cardiograms and any neuro-psychological testing plus any lab or major diagnostic test expected to cost more than $2,500, including biofeedback and other behavioral testing (based on total charges for all tests from that provider for any date of service).
- Office visits in excess of six with any one provider (unless prior authorization is already required)

KTF PRIOR AUTHORIZATION RULES CONTINUED

- Physical Therapy (Outpatient) must be preauthorized as medically necessary for the first six (6) visits and any additional visits, in blocks on ten (10) to a maximum of 50 total visits per benefit year. (*See also Vision Therapy below.)*
- Prosthetics that cost more than $1,500. (See also Artificial Aids and DME in the Definitions and Exclusions Section in Part B of the Plan.)
- Specialty drugs must be approved prior to treatment. Specialty drugs are to be supplied through the Specialty Pharmacy, including chemotherapy, radiation, and other infusion drugs that may be administered in a provider's office, free standing clinic, or outpatient hospital setting.
- Surgical procedures (in or outpatient) expected to cost $2,500 or more (total charges).
- Transplants, donor services, and any testing or services related to organ transplant as a donor or recipient. Patients are recommended to use a Center of Excellence as approved by the Plan.
- Unlisted Procedures - Procedures that do not have a specific procedure code to describe the service performed require prior authorization and must be submitted with documentation to assist in determining coverage.
- Urgent Care Facility (out-of-network) while traveling when you wish to use urgent care in lieu of an emergency room you must call for prior authorization to have the visit covered the same as a PPO benefit. Failure to preauthorize services will result in urgent care being paid as out-of-network benefit subject to the NPPO deductible and coinsurance. This also applies when you visit an OOA PPO Network (First Health Network).

The Schedule of Benefits is as follows:

Section I	Deductibles and Out-of-Pocket Limits
Section II	ER, Ambulance, lab, Diagnostic and X-Ray
Section III	Inpatient Hospital & Surgical Benefits
Section IV	Preventive Benefits Paid at 100% - PPO Only
Section V	PPO Outpatient Benefits
Section VI	Other PPO/OOA Benefits
Section VII	NPPO (Out-of-Network) Benefits
Section VIII	Prescription Drug Plan
Section IX	Diabetic Program
Section X	Infertility and IVF Program
Section XI	Mental Health and Addiction Benefits
Section XII	Non-Covered Treatment

SECTION I - DEDUCTIBLES AND OUT-OF-POCKET

(2025 Changes are in RED)

Benefit	PPO Providers and OOA Members	NPPO (Out-of-Network Providers)
Annual Outpatient Deductible	PPO Providers - No Deductible	• $1,800 Individual • $4,800 Family
	Deductible applies to outpatient services only. Order of benefit payment: deductible must be met first then copays and coinsurance apply.	
Annual Out-of-Pocket (OOP) ** *Separate limits apply to PPO and NPPO services. OOA OOP limit is subject to the PPO OOP limit and benefit schedule.*	PPO Inpatient/Outpatient copays and coinsurance combined is limited to (INCLUDES hospital copays): • $1,500 per individual • $3,000 per family	NPPO Inpatient/Outpatient (Includes: coinsurance hospital copays and deductible; applicable to all NPPO providers): • $2,700 per individual • $5,200 per family
	** Limited Benefit Exclusion from Out-of-Pocket Limit: Coinsurance and excess charges for any limited benefit is not subject to the Plan's out-of-pocket limits nor is it credited towards the out-of-pocket limit. Copays always apply towards your out-of-pocket, unless the copay is for a limited benefit, e.g., chiropractic copays. Limited benefits are considered "ancillary benefits" and include alternative providers, acupuncture, chiropractic, holistic medicine, Lasik benefit, eye care, hearing aids, limited dental, infertility benefits, massage therapy, weight loss, and wellness benefits.	
Lifetime Limits	As of October 1, 2010, there shall be no lifetime limits.	
Benefit Year (Calendar Year)	The calendar year is the period used for all annual benefit limits (dollar amounts or number of visit limits). PPO and NPPO services are combined for most limits.	
Outpatient PPO Copay/NPPO Coinsurance	In-Network or Medicare Providers: $30 In-Network Mental Health PPO: $30 OOA copay for First Health or NPPO Providers: $30	30% coinsurance applies to both inpatient and outpatient services as designated for out-of-network services
Out-of-Area (OOA) (First Health Network Access)	Medical/Surgical Benefits: Will be paid in accordance with the PPO schedule based on the NPPO copays for all medical/surgical PPO providers and NPPO providers. OOA For Mental Health/Addiction Services: All other providers: $30, the same as for medical NPPO copay.	

SECTION I - DEDUCTIBLES AND OUT-OF-POCKET CONTINUED		
PPO Providers	KTF and MagnaCare PPO Providers are paid as in-network. Medicare providers for Medicare primary Members treated same as in-network PPO. Non-KTF or Non-MagnaCare PPO Providers: First Health is paid as out-of-network except for service outside of New York State with an out of New York State address on file with the KTF Compliance Office.	All other providers are considered out-of-network providers, including ancillary providers, unless a specific exception is made, e.g., anesthesia or emergency room treatment. If out-of-network providers are used, including ancillary providers, members may be responsible for excess charges.
Behavioral Health PPO Providers	Hospitals for behavioral and/or addictive treatment are limited to in-network hospital facilities. All other facilities are considered out-of-network hospitals for behavioral and addictive treatment. Both partial hospital and intensive outpatient programs are treated as an inpatient hospital stay. If a member is Medicare primary, any behavioral provider who accepts Medicare will be considered the same as a PPO provider. If Medicare is primary, you will pay more for services if you do not use a Medicare provider.	

SECTION II – ER, AMBULANCE, LAB, DIAGNOSTIC AND X-RAY		
Benefit	**PPO Providers and OOA Members**	**NPPO (Out-of-Network Providers)**
Emergency Room Copay *If admitted, charges are paid per PPO or NPPO schedule, hospital copays, and NPPO coinsurance apply.*	Emergency Room *(in and out-of-network)*: $100 *($125 for non-acute emergency)* Emergency room copay is waived if admitted within 24 hours in the U.S., U.S. territories, Canada, or Mexico. After admission, hospital copays and coinsurance apply based on whether the provider is a PPO or NPPO facility. A Foreign Copay of $250 also applies to emergency room admissions outside the U.S., U.S. territories, Canada, or Mexico. Ancillary ER providers in a PPO hospital will be covered at the in-network level up to allowable charges. The Plan considers this "reasonable compensation," and this follows Section 1302(a) (4) (E) of the Patient Protection and Affordable Care Act/Reconciliation Act of 2010. *(See also Urgent Care – Section IV.)*	
Foreign Copay	$250 annual foreign copay applies to emergency room, outside Canada and Mexico, in addition to the emergency copay, NPPO deductible, and coinsurance. Foreign services are not covered unless preauthorized in advance of service except for emergency treatment and extended treatment following an emergency admission where medically necessary. Travel insurance is always primary to this Plan.	
Air Ambulance (In or Out-of-Network)	$250 copay applies in the case of an acute, life-threatening emergency. Non-life-threatening situations will be covered at 50%. Maximum benefit is limited to $200 per air mile for medical support staff and equipment or the prevailing rate for the service area for network providers as determined under NY Insurance Law 5108(A) pertaining to claims resulting from a vehicular accident, allowable charges are limited to the Workers Compensation Schedule and excess charges may not be balance billed. Air ambulance transportation is covered if medically necessary for a life-threatening condition and no other transport is appropriate. Complete documentation is required.	
Ambulance and Paramedic Services (Also subject to NY Insurance Law (A))	Transport is limited to medically necessary transportation. Ambulances must be licensed by the state in which they operate. Ambulance service used to transport a covered family member from a hospital or other health care facility to an inpatient confinement at another hospital or health care facility and home is covered when medically necessary, subject to prior authorization by the prior authorization office. Paid at 100% *(Paid at 50% for non-emergency, except for intra facility transfers that are medically necessary, which will be paid as any other benefit at 90 %.)*	

SECTION II – ER, AMBULANCE, LAB, DIAGNOSTIC AND X-RAY CONTINUED		
Benefit	**PPO Providers and OOA Members**	**NPPO (Out-of-Network Providers)**
Emergency Detoxification	Detoxification is covered the same as any other benefit provided the member, subject to hospital copay and completion of an addiction treatment program after detoxification. If the treatment program is not completed, detox benefits are paid at 50%.	NPPO hospital copay and 30% NPPO coinsurance applies to all inpatient services after copay.
Lab *(See Complex Testing & X-ray.)*	Preventive lab tests are covered at 100% in-network only. Inpatient tests are covered as part of hospital charges.	30% coinsurance applies to outpatient NPPO services after NPPO deductible is met.
Preadmission Testing/X-rays	Paid at 100% if performed within 48 hours of scheduled surgery in a PPO facility or with a PPO surgeon.	NPPO deductible and 30% coinsurance apply to all outpatient NPPO services after deductible.
Urgent Care	The PPO outpatient copay of $30 applies to in-network urgent care facilities only. The OOA copay applies to OOA members and to urgent care visits preauthorized while traveling outside the coverage area.	NPPO deductible and coinsurance of 30% applies to all outpatient NPPO services. Coinsurance limited to NPPO Out-of-Pocket (OOP) limit.
X-rays and Diagnostic Tests (Outpatient) *All complex testing and other diagnostic tests exceeding $2,500 are subject to prior authorization.*	Outpatient PPO copay applies to X-rays or tests not exceeding $2,500. $100 copay applies for tests or X-rays over $2,500, including complex CT scans, MRI, and other complex testing performed on an outpatient basis *(excluding preadmission X-ray or testing.)* Copay applies to all tests done on single day.	NPPO deductible, then 30% NPPO coinsurance applies to all outpatient NPPO services. Coinsurance limited to NPPO Out-of-Pocket (OOP) limit.

SECTION III – INPATIENT HOSPITAL & SURGICAL BENEFITS		
Benefit	**PPO Providers and OOA Members**	**NPPO (Out-of-Network Providers)**
Inpatient Hospital Copay ** *(Subject to PRIOR authorization, medical necessity, and concurrent review for medical and mental health treatment) Surgical copay also applies if surgery is performed on an inpatient basis.*	KTF or MagnaCare ** Hospital Copay: $50 per day up to $250 per admission (waived for Healthy Beginnings). First Health for OOA members only - OOA Copay: $50 per day up to $250 plus surgical copay (if applicable). Hospital copays are credited to and subject to the out-of-pocket limit.	NPPO Hospital Copay: $500 up to the maximum of $1,000 in any calendar year plus 30% Coinsurance up to the NPPO Out-of-Pocket Limit. **As of 1/1/2013 NPPO deductible, coinsurance, and copays (**including hospital copays**) are included in and subject to the NPPO OOP limit.
Surgical Copay *(Waived for Healthy Beginnings Enrollees for PPO Providers only)*	KTF or MagnaCare Providers: $100 ** First Health – paid as NPPO if you are not outside of New York State. Surgical copay applies to both inpatient and outpatient surgery and is in addition to the hospital copay for inpatient surgery.	NPPO Deductible applies first and then a $250 copay (**Inpatient and Outpatient**), followed by 30% coinsurance.
Anesthesia *Members are advised to verify the PPO status of anesthesia providers PRIOR to surgery.*	Anesthesia is paid at 100% up to allowed charges (in or out-of-network) for all providers. When two anesthesiologists bill, one as the supervising anesthesiologist and one as the CRNA, each anesthesiologist will be paid at 50% of the allowed rate per AMA rules. Providers are violating AMA rules if they attempt to balance bill you for the other 50%. Member is responsible for excess charges for out-of-network providers unless the provider agrees to write them off. Members should discuss the anesthesia services PRIOR to surgery.	
Cataract Surgery	100% after surgical copay (standard lens). Premium lens is paid at 80% up to maximum benefit of $1,000 per lens. Medicare only covers standard lens.	
Multiple Surgical Procedures	If more than one surgery/procedure is performed using the same incision, the second procedure will be paid at 50%, the third and fourth procedure at 25%. Assistant Surgeon charges are limited to 25% of the surgeon's allowed charges and surgical center or facility is paid at 100% for PPO providers.	
Lasik Surgery (PPO or NPPO)	Shall be covered at 50% up to a maximum benefit of $750 per eye every five (5) years. Deductible waived for PPO and NPPO providers. PPO surgical copay applies. Coinsurance does not apply toward out-of-pocket (PPO or NPPO).	

SECTION III – INPATIENT HOSPITAL & SURGICAL BENEFITS CONTINUED		
Benefit	**PPO Providers and OOA Members**	**NPPO (Out-of-Network Providers)**
Skilled Nursing *(Nursing home, custodial and long-term care is not covered.)*	Paid at 100% after hospital copay. A second hospital copay does not apply if a patient is transferred directly from the hospital to a skilled nursing facility following an illness or surgery.	Subject to deductible and 30% coinsurance. Limited to maximum of 100 days (PPO and NPPO combined). Extended benefits are not available for out-of-network.
	Available days are pro-rated for benefits paid as secondary. If benefits are exhausted under the primary plan and this Plan becomes primary, benefits must be preauthorized. Maximum benefit is 100 days. Days paid as secondary shall be pro-rated and will count towards the 100-day limit. **Lifetime Extended Benefit**: Case Management may extend benefits for a PPO provider only, for an additional 60-day lifetime maximum, at the sole discretion of the Plan, based on medical necessity. This does not apply to nursing homes or other long-term care services once the patient reaches maximum medical improvement. **Extended Benefit Copay**: The per visit copay is the same as the Medicare Skilled Nursing copay ($209.50 effective 01/01/2025) and is not credited to or subject to the out-of-pocket limit.	
Surgical Center	Facility charges are paid at 100%.	Subject to deductible and coinsurance for outpatient surgery.
Transplants *(Donor Expenses)*	Donor fees to recover an organ or stem cells for a transplant procedure will be paid at 80% after $500 copay up to a maximum of $25,000. If the donor is a family member or both donor and recipient are Plan members, donor expenses are paid at 100%. Transplant recipient's plan is always primary and payment under this Plan will only be made after payment by primary plan.	Subject to NPPO hospital copay then 30% coinsurance for out-of-network facilities. Outpatient Services are subject to NPPO deductible then 30% coinsurance.
Transplants *(Donor Testing)*	Bone marrow and stem cell testing are covered at 100% up to 4 donors. Testing after 4 donors is paid at 80%.	Subject to NPPO deductible (outpatient) or hospital copay (inpatient) and 30% coinsurance.
Transplants (Surgery) *(Subject to prior authorization and Plan approval for Centers of Excellence)*	All transplant expenses (inpatient and outpatient) are paid at 100% if Centers of Excellence are used; travel expenses for the member's family are reimbursed at 80% up to $100 per day while the member is confined. Other PPO Providers: Normal hospital, surgical, and outpatient copays apply.	Subject to NPPO hospital copay then 30% coinsurance for out-of-network facilities. Outpatient services are subject to the NPPO deductible then 30% coinsurance applies.

SECTION III – INPATIENT HOSPITAL & SURGICAL BENEFITS CONTINUED		
Benefits	**PPO Providers and OOA Members**	**NPPO (Out-of-Network Providers)**
Transplants (Transportation Expenses) *(Subject to prior authorization)*	Covered at 100% to receive a donor organ or stem cells up to $10,000.	Outpatient services are subject to the NPPO deductible then 30% coinsurance applies.
Voluntary Abortion *(Prior authorization is required)*	Only covered in the case of medical necessity due to documented rape, incest, or when necessary due to mother's health, to preserve the life of the mother, or when the life, health or "viability" of the fetus is in question. The abortion may be performed with impunity and without punishment within first 24 weeks upon the advice of M.D. and prior authorization by the Plan.	
Voluntary Sterilization	Covered subject to surgery or hospital copay depending on whether performed while inpatient or on outpatient basis. Covered at 100% if performed during a C-section delivery.	Outpatient Services are subject to the NPPO deductible, and then 30% coinsurance applies.
Weight Loss Surgery	Member must be enrolled in a supervised weight loss program for a minimum of 12 months prior to authorization of any bariatric, lap band, or other stomach bypass-type surgery and undergo counseling regarding the possible side effects of such procedure.	

SECTION IV – PREVENTIVE BENEFITS PAID AT 100% - PPO ONLY

PPO deductible or copays do not apply to these benefits when using a PPO provider. Any preventive or wellness visits in excess of those provided below are not covered unless they are medically necessary and such diagnostic benefits will be subject to the normal plan copays and/or deductibles. Diagnostic procedures are not considered "preventive" benefits except as specifically provided and will be subject to the normal plan copays and deductibles. Preventive benefits are only covered at 100% when the services are provided by in-network (PPO) providers. (***See Part C for Preventive Benefits Notice**.)* Preventive benefits mandated by PPACA are subject to change. Only in-network PPO providers are covered for preventive visits. Special PPO rules apply for out of area (OOA) members and Medicare primary members. Medicare members may use any Medicare provider for preventive care.

- Allergy Injections (with no office visit.)
- Annual Adult Physical (age 19 and older) - Two preventive exams, including well woman and Ob/Gyn care. Excess preventive benefits are not covered. (*See Well Child Care to 19.)*
- Breast Cancer Screening (CT scan – limited to one per year or as medically necessary.)
- Breast Feeding (counseling, supplies, and equipment) (See Part C Notice on Preventive Benefits and Coverage.) (Also, see Well Woman Care.)
- Birth Control (pills, diaphragm, patch) generic birth control pills and covered contraceptives, with a prescription and filled at a covered pharmacy, are covered with no copay.
- Assistant Surgeon (limited to 25% of primary surgeon's allowed charges).
- Bone Density or Osteoporosis exam (one per year after age 50).
- Chemotherapy/Radiation or other infusion therapy – prior authorization is required; copays for Rx drugs apply. Physician office visit copays are waived during treatment.
- Cholesterol Screen with no office visit (up to 4 times per year).
- Colonoscopy, Endoscopy, Sigmoidoscopy (every 5 years after age 45) shall be covered, including all related charges. All others shall be subject to normal diagnostic exam copay and related copays.
- Diabetic Supplies for Enrolled Diabetics – (See Diabetic Schedule and special rules for Medicare primary members for supplies covered by Medicare Part B.) (Also, see Rx Schedule.)
- Dialysis (including home dialysis.)
- Durable Medical Equipment (DME) - prior authorization required if expected to cost over $500. *(See exclusions under Definitions and Exclusions Section.)* Certain durable medical supplies may be covered as major-medical drugs. (*See Rx Schedule of Benefits.)*
- Facility or Ambulatory Surgical Center Charges - Includes hospital outpatient surgical center, copays apply for X-rays and diagnostic tests.
- FTS (Downs Syndrome Test) – limited to one test during the first trimester only.
- Genetic (Level II) Obstetrical Ultrasound (limited to one test per pregnancy). All other genetic testing must be preauthorized and is covered as Any Other Benefit.
- Hearing Screening for all newborns.
- Hospice (limited to 210 days per spell of illness/ injury.) More than 180 days must elapse between each hospice confinement. When coordinating benefits with another plan, available visits will be prorated to reflect partial benefits paid as secondary plan. (e.g., if primary plan is limited to 100 days and this Plan pays 30% as secondary, once primary insurance benefits are exhausted, this Plan's limit would be prorated to 190 days.)

PREVENTIVE BENEFITS CONTINUED

- Immunizations (per Health Care Reform Guidelines for children and adults - *See Addendum A.*)
- Injections (non-insulin injections) – office visit copay applies if office visit is billed.
- Lab Tests – Preventive only lab tests and those performed during a physician's office visit and included in the office visit. All other lab tests performed by a PPO Provider are subject to the Physician Office Visit copay. *(See Section II.)*
- Mammogram (one per year after age 40)
- Maternity – Healthy Beginnings Prenatal Program (must enroll during first 14 weeks or within 60 days of coverage). Paid at 100% after first copay and office visit. Hospital and surgical copays are waived. Members must remain active and respondent to the program throughout the pregnancy to remain enrolled. Contact the prior authorization department to enroll in the program.
- Prenatal Visits– these services are covered under Well Woman Care as set out by Health and Human Services (HHS) guidelines.
- Nutrition Counseling – limited to 10 visits per year 20 visits if enrolled in the diabetic program.
- Pap Smear/Prostate Exam – limited to two per year separately or as part of your annual physical.
- Physical Therapy (Inpatient) – Must be preauthorized. Limited to 30 visits per therapy while confined. Extended treatment may be approved for an additional 20 visits, if medically necessary and the patient has not reached maximum medical improvement, subject to prior authorization.
- Prenatal Ultrasound (limited to one per pregnancy unless medically necessary.)
- Preventive Treatment as mandated by the Patient Protection and Affordable Care Act shall be covered as required. (*See Part C for information on preventive benefits.)*
- Preventive Vaccinations per PPACA requirements shall be covered at 100%. Any changes to the recommended vaccinations (deletions and/or additions) will automatically be incorporated as of the required implementation date. *(See Part C for more information on preventive benefits.)*
- Well Child Care to 19 – well care visits are covered, limited to 7 visits to age 1, then 6 visits per year ages 1 to 19. Non-routine well care or diagnostic visits are subject to office visit copay.
- Well Woman Care – *(See Part C – Notice on Preventive Benefits for Plan Years Beginning after August 1, 2012.)* Office visit copays apply if other services are provided, other than well woman care (mammogram, Pap smear, annual checkup). Well woman services can be combined in a single visit.

SECTION V – PPO OUTPATIENT BENEFITS

KTF, MagnaCare, OOA Members and Medicare - Outpatient Copays: $30

- Acupuncture or Chiropractic Office Visit - prior authorization is required for excess acupuncture visits over 6 or excess chiropractic visits over 12. The maximum benefit is limited to $100 per visit for acupuncture and $75 per visit for chiropractic after the copay. The maximum benefit applies to all modalities and/or treatments received during any office visit and are limited to one visit per day for all acupuncture, chiropractic, and physical therapy providers. Benefits for acupuncture, chiropractic, and massage therapy are limited to $2,500 per benefit year.
- Addictive and/or Behavioral Counseling/Therapy. Copay applies to each visit. Counseling includes outpatient counseling and group therapy as approved by the prior authorization department. Intensive outpatient therapy and partial programs are treated the same as any other inpatient or hospitalization program. *(See Section XI.)*
- Allergy Testing and Treatment (excluding allergy injections)
- Alternative Providers - Normal office visit copay applies; maximum benefit is limited to $500 combined for PPO and NPPO. NPPO providers are paid at 70% after deductible.
- Any Other Benefit – Medically necessary benefits not listed under the PPO schedule (subject to prior authorization) are payable at 90% in-network (70% out-of-network after NPPO deductible)
- Biofeedback – prior authorization is required.
- Cardiac Rehab – Office visit copays apply to all provider office visits; maximum 40 visits; subject to prior authorization after 6 visits.
- CT Low Radiation Lung Cancer Screening (one every two years or as medically necessary)
- Diagnostic Testing – (See Section II – X-rays and Diagnostic.)
- Eye Exam - One routine eye exam is covered annually (each calendar year) after office visit copay. This Plan is secondary to any standalone vision exam. Applies to PPO and NPPO providers, deductible waived. (*See also Eye Care in Section VI for glasses and contacts benefits.)*
- Genetic, Infertility or Impotence Testing – Basic infertility testing is covered the same as any other test. Genetic testing must be medically necessary and preauthorized prior to treatment.
- Hearing Exam is covered once every five years or when medically necessary.
- Home Health Care is limited to 200 visits per calendar year and 4 hours equals one visit paid at 100% after office visit copay. When coordinating benefits with another plan, available visits will be prorated to reflect partial benefits paid as the secondary plan. (e.g., if primary plan is limited to 100 days and this Plan pays 30% as secondary, once primary insurance benefits are exhausted, this Plan's limit would be prorated to 190 days.) Prior authorization is required for all home health care and the care must be medically necessary, not custodial. Copay applies to each visit until out-of-pocket is met.
- Home Health Extended Benefits - Up to 50 additional lifetime visits, subject to medical necessity and prior authorization. Normal copay continues to apply but is not credited to or subject to the OOP.
- Home Infusion Therapy is covered when medically necessary, subject to prior authorization.

- Impotence or Erectile Dysfunction – is limited to the diagnostic testing for the condition and oral medication under the prescription drug plan. The maximum benefit for the treatment of this condition is limited to $2,000 per year for prescription drugs, including any alternative medication, such as hormone implants paid under the major-medical plan. Hormone implants are subject to prior authorization and medical necessity.
- Lab Tests (Diagnostic) – PPO copay applies to tests not exceeding $2,500. $100 copay applies for tests over $2,500, subject to prior authorization. (*See Section II and Section IV for preventive lab tests.)*
- Laser Therapy – For conditions where a cure is not expected but may minimize the condition, is limited to $2,500 annually (e.g., vitiligo)
- Massage Therapy – Maximum benefit limited to $70 per hour/$35 for 1/2 hour visit up to 15 visits a year. You must have a script from the provider prior to treatment. Members are responsible for PPO copay plus excess charges over $70.
- Mental Health Counseling – Copay applies to each visit. Counseling includes outpatient counseling and group therapy as approved by the prior authorization department. Intensive outpatient therapy and partial programs are treated the same as any other inpatient or hospitalization program. *(See Section XI.)*
- Maternity (Prenatal Program) – Normal office visit and hospital copays apply if patient does not timely enroll in the Healthy Beginnings Prenatal Program during the first trimester or 14 weeks. Routine nursery care is covered under the baby's own claims and is subject to per diem hospital copay. All non-routine nursery care, whether enrolled or not in the prenatal program, will be paid under the baby's own claim, subject to the hospital copay. Contact the prior authorization department to enroll in the program.
- Orthotics – Maximum benefit limited to $500 per year, subject to office visit copay.
- Pain Management Therapy - Subject to prior authorization after 6 visits per benefit year, subject to copay. Benefits will be based on medical necessity, appropriateness of care, and measurable improvement for continued care based on a stated treatment plan, as provided by a doctor.
- Physical Therapy (Outpatient) – Must be preauthorized as medically necessary for the first six (6) visits and any additional visits, in blocks on ten (10) to a maximum of 50 total visits per benefit year. Must be performed by a licensed therapist or physician. Benefits will be based on medical necessity, appropriateness of care, and measurable improvement for continued care based on a stated treatment plan, as provided by the doctor. (*See also Vision Therapy below.)*
- Physician Office Visit (also Urgent Care), Occupational Therapy, Speech Therapy and Cognitive Therapy – Must be preauthorized after 6 visits for any single provider, if not preauthorized as part of an ongoing treatment program for cancer, chemotherapy or any other chronic or serious ongoing medical condition (applies to visits after July 1, 2010). Single copay applies to all charges billed during visit (office visits with charges over $500 will incur a $100 copay), includes acupuncture, chiropractors, dermatology, osteopaths, podiatrists (for non-routine foot care), and other licensed medical providers for non-preventive visits.
- Prosthetic appliances and orthopedic braces must be preauthorized if cost exceeds $1,500, paid at 100%, copay waived. (Including cranial helmets.)
- Podiatry (foot care) Office Visits – Includes injections and non-routine foot care. Trimming of nails and non-routine foot care (except for diabetics or if medically necessary) are not covered.
- Temporomandibular Joint Syndrome (TMJ) – is paid at 90%. Member coinsurance is not credited towards your out-of-pocket limit. Non-surgical treatment and diagnosis of degenerative joint

disease up to $2,500 lifetime maximum. If TMJ is covered under the Dental Plan, this Plan will be the secondary plan.

- Vaccines (Routine, Non-Preventive) – subject to office visit copay. Special vaccines and immunizations required for work, travel, or school are not covered.
- Vision Therapy is covered to treat visual problems such as lazy eyes, crossed eyes, double vision, convergence insufficiency, and some reading and learning disabilities that interfere with reading, learning, and educational instruction.
- Urgent Care – (*See Physician Office Visit and Section II – Emergency Care.)* Must be preauthorized if using a NPPO facility while traveling outside primary coverage area.
- Wigs (including cranial prosthesis) – scalp hair prosthesis for hair loss due to chemotherapy is covered up to a maximum of $350 for one wig per spell of illness.
- X-rays – (See Section II.)

SECTION VI – OTHER PPO/OOA BENEFITS

- Benefits While Residing Outside the U.S. – (subject to Plan approval for retirees only) – Benefits are paid per the NPPO schedule and will also be subject to annual $250 foreign coverage copay. Allowed charges for any foreign charges are limited to what would have been allowed by Medicare once the member is Medicare primary, maximum benefit paid by this Plan takes into account what Medicare would have paid. Exchange students or dependents living abroad are not covered except for emergency services. Individual foreign coverage should be purchased for any student planning to study abroad.
- Dental (limited benefit) – Removal of impacted wisdom teeth (subject to surgical copay) and accidental injuries treated within 12 months are paid as any other medical benefit. Other oral surgery and bone grafts for dental implants are not covered under the medical plan but may be covered under the dental plan. Jaw surgery due to genetic defect or medical condition (including TMJ) is subject to prior authorization and treated as any other surgery. All other dental related procedures are not covered under this Plan.
- Eye Care (limited benefit) – Eyeglasses and/or contacts are covered at 50% up to a maximum benefit of $300 per year. Coinsurance excluded from the out-of-pocket limit. Copays and deductibles are waived.
- Foreign Travel/Foreign Coverage – Emergency care is subject to emergency copay plus foreign travel copay of $250 per injury or spell of illness. The foreign copay is not credited to or subject to the out-of-pocket limit. If confined due to an emergency admission or if follow up care is medically necessary, all claims will be paid per the NPPO Schedule of Benefits. Non-emergency care is not covered while traveling or residing outside of the United States or any U.S. territory unless approved by the Plan.
- Hearing Aids – (Limited Benefit) – Plan will pay 100% (PPO & NPPO) of the cost of any hearing aid(s) up to $1,500 for a single hearing aid or $3,000 for a pair of hearing aids every five (5) benefit years. The batteries are not covered. Member is responsible for excess charges. Hearing aid for children up to age 22 is limited to $1,000 per calendar year. Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as surgically induced malformation or congenital malformation), limited to $1,000 per calendar year, per ear.
- Holistic Rx (NPPO deductible waived) – Plan will pay 80% up to a maximum of $500 for both PPO and NPPO pharmacies as a major-medical benefit claim. Members must file a claim for reimbursement.
- Major-medical Rx – Drugs will only be covered under the Rx program through the Prescription Benefits Manager, unless this Plan is secondary, or the drugs are not available through the Prescription Benefits Manager (ostomy supplies or infertility drugs). Any drugs covered as a major-medical drug will be covered at 80%, subject to deminis copay rules. Infertility drugs are subject to prior authorization and are only covered under the Infertility Program. Drugs for ED (Erectile Dysfunction) such as hormone implants must be preauthorized and will only be covered up to a combined maximum benefit of $2,000, including those drugs for that condition under the Rx Plan. Female hormone implants are not covered. Patient is responsible for any costs in excess of the annual dollar limit for such drugs. Durable medical supplies such as ostomy supplies are covered as major-medical Rx.
- Medical Marijuana for Pain Management – (*See Section VII for Prescription Drugs.)*

SECTION VI - OTHER PPO/OOA BENEFITS CONTINUED

- Skilled Nursing – *(See Section III.)*
- Sleep Apnea – Testing is covered as any other diagnostic test subject to the applicable copay and prior authorization. Sleep apnea equipment is covered as Durable Medical Equipment, subject to prior authorization. Sleep apnea supplies are covered as durable medical supplies and as major-medical Rx.
- Transportation cost back to the United States is not covered, except for acute emergencies, NPPO coinsurance for all charges related to transporting an individual back to the U.S., if medically necessary.
- Weight Loss Incentive Program – Healthy Lifestyle – Wellness Program (enrollment required) – (Limited Benefit)
- For any member or their spouse who is at least 20 pounds over their recommended weight, they will be reimbursed a Fitness or Wellness Benefit of $150 for 15 to 25 lbs., $200 for 26 to 50 lbs., and $250 for over 50 lbs. upon completion of successful weight loss program where there has been a minimum of 15 lbs. lost and maintained for a minimum of one year.
- The Weight Loss Program must be certified by an independent certified weight loss professional or M.D. You must enroll in the Weight Loss Program to be eligible for this program and provide monthly progress updates. Contact the prior authorization department or compliance office to enroll in the program.
- Wellness Benefit/Health Club Dues – (Limited Benefit) Members will be reimbursed at 100% up to $100 per year for single membership or $150 per year for member and spouse. Spouse and non-member spouses are limited to $50 membership reimbursement. Membership reimbursement not to exceed $150 per household unless dual members. Membership, while not actively covered, will not be considered. Claims must be submitted within one year after your 12 months of membership. This is an ancillary benefit and does not apply to and is not subject to out-of-pocket limit.

SECTION VII – NPPO (OUT-OF-NETWORK) BENEFITS	
All Outpatient Non-PPO Benefits are subject to NPPO Deductible first, unless specifically waived or paid same as PPO providers, such as for eye exam and hearing aids. After the deductible is met, NPPO benefits are subject to NPPO coinsurance until the NPPO Out-of-Pocket is met. Members are responsible for billed charges that exceed this Plan's allowable/eligible charges for benefit payment.	
NPPO Outpatient Deductible	$1,800 individual/$4,800 family per Benefit Year (Calendar Year.) After the deductible is met, the member is responsible for 30% coinsurance up to allowed charges until NPPO out-of-pocket is met, then allowable charges are paid at 100%. Member is always responsible for excess charges over the allowed/eligible charges for benefit payment. The deductible does not apply to inpatient services.
NPPO Hospital Copay	$500 copay up to maximum of $1,000 per year, then balance of hospital charges is subject to 30% coinsurance up to Allowed Charges until NPPO out-of-pocket is met, then allowed charges are paid at 100%. Member is responsible for excess charges over the allowed/eligible charges for benefit payment.
Outpatient Surgery Inpatient Surgery	Deductible applies first and then the $250 copay, followed by the NPPO coinsurance.
NPPO Out-of-Pocket (OOP) Limit	$2,700 individual/$5,200 family (includes hospital copays, coinsurance, and deductible). The NPPO out-of-pocket limit is separate from and in addition to the PPO out-of-pocket limit. Once the OOP is met, allowed/eligible charges are paid at 100%; however, member is still responsible for excess charges.
Combined Deductible & NPPO Out-of-Pocket Coinsurance Limit	$2,700 individual/$5,200 family (includes hospital copays.) Specific annual dollar or visit limits apply to PPO and NPPO services combined.
Member Responsible for Excess Charges	*See Part B* for a complete description of how allowable charges are determined by this Plan. Members, including OOA (out of area) members, are responsible for excess charges if a NPPO provider is used, except when fees are negotiated by this Plan under a single case agreement with the provider prior to treatment. Excess charges are those charges as billed by the provider that exceed the allowable charges as defined by the Plan for purposes of determining benefits.

SECTION VII - NPPO (OUT-OF-NETWORK) BENEFITS CONTINUED

- **Alternative Providers** – **(Limited Benefit)** Combined benefit is limited to $500 for PPO and NPPO providers. NPPO providers are subject to the NPPO deductible and coinsurance. *(See Section IV.)*
- **Any Other Benefit** – Medically necessary benefits not specifically listed under the PPO schedule (subject to prior authorization) shall be payable at 70% out-of-network after the NPPO deductible.
- **Behavioral and Addictive Counseling/Therapy** – Subject to NPPO deductible and coinsurance. *(See Section XI.)*
- **Chiropractic and Acupuncture – (Limited Benefit)** is subject to the deductible and coinsurance up to a maximum benefit of $75 per visit. NPPO benefits are combined with PPO benefits with an annual maximum benefit of $2,500, including massage therapy benefits.
- **Durable Medical Equipment (DME)** – is paid at 70% up to allowable charges. NPPO deductible is waived. Any charges in excess of $500 must be preauthorized. *(See exclusions for certain DME that is not covered or is limited, e.g., blood pressure monitors, pillows, etc.)*
- **Emergency care** – is paid the same as the PPO emergency benefits.
- **Excess Outpatient Visits (Over 6) Must be preauthorized** – If office visits, physical or other therapy treatment, behavioral or addictive counseling exceed six (6) outpatient visits, those visits are subject to prior authorization and medical necessity. Members or providers may request a copy of the medical necessity criteria from the prior authorization department.
- **Eye Exam** – Paid same as PPO provider after PPO office copay, deductible waived.
- **Hearing Exam** – Subject to deductible and coinsurance.
- **Hearing Aids – (Limited Benefit)** Covered at 100% up to $1,500 (single) or $3,000 (pair) every 5 years. Deductible waived, not subject to out-of-pocket limit. Paid same as PPO benefit.
- **Inpatient Benefits** – Inpatient procedures are subject to NPPO hospital copay and NPPO 30% coinsurance, except where NPPO providers are specifically paid the same as PPO benefits. Specific benefits are paid the same for both PPO and NPPO providers, e.g., ambulance, air ambulance, anesthesia, and emergency room.
- **Limited Benefits –** are paid the same for both PPO and NPPO providers, unless otherwise noted under the specific benefit, but these benefits are not subject to the Plan's out-of-pocket limits nor is the member's coinsurance credited towards the out-of-pocket limit. Limited benefits include alternative providers, acupuncture, chiropractic, holistic medicine, Lasik benefits, eye care, hearing aids, infertility benefits, massage therapy, weight loss and wellness benefits.
- **Massage therapy** – **(Limited Benefit)** is paid with a maximum benefit of $50 after a PPO office visit copay. Subject to script from provider. Maximum benefit for acupuncture, chiropractic, and massage therapy is limited on a combined basis for PPO and NPPO providers.
- **Urgent Care** - PPO copay applies to network providers or NPPO urgent care facility while traveling, if preauthorized in lieu of emergency room for non-acute situations. Otherwise, use of an urgent care facility is subject to NPPO deductible and coinsurance.
- **Vision/Eye Care** – paid same as PPO vision benefit. NPPO deductible is waived. (*See Section VI for eye care benefits.)*

(For Non-Covered Treatment and Exclusions, See Section XII and Part B.)

SECTION VIII – PRESCRIPTION DRUG PLAN

PRESCRIPTION DRUG RULES FOR RETAIL AND MAIL ORDER RX

You may use your KTF ID card only when this Plan is the individual's primary Rx plan. **Members are liable for reimbursing the Plan for drug charges for any covered member if another plan is primary for Rx.**

When this Plan is your Secondary Rx Plan – Submit your Rx receipts or a printout from your pharmacy, along with a claim form, for reimbursement as Major-medical Rx to the KTF Compliance Office. All covered drugs with a copay or coinsurance in excess of $15 are reimbursable at 80% until you reach your PPO out-of-pocket limit, then they will be covered at 100%. The Rx out-of-pocket limit does not apply to these drugs.

Medicare Part D – **The Sole Rx Plan** for any member with Medicare Part D Plan will be the Medicare Part D Plan. There is no coordination of benefits under this Plan with Medicare Part D.

Out-of-Pocket Limit on Rx Copays – When this Plan is primary, all covered drugs are paid at 100% when the Rx OOP limit is met ***(penalties for refusal to use mail order or generic drugs continue to apply after the OOP is met.)*** This only applies when this Plan is the primary plan for prescription drugs. The annual out-of-pocket limit on Rx co-pays (excluding penalties) shall be equal to 50% of the Medicare Part D OOP limit. For 2025, the non-Medicare member OOP limit is $4,000 and the Medicare member OOP limit is $2,000. This limit will be adjusted automatically each January 1. The OOP limits are separate from the medical and dental limits.

Rx While in Nursing Home – Request must be made to this Plan to have all Rx dispensed from a local pharmacy in blister packs. **Mail order requirement will be waived**. This Plan must be timely notified when a covered member is confined to a nursing home.

EXCEPTIONS TO DRUG POLICY/VACATION OVERRIDE

Request for an exception must be submitted in writing by your doctor with all relevant considerations and the medical necessity for such medication. Such requests will be treated the same as any other appeal. Exceptions will be at the sole judgment of the Plan based on medical necessity and all relevant facts. A written letter of medical necessity is required if you are unable to take certain generic drugs. Contact Four Corners Health if you are unable to take certain generic drugs. Contact Four Corners Health via 866-443-9331 if you need a vacation override for Rx or a request for medically necessary Rx.

MANAGE YOUR PRESCRIPTION DRUGS ONLINE – MAIL ORDER CHANGES

Please be sure to have payment information on file with Manifest Pharmacy and a current address to avoid problems. Rx may not be returned for credit. Call Manifest Pharmacy if you have a problem getting a mail order prescription. Contact Manifest Pharmacy at 888-770-4009 for address changes or change online for delivery of mail order drugs. You must notify the compliance office and submit address changes in writing (temporary and permanent) to change your mailing address for claims.

STEP THERAPY APPLIES TO CERTAIN DRUGS

This program requires you to try up to two (2) other drugs in the same therapeutic classification prior to approving a drug covered by the step therapy program. It is important for your provider to respond immediately to requests for medical information to avoid delays in filling your prescription. You are required to try the generic of any drug before getting a medical override for brand due to medical necessity.

SPECIALTY PHARMACY (MAIL ORDER ONLY) - PRIOR AUTHORIZATION REQUIRED

You or your provider should first call Four Corners Health. They will coordinate with your doctor to obtain specialty drugs through the Specialty Pharmacy.

- Specialty drugs provided during outpatient treatment are subject to prior authorization. (*See also Chemotherapy, Radiation, and Infusion Therapy under Medical Schedule of Benefits.)* All drugs costing over $1,000 are subject to prior authorization.
- Prior authorization and step therapy rules apply to any specialty medication costing more than $1,000, including requests for a waiver of the failure to use generic drugs due to medical necessity.
- Call Four Corners Health via 866-443-9331 for information. Pharmacists specializing in your illness are available for consultation for you and your provider.
- Specialty drug copay (mail order only) is 20% per treatment per 31-day supply. This percentage will apply to the Rx OOP limit. This includes chemotherapy and/or radiation specialty drugs. Specialty drugs must be ordered through this Plan's contracted drug provider.

PENALTY FOR FAILURE TO USE GENERIC WHEN AVAILABLE

Mandatory Generic Substitution Rules Apply – Copay is the cost of the generic copay PLUS the cost difference between brand and generic if you do not use generic in lieu of brand drugs when available. Generic drugs (AB-rated only) will be automatically substituted for any brand drug unless you elect to pay the additional copay. This includes prescriptions written "DAW" (dispense as written). The copay will be the cost of the generic copay PLUS the cost difference between brand and generic unless a medical necessity override is in place based on a physician's documentation of adverse reaction or ineffectiveness of the generic. Your copays will continue to be the cost of the generic copay PLUS the cost difference between brand and generic after you meet the Rx out-of-pocket limit.

PENALTY FOR FAILURE TO USE MAIL ORDER FOR MAINTENANCE DRUGS

Mandatory Mail Order Required – Copays will be doubled on non-restricted drugs per pharmacological guidelines, including insulin and diabetic supplies, if you do not use mail order on any maintenance drug not filled after the third refill. If you choose to use a local pharmacy to fill your prescriptions, you will pay more for your drugs.

Only one-half of your copay is credited towards your out-of-pocket. Your copays will continue to double if you use retail pharmacy instead of mail order even after you meet your Rx out-of-pocket.

<table>
<tr><th colspan="4">RX COPAYS (WHEN KTF IS PRIMARY RX PLAN)</th></tr>
<tr><td><u>Maximum Out-of-Pocket Limit on Copays for Retail and Mail Order Rx Only, including Specialty Drugs: $4,000 non-Medicare member; $2,000 Medicare member (excludes penalty copays)</u>
Mandatory Mail Order and Mandatory Generic Rules apply.</td><td>Retail Copay
(31-DS)</td><td>Mail Order Copay**
(93-DS)</td><td>Out-of-Pocket (OOP) Limit on Copays or Coinsurance</td></tr>
<tr><td>Generic Drugs</td><td>$15</td><td>$20</td><td rowspan="4">$4,000 non-Medicare member
or
$2,000 Medicare member</td></tr>
<tr><td>Preferred Brand Drugs**
Non-Preferred Brand Drugs**</td><td>$25
$60</td><td>$50
$120</td></tr>
<tr><td>Specialty Drugs – Must be ordered through the Specialty Pharmacy and be preauthorized.</td><td>N/A</td><td>20% per 31-day supply</td></tr>
<tr><td>Multi-Source Brand where script is written DAW (dispense as written), or generic is refused without medical necessity override. Step Therapy may be required.</td><td colspan="2">Cost of generic copay plus cost difference between generic and brand.</td></tr>
<tr><td>Nursing Home Patients - Must apply for override for blister packs to be filled locally by independent pharmacy that supplies Rx for Nursing Homes.</td><td colspan="2">Normal Copays and OOP limits apply.</td><td rowspan="3">OOP does not apply. Subject to maximum benefit.</td></tr>
<tr><td>Enteral Formulas/Food Supplements – Maximum annual benefit is $2,500.</td><td colspan="2" rowspan="2">Paid as major-medical at 80% with 20% coinsurance.</td></tr>
<tr><td>Holistic Drugs – Maximum Benefit is $500.</td></tr>
<tr><td>Impotency Drugs</td><td colspan="2">Normal copays apply. The maximum benefit is $2,000 per year. Members pay 100% of costs after $2,000.</td></tr>
<tr><td>Infertility Drugs – Must submit for reimbursement as a major-medical Rx.</td><td colspan="2">Subject to annual and lifetime limit on infertility drugs. Paid at 80% under your infertility benefit.</td><td>Not subject to out-of-pocket limit.</td></tr>
<tr><td>Compound Drugs – Must be preauthorized through Four Corners Health.</td><td colspan="2">Brand Copay</td><td>$4,000 non-Medicare member or
$2,000 Medicare member</td></tr>
</table>

RX COPAYS (WHEN KTF IS PRIMARY RX PLAN) CONTINUED	
Preventive Medications	*(See Part C – Preventive Benefits Notice.)* Certain preventive medications are paid at 100% with no copay.
Major-medical Drugs – must submit for payment or reimbursement.	Paid at 80% as Major-medical benefit. Also applies to Rx when this Plan is the secondary prescription drug plan.
**Members are not enrolled for Medicare Rx benefits until AFTER the Plan receives a copy of their Medicare ID Card and updated enrollment information. (No retroactive adjustments will be made.)	

DIABETIC SUPPLIES COVERED AT 100% - SPECIAL RULES FOR MEDICARE PRIMARY DIABETICS ##	
Glucophage & Glucophage kits Metformin Inhaled Insulin devices (Inhalers) Insulin (except for an insulin pump) Supplies for administration of insulin Syringes Needles Alcohol swabs Gauze	Insulin pump ## Blood sugar (glucose) testing monitors ## Blood sugar (glucose) test strips ## Lancet devices and lancets ## ## These supplies are not covered for Medicare primary diabetics as these supplies are covered by Medicare Part B at 80% and this Plan pays 20%.

MAIL ORDER PHARMACY AND MEDICARE PRIMARY MEMBERS DIABETIC BENEFITS

The following diabetic supplies and drugs should be ordered through Manifest Pharmacy Mail Order and are covered at 100% for all enrolled diabetics unless you elect a Medicare Part D Drug Plan.

- Supplies for administration of insulin (Syringes, Needles, Alcohol swabs, Gauze)
- Inhaled Insulin devices (Inhalers)
- Insulin (except insulin for an insulin pump)
- Glucophage
- Metformin

For Medicare Primary Members, the above drugs ## are covered by Medicare Part B. You may order these drugs from a mail order pharmacy or get them at your local pharmacy. Your pharmacy must be able to accept your Medicare card for payment at 80%. The pharmacy must be able to "bill" this Plan as your secondary drug plan or you must submit your pharmacy coinsurance of 20% to this Plan for reimbursement as your secondary drug plan.

Non-Medicare primary diabetics must order their supplies through Manifest Pharmacy.

You must contact Medicare for a list of pharmacies that will bill Medicare. After the pharmacy bills Medicare, they will then bill this Plan for the balance and will ship your diabetic supplies to your door. Medicare is primary for the above diabetic supplies under Medicare Part B and this Plan is secondary.

COVERED DRUGS INCLUDE
• Any drugs, including specialty drugs, as preauthorized by the Plan. • Birth Control Pills – Including oral contraceptives, Systemic, Non-Oral (IUD, NuvaRing, Ortho Evra Patch) and Contraceptive Injections. Injectable contraceptives, Nor-Plant and other contraceptive devices are covered as a Major-Medical expense. *(See Section II.)* • Compounded medications when at least one ingredient is a legend drug and federal legend drugs EXCEPT for state restricted drugs must be preauthorized through Four Corners Health. • Hemophilia factors, except as covered under a specialty drug program. • Holistic Prescription Drugs (Limited Benefit) – Are covered at 80% as a Major-Medical expense limited to a maximum benefit of $500 per year, including those from a non-PPO pharmacy. NPPO deductible is waived. • Growth Hormone Injectables – subject to prior authorization by the prior authorization department and are only covered if it is determined the Plan's medical necessity criteria is met. • Impotence (Erectile Dysfunction or ED) Rx – Covered the same as other Rx, limited to a maximum benefit of $2,000 a year, including ED drugs used for dual purposes secondary diagnosis of ED. • Inhaler Devices. • Insulin, needles, and syringes for enrolled diabetic members except for diabetic supplies covered under Medicare Part B for Medicare primary members. • Medical Marijuana for major illnesses (cancer, AIDS, MS, and Muscular Dystrophy) is covered only as a major-medical expense (where legal), reimbursable at 80% up to a maximum of $2,000, subject to medical necessity review from a provider in those states where it is legal. Step Therapy rules apply, subject to the NPPO deductible and coinsurance if this drug is only available from out-of-network providers. • OTC (over the counter) Diabetic supplies for enrolled diabetic members. • Prenatal vitamins and mega vitamins, if approved by the Plan, due to a serious or chronic ongoing medical condition when OTC (over the counter) vitamins are not appropriate. • Preventive medications as required by PPACA. (See Part C for information on preventive benefits.) • Preventive vaccines, biological, immunization agents or vaccines, Relenza, Tamiflu. Preventive vaccines are covered according to the medical plan. • Smoking cessation drugs. • Weight loss or anti-obesity drugs require prior authorization by the Rx prior authorization department.

EXCLUDED DRUGS

- All non-legend drugs, over the counter drugs, or drugs available without a prescription, except for certain durable medical supplies and diabetic supplies.
- Allergy Serums (Allergy injections are covered under the medical plan).
- Any prescriptions refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Baby Formula (prescription or non-prescription) is not covered.
- Blood or blood plasma products, including storage costs for blood, stem cells, etc.
- Charges for the administration or injection of any drug (covered as part of a routine office visit, subject to the normal copay). Medication that is to be taken by or administered to an individual, in whole or part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution that operates on its premises or allows an in-house pharmacy to be operated on its premises, or a facility for dispensing pharmaceuticals. Member or authorized representative must notify the Plan of nursing home status for a covered member, and they may request an override to permit the nursing home to obtain prescriptions from an independent pharmacy in blister packaging for a covered nursing home patient. The nursing home may automatically enroll the patient in Medicare Part D if the patient is covered by Medicare and Medicaid. If a member is enrolled in Medicare Part D, there will be no Rx covered under this Plan.
- Contraceptive jellies, creams, foams, devices, implants, Mifeprex.
- Cosmetic medication including but not limited to anti-wrinkle medications, dermatological medications, hair growth and other growth medications or any drug FDA approved for cosmetic use only, including drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®), or for cosmetic purposes (e.g., Renova®, Vaniqa®, Tri-Luma®, Botox-Cosmetic®, Solage, Avage®.)
- Drugs labeled "Caution: Limited by Federal law to investigational use," or experimental drugs, even though the individual is charged for these drugs.
- Enteral Formulas (prescription and non-prescription) or Food Supplements are generally not covered except for the following, subject to prior authorization and a written prescription from a provider that specializes in the treatment of such disorders. When the following food supplements are covered, they shall be paid as Major-medical at 80% with a 20% coinsurance, up to a maximum benefit of $2,500 a year. When enteral formulas are medically necessary as a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic physical disability, mental retardation, or death, if left untreated. Food Supplements, including modified solid food products for treatment of certain inherited diseases of amino acid or organic acid metabolism. The member's coinsurance for supplements will not be credited toward the out-of-pocket limit.
- Experimental drugs (non-FDA approved/unlabeled drugs), except for drugs prescribed during an approved experimental program as approved under ACA rules.
- Growth hormones, except as approved by the Plan due to medical necessity, which are related to a diagnosis where growth hormones are an accepted or recommended treatment.
- Infertility drugs are only covered under the Infertility Program and must be reimbursed as major-medical drugs under the fertility program per Plan rules. *(See Infertility Program for details.)*

EXCLUDED DRUGS CONTINUED

- Injectable drugs, except for insulin and other preauthorized drugs. Certain injectable medications may be covered by the Plan as a major-medical expense, such as certain injections by a physician. In such situations, the member must pay for the medication and a claim must be submitted to the Medical Claims Department for reimbursement. These drugs are not available with your Rx card or from mail order except when authorized (certain specialty drugs) by the Plan based on medical necessity.
- Light devices are not covered as Rx nor as Durable Medical Equipment (DME).
- Medical marijuana, except as expressly provided by the Plan, from licensed pharmacies.
- Medication, where cost is recoverable under Workers' Compensation or Occupational Disease Law, a State or Governmental Agency, or medication is furnished by another plan or agency at no cost to the member.
- Methadone and methadone maintenance drugs.
- Over the counter drugs, even if they are prescribed, unless mega doses are required due to a serious medical condition, such as diabetes, unless they are approved by the Plan.
- Ostomy Supplies – (See durable medical supplies and major-medical.)
- Proton Pump Inhibitor Drugs that are approved are covered with normal Rx copays.
- Replacement drugs for drugs that are lost, stolen, or misplaced are not covered.
- Retin A for persons aged 26 and older, except for the treatment of acne as approved by the Plan.
- Therapeutic/diagnostic devices and appliances including needles, glucose monitors and other diabetic devices, including syringes (except for diabetic patients – *see Section IX – Diabetic Program*), support garments, blood pressure monitors, and other non-medicinal substance or devices. Certain therapeutic/diagnostic devices may be covered as DME or as part of the major-medical benefit, if medically necessary. DME equipment and supplies are not covered under your Rx card or through mail order.
- Vitamins, minerals, food supplements, or nutritional products obtainable with or without a prescription are not covered except for vitamins preauthorized by the Plan based on medical necessity, facts, and circumstances, at the sole discretion of the Plan. (e.g., Certain mega dose vitamins for patients with kidney failure or dialysis, or prenatal vitamins, etc.)
- Weight loss drugs, anti-obesity/appetite suppressants except for those provided in conjunction with a morbid obesity treatment program when preauthorized.

SECTION IX - DIABETIC PROGRAM

ELIGIBILITY AND ENROLLMENT IN DIABETIC PROGRAM

1. If you are diagnosed with diabetes or are a borderline diabetic, you must first enroll as a diabetic member by calling the prior authorization department or the compliance office. These benefits have been designed to aid in the reduction of diabetic complications and to encourage PROPER AND AGGRESSIVE SELF-MANAGEMENT through diet, exercise, self-testing, and medication. The following schedule provides special benefits under the Plan's disease management program after your enrollment.
2. If another plan is primary, all Rx must first be provided by that plan. This Plan pays as secondary plan and will cover out-of-pocket costs under the primary plan, except for deminis copays. If Medicare is primary, Medicare Part B must first cover certain supplies, and then this Plan will pay the balance at 100%.

SPECIAL DIABETIC BENEFITS PAID AT 100% FOR ENROLLED MEMBERS

1. Diabetic Training and Education – Up to 20 visits per year for a certified diabetic trainer or dietician.
2. Nutrition Counseling – Up to 20 visits per year.
3. Insulin Pumps - Includes infusion pump and supplies.
4. Diabetic Supplies (test strips, syringes, swabs, and insulin) and Testing *(See Prescription Drugs for additional information)*:

a. Annual eye exam and foot exam
b. Urine protein measurement, as needed
c. Lipid profile, as needed
d. Blood pressure exams, as needed
e. HbA1c exams
f. Supplies for administration of insulin (Syringes, Needles, Alcohol swabs, Gauze)
g. Inhaled Insulin devices (Inhalers)
h. Insulin (except insulin for an insulin pump)
i. Glucophage
j. Metformin
k. Insulin for anyone on an insulin pump ##
l. Blood sugar (glucose) testing monitors ##
m. Blood sugar (glucose) test strips ##
n. Lancet devices and lancets ##

These supplies are not covered for Medicare Primary Diabetics as these supplies are covered by Medicare Part B. This Plan will cover the 20% that Medicare does not pay as the secondary plan. These supplies are covered at 100% for non-Medicare diabetics.

SECTION X - INFERTILITY AND IVF PROGRAM (TO AGE 45)

INFERTILITY PROGRAM RULES AND CONDITIONS (LIMITED BENEFIT)

If you elect to participate in this program, infertility treatment will be covered, subject to the conditions of participation below:

1. Enrollment is required: You must be enrolled in this Plan for at least 18 months before you are eligible to enroll in any infertility program. The patient must enroll in the Infertility Program by calling the prior authorization number on your ID card. A preliminary information form must be completed to identify your provider if one has been selected or we can assist you in locating a board-certified specialist in your area. The member is responsible for enrolling in the prenatal program within 14 weeks of becoming pregnant.
2. Treatment Plan is required: The provider must submit a treatment plan, as well as any subsequent changes, for prior authorization. The provider must agree to follow the Plan rules regarding any treatment, subject to the exclusions.
3. Provider Agreement and Qualifications: The American Board of Obstetrics must certify the primary doctor is Board Certified in Gynecology with a Sub-Specialty in Reproductive Endocrinology and the provider must agree to participate in the program. No benefits will be paid for non-board-certified specialists. The provider must agree that if they fail to follow these rules, charges will not be balance billed to the patient unless the patient has agreed to personally pay for the procedures in advance.
4. Maximum Infertility Benefits: The Plan will pay 90% of all covered charges, up to a maximum of $45,000/lifetime, including infertility drugs payable at 80%. No benefits will be paid once the patient attains the maximum age (end of the month in which 45 is attained.) Member is responsible for all excess charges for infertility treatment.
5. Member Coinsurance: The member's coinsurance is 10% *(20% for NPPO providers)* of all covered charges, except for infertility prescriptions.
6. The coinsurance will not apply toward the major-medical or Rx out-of-pocket limits or deductible.
7. Prescriptions are reimbursable at 80% if preauthorized under the treatment plan. The Rx card can be used to secure infertility drugs at the Four Corners Health discount. You must pay for these drugs in full and submit for reimbursement under the major-medical plan.
8. Excluded Treatment: Treatment outside the approved treatment program will result in immediate disqualification of any future benefits with the program.
    - Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal is not covered.
    - The purchase, freezing and storage of donor sperm and donor embryos is not covered.
    - Any surgical procedure, directly or indirectly related to infertility, must be preauthorized and is subject to a second opinion by a board-certified specialist.

SECTION XI – MENTAL HEALTH AND ADDICTION BENEFITS

KTF and MagnaCare providers are in-network for all mental health and addictive treatment; however, out-of-network treatment is permitted, subject to meeting the Plan requirements with respect to prior authorization and adherence to this Plan's claims filing rules for all providers. Prior authorization applies to any outpatient services more than six (6) visits with any provider. All inpatient services must be authorized PRIOR to treatment except for emergency care. Emergency care must be preauthorized within 24 hours or the next working day if the patient is admitted for continuing care.

1. All providers who are not in-network will be paid in accordance with the NPPO schedule based on allowable charges.
2. Benefits will not be paid for treatments that are not preauthorized as required by the Plan.
3. All inpatient services are subject to medical necessity, prior authorization, and utilization management.
4. The maximum allowable charges for outpatient services provided by out-of-network providers are limited to the allowable charges under the Usual, Customary, and Reasonable rules.
5. If Medicare is primary, the maximum benefit for all behavioral and/or addictive treatment *(in or outpatient)* will be equal to the difference between the maximum billable charges under Medicare and the amount that would have been paid by Medicare. This Plan accepts assignment of benefits from NPPO providers. When members pay the fees up front, they must timely file claims (within 90 days of the date of service or payment by the primary plan).

BEHAVIORAL BENEFITS

All Inpatient Care, Intensive Outpatient Care, and Partial Programs are subject to the Hospital Copay *(See Section I – Deductibles, Copays, etc.)*

PPO Outpatient care is subject to PPO copay *(See Section V.)*

All NPPO Outpatient care is subject to NPPO deductible and coinsurance *(See Section VII.)*

BENEFIT PENALTIES AND EXCLUSIONS

Anytime a treatment program is not completed, the benefits will be reduced. This reduction applies if a patient refuses to complete the program or checks themselves out of the hospital or program against medical advice. Non-covered charges include educational programs, court ordered treatment or treatment undertaken (voluntarily or involuntarily) to avoid civil or criminal or other court ordered penalties or treatment, treatment which is not medically necessary, or which will not change the patient's condition or behavior, institutionalized treatment, etc. As of 1/1/2013, Behavioral Health exclusions exclude treatment for learning disabilities, educational facilities, half-way houses, and residential camps, such as wilderness camps and Outward-Bound programs, or member and staff programs unless preauthorized by the Plan as an alternative treatment and cost-effective program. ***(See Section I for details and Part C for Medical Necessity for mental health or addiction treatment.)***

CLAIMS SUBMISSION

Providers (or members) are required to submit all Mental Health or Substance Abuse claims to MagnaCare on HIPAA compliant CMS-1500 forms at the address on the Member's ID card. HIPAA rules require providers to utilize standardized forms for submitting claims. All claims must be typed, printed, or electronically filed.

GROUP COUNSELING

Group Counseling is subject to office visit copay and is not covered as a preventive care benefit.

MEDICARE PRIMARY BENEFITS AND BEHAVIORAL REIMBURSEMENT CHART					
Medicare benefits for mental health/addictive treatment are per the following chart. This Plan will pay the difference between allowable charges and what Medicare covers. The benefits paid by this Plan will be determined by whether you see a Medicare provider only, an in-network provider, or an out-of-network provider. See the chart to determine this Plan's percentage. Medicare pays 80% of allowed charges.					
Benefit Year	Medicare Benefit % for any Medicare Provider	When Medicare provider is NOT used – KTF benefit/percentage reimbursed to member if the provider does NOT accept assignment		When Medicare provider is used – KTF benefit/percentage reimbursed to member if provider does NOT accept Medicare assignment	
		Out-of-Network Provider (4)	In-Network Provider (3)	Medicare Provider Accepts Assignment for Medicare Payment (1)	Medicare Provider Who Only Bills Medicare for any Medicare Covered Benefit (2)
2014 and forward	80%	20%	35%	20%	35%

1. A Medicare provider who accepts assignment is limited to the Medicare Allowed Rate. If this Plan is secondary, the Plan will cover the portion of the allowed charges not covered by Medicare.
2. A Medicare provider who does not accept assignment but will bill Medicare (you must pay the provider up front), may charge 115% of the Medicare allowed charges, but Medicare still limits its payment to 80%, or the basic Medicare percent for behavioral and addictive services, of Medicare allowed charges. Normally, the member would be responsible for 35% (20% + additional 15%) of the Medicare allowed charges, but this Plan will cover up to 35% of the Medicare Allowed fee when you use a Medicare provider who only bills Medicare.
3. When you use an in-network provider, even though they are not a Medicare provider, we will cover the benefit the same as if you used a Medicare provider who only bills Medicare.
4. Out-of-network providers for behavioral health and addiction benefits, reimbursement or benefits are limited to what the Plan would have paid had you used a Medicare provider who accepts assignment from Medicare.

Members are REQUIRED to have both Medicare Part A and Part B in effect once they are eligible for Medicare and Medicare would be their primary plan. In all situations, a member is expected to elect Medicare Part A at age 65 or the beginning of the 25th month if they become Social Security Disabled, even if Social Security Benefits are deferred. There is no charge for Medicare Part A. In all situations, the benefits paid will take into account what **"should have been paid by Medicare."**

SECTION XII – NON-COVERED TREATMENT AND EXCLUSIONS

- Care provided by a facility not appropriately accredited as a hospital, skilled nursing facility, or behavioral health or addiction treatment facility are not covered unless approved by the Plan. Any specialized treatment program must be approved in advance.
- Care not preauthorized in accordance with Plan rules is subject to Plan penalties and may not be covered unless retrospectively preauthorized.
- Chronic conditions that cannot be favorably changed by a specific treatment plan are considered custodial and not considered medically necessary once no additional improvement is expected.
- Court Ordered Treatment: Any treatment (inpatient or outpatient) ordered by a local, state, or federal court will not be covered. Treatment undertaken to avoid or reduce any legal judgment or penalty that would otherwise apply as a result of an illegal act is not covered.
- Disabled dependents who are Medicare eligible are not eligible for continued coverage after age 26. Any dependent coverage for a disabled dependent after age 26 is subject to the dependency rules of the Plan and timely application for disability status. Members are required to apply for Social Security Disability and/or Medicare on behalf of a disabled dependent when they are first eligible. Verification of Social Security Disability benefits and Medicare coverage is required.
- Drug Testing
- Educational Services/Treatment: Educational services for the treatment of medical, behavioral, or learning disorders, behavioral training, and cognitive rehabilitation, including special facilities that provide both treatment and educational services for individuals with chronic conditions.
- Experimental treatment or clinical studies not approved in writing, in advance of treatment, by the Plan subject to PPACA rules. Complete details must be submitted to the prior authorization department.
- Failure to Complete Treatment Program: Penalties for failure to complete any medical, behavioral, or addiction treatment program or to complete a treatment program following detoxification – benefits limited to 50% of allowable charges.
- Half-way houses, group homes, any shelter/facility not licensed or approved by the Plan as a medical facility with appropriate medical staffing and physician/psychiatrist management.
- Long Term Care, training, or institutional care, including educational services, for any medical, mental health or behavioral condition is not covered under this Plan, as it is considered "custodial" care. This includes treatment for acute cases of autism, bi-polar, Asperger Syndrome, and other mental health or addiction conditions once maximum medical or mental health stability or psychological improvement is made and there is no expectation that continued treatment will favorably change the patient's condition.
- Sex-Related Treatment: Sex-related surgical procedures that are considered "cosmetic" by the IRS are not eligible medical expenses under Section 213 of the Internal Revenue Code.

IMPORTANT PLAN INFORMATION		
Plan Sponsor and Plan Administrator	Kingston Trust Fund PO Box 4461 Kingston, NY 12402-4461	Trust Director: Lauri Naccarato
Serial Number: 501	Plan ID: 153	Plan Effective Date: October 1, 1997
Claims Supervisor	MagnaCare PO Box 1001 Garden City, NY 11530	Phone: (800) 352-6465
PPO Network for Medical and Behavioral Health	KTF & MagnaCare PPO Networks PO Box 1001 Garden City, NY 11530	EMDEON Payor ID: 11303
Agent for Legal Service	Board of Trustees – Lauri Naccarato Kingston Trust Fund	Phone: 844-KTF-FUND Fax: (770) 874-1097
Compliance Office and COBRA Administration	KTF Compliance Office 416 Creekstone Ridge Woodstock, GA 30188	Phone: 844-KTF-FUND Fax: (770) 874-1097
Source of Benefits and Contributions	This is a self-funded, non-federal governmental plan subject to the Public Health Service Act (PHSA) and is exempt from state laws and any state mandated benefits. Contributions from Kingston City School District and COBRA premiums are segregated and deposited into a separate Trust Account. Assets are held under a 501(c) (9) Trust funded by direct contributions from the district. Any employee contributions are set by the collective bargaining agreement. Assets are used solely to pay claims, administration expenses, stop loss premiums, and other Trust/Plan expenses for enrolled members.	
Employee Contributions	Employee contributions will be deducted in accordance with the collective bargaining agreement and made with pretax dollars under a §125 Flexible Benefits offered by the School District.	Any employee contributions are deemed to be included in the District Funding to Kingston Trust Fund. The contributions are allocated directly for the payment of claims and Plan expenses. The Trust reserves the right to assess premium surcharges.
Benefit Year	All deductibles, out-of-pocket limits and benefit limits are based on the calendar year.	Plan Year for IRS Reporting is: July 1 to June 30