**Port Authority Retirees Association, Inc**
**13 Leghorn Court**
**Huntington Station, New York 11746**
**(Tel: 631 271 8862)**

The Port Authority of New York and New Jersey
Secretary's Office
225 Park Avenue South
New York, NY 10003

May 17, 2011

Re: Freedom of Information Request

Dear Sirs;

Request is hereby made on behalf of the Port Authority Retirees Association pursuant to the Freedom of Information Policy of the Port Authority of New York and New Jersey and applicable State and Federal Laws for copies of the material described on the attached "List of Requested Documents". Printed (hard) copies of this material are requested. Please advise of any cost. Questions with respect to this matter may be directed to me at the above telephone number and/or address.

Thank you for your kind attention to this matter.

Very truly yours,

Ralph T. Verrill
Secretary

Cc: The Port Authority of New York and New Jersey
Mr. Louis J. LaCapra
Chief Administrative Officer
225 Park Avenue South
New York, NY 10003

The Port Authority of New York and New Jersey
Law Department
Lawrence Hofrichter, Esq.
225 Park Avenue South
New York, NY 10003

**Port Authority Retirees Association, Inc.**
**List of Requested Documents**

Copies of the following Specific
Documents* are Requested

1. Those PAIs (Port Authority Instructions) and APs (Administrative Procedures) concerning the issuance of "paper passes" and EZPasses to employees and retirees in connection with the non-revenue use by Port Authority employees and retirees of Port Authority tunnels, bridges, airport parking and other facilities for the period that the PAIs and APs referenced the same including amendments and supplements issued from time to time with respect thereto.
2. PAIs and APs concerning the non-revenue use by employees and retirees of Port Authority tunnels and bridges, airport parking and other facilities for the period from January 1, 1960 to the present time including amendments and supplements issued from time to time, with respect thereto.
3. Memoranda, letters, e-mails or other written communications to and from the Governor of New Jersey and/or the Governor New York and/or their staffs to Port Authority staff and/or its Board of Commissioners or any of them with respect to the non-revenue use by Port Authority employees and retirees of Port Authority tunnels, bridges, airport parking and other facilities for the period from February 26, 1993 to the present time.
4. Reports and other writings prepared by Port Authority staff or Port Authority contractors with respect to the use, non-use and alleged abuse by Port Authority employees and retirees of the non-revenue use of Port Authority facilities for the period from February 26, 1993 to the present time.
5. Reports, memoranda or other documents including but not limited to those concerning alleged cost savings prepared for the Port Authority Board of Commissioners or any of them in connection the Board action on November 18, 2010 titled PORT AUTHORITY E-ZPASS PROGRAM – ELIMINATION OF NON-REVENUE COMPONENT FOR PERSONAL USE.
6. Documents including booklets, brochures, checklists and forms provided to or required to be signed by Port Authority employees upon their retirement from employment during the period from January 1, 1960 to the present.
7. Memoranda, letters or other written communications from Port Authority Management or other staff to Port Authority employees and/or retirees with respect to benefits and/or the vesting or change in vesting of benefits including, but not limited to, health, dental, vision, prescription drug coverage, life insurance coverage and non-revenue use of Port Authority facilities or other benefits during the period from January 1, 1960 to the present time.
8. On May 31, 1978 the Port Authority Committee on Operations adopted a Resolution designated Number 17 containing the following language "...the vesting of health and life insurance benefits of long-term management, professional, technical and supervisory employees with twenty or more years of service". Any material prepared in connection with this recommendation for the vesting of benefits.
9. Executive Director George Marlin issued Office Memorandum 6-96 dated March 22, 1996 which in part stated "...retiree contribution for benefits based on a new vesting schedule will be implemented for employees who retire on or after July 1, 1996." Please provide any material prepared in connection with this Memorandum with respect to

retiree contributions for benefits based on a new vesting schedule.

10. Louis J. LaCapra on March 25, 1996 wrote a letter to "Dear Fellow Employee". In a section of that letter captioned "Vesting of Retiree Benefit Contributions" he sets forth that there would be no insurance premium costs for health, dental and life insurance for those retiring after July 1, 1996 with 25 or more years of service. Please provide all material and documents prepared for the vesting of retiree benefit contributions in connection with the above letter.

11. The Port Authority Human Resources Department in May of 1996 issued its "1996 Benefit Program Changes (Employees Not Represented For Collective Negotiations)". That document stated "...for employees retiring on or after July 1, 1996, with 25 or more years of Port Authority Service there will be no contribution toward group health, dental and life insurance". Please provide all documents related to when contributions would or would not be required which were prepared in connection with the referenced 1996 program change.

*Wherever the term document(s) or material(s) is used above it is intended to include electronic records as well as written and printed materials.

**THE PORT AUTHORITY** OF NY & NJ

Daniel D. Duffy
*FOI Administrator*

November 18, 2011

Mr. Ralph T. Verrill
Port Authority Retirees Association, Inc.
13 Leghorn Court
Huntington Station, NY 11746

Re: Freedom of Information Reference No. 12346

Dear Mr. Verrill:

This is a response to your May 17, 2011 request, which has been processed under the Port Authority's Freedom of Information Policy (the "Policy") for various records related to the E-ZPass program and employee and retiree benefits.

Material responsive to your request and available under the Policy, which consists of 858 pages, will be forwarded to your attention upon receipt of a photocopying fee of $214.50 (25¢ per page). Payment should be made in cash, certified check, company check or money order payable to "The Port Authority of New York & New Jersey" and should be sent to my attention at 225 Park Avenue South, 17th Floor, New York, NY 10003.

Certain records related to Item 7 of your request and available under the Policy are included in the page count above. To locate records responsive to Item 6 as well as any additional records responsive to Item 7 of your request, it will require more than 600 hours of staff time, thereby incurring a substantial research fee. You may wish to resubmit your request with more specificity as well as a narrowed timeframe.

Certain material responsive to Items 3 and 4 of your request is exempt from disclosure pursuant to exemptions (7) and (5) of the Policy, respectively.

Please refer to the above FOI reference number in any future correspondence relating to your request.

Very truly yours,

Daniel D. Duffy
FOI Administrator

*225 Park Avenue South*
*New York, , NY 10003*
*T: 212 435 3642 F: 212 435 7555*

# PORT AUTHORITY PASSES AND FREE USE OF PORT AUTHORITY FACILITIES

## I. Introduction

This instruction sets forth the policies and procedures governing the issuance and use of Port Authority passes. It also outlines the procedure for the authorization of free employee parking in revenue producing areas on a regular basis.

## II. Passes

### A. Annual Passes

Annual passes are issued to Commissioners, officers, other executive staff members of the Port Authority and a limited number of officials of New Jersey, New York and municipalities within the Port District. Past Commissioners, officers and retired Service A staff members of the Port Authority are also recipients of annual passes. Annual passes may be used only by a specific individual and are not transferable. Cars carrying a passholder presenting an annual pass are permitted free passage at tunnels and bridges and use of air terminal parking lots. An annual passholder who uses an air terminal parking lot will, upon presenting the pass, sign and date the parking lot ticket, write the pass number thereon, and give the ticket to the lot attendant. There is no time or air terminal parking lot limitation on this free parking privilege.

### B. Employee Passes

Employee passes may only be used by Port Authority employees who must be prepared to present Port Authority photographic identification when any employee pass is used.

#### 1. Commutation Passes

Commutation Passes, form PA 166, are issued on request to any Port Authority employee regardless of length of service for commuting to and from work via Port Authority tunnels or bridges in a vehicle in which the employee is an operator or a passenger.

These passes are to be used in lieu of paying the toll fee. They are not valid for use at parking lots at any facility.

#### 2. Personal Passes

a. Personal Passes, form PA 378, are issued on request, in accordance with the pass allowance schedule given below, to Port Authority permanent and project employees, retired employees, and employees on military leave, for use at tunnels, bridges and some air terminal parking lots.

(5) Use of Port Authority personal passes for free parking in public airport lots is a privilege for isolated instances of parking. Personal passes are not to be used to park during work hours by Port Authority employees who are assigned full-time to jobs at JFKIA, LaGuardia or Newark Airports.

C. Official Business Passes

Official Business Passes, form PA 430, are issued to contractors and other designated individuals who use tunnels and bridges or air terminal parking lots while making trips on Port Authority business in other than Port Authority vehicles. A pass holder who uses an airport parking lot must, upon leaving the parking lot, sign and date both the Official Business Pass (form PA 430) and the parking lot ticket, and submit both to the lot attendant. If this individual is on official Port Authority business, any charge for parking for more than 24 hours based on the rate progression set forth in the Schedule of Charges should be paid and a receipt should be obtained and submitted for reimbursement to the Port Authority.

III. Additional Free Use of Air Terminal Parking Lots, Tunnels and Bridges

A. Free parking at air terminal parking lots is provided for:

1. Port Authority vehicles. Except for Parking Lot 6 (Pan American Roof Top) at JFKIA, Hourly Parking Lots A, B and C at Newark International Airport, and the Parking Garage at LaGuardia Airport, the free use of air terminal parking lots is unlimited. These restrictions do not apply to facility based vehicles requiring entry into a lot in the course of their official duties (i.e., Facility maintenance and operations vehicles). When a Port Authority Vehicle Pass, form PA 684, is presented for payment, the employee must sign his/her name and print the P.A. vehicle number and date on both the vehicle pass and parking lot ticket, and submit both to the parking lot attendant. If the employee cannot present a vehicle pass the employee must sign his/her name and print the P.A. vehicle number and date on the parking lot ticket and submit it to the parking lot attendant.

2. Vehicles carrying representatives of the media and photographers with press passes. Press vehicles which park for more than 24 hours will be required to pay the parking charges for time in excess of 24 hours, starting with the first day rate. Media representatives with proper press credentials can park for an unlimited time in certain designated "long-term" airport lots, provided they receive written permission (Port Authority Press Parking Permit) from

d. mayors of municipalities in which Port Authority air terminals are totally or partially located;

e. Chiefs of Staff of the Army and Air Force, the Chief of Naval Operations, the Commandant of the Marine Corps and Chiefs of Military Missions;

f. foreign Ambassadors and Consul-Generals or individuals of equivalent rank.

B. Free use of Parking Lot 6 (Pan American Roof Top) at JFKIA and the Parking Garage at LaGuardia Airport is not available to vehicles enumerated in Par. III, A, 1, 3 and 4.

C. Free use of tunnels and bridges is provided for:

1. Port Authority vehicles;

2. public utility vehicles, providing the trip is necessary for inspection and/or repair to the crossing used;

3. police and fire equipment domiciled in the States of New York or New Jersey, providing such vehicles have permanent exterior identifying markings, as well as police and fire vehicles going to and from emergency calls;

4. vehicles used in the course of an inspection tour conducted or approved by the Port Authority;

5. vehicles displaying civil defense placards during official civil defense drills (provided prior notice of such tests has been received by the Port Authority) or in the event of enemy attack;

6. all non-commercial ambulances going to and from emergency calls;

7. a commercial wrecking vehicle, when it is called to remove a disabled vehicle from a Port Authority tunnel or bridge plaza and it does not use the tunnel or bridge. However, if the commercial wrecker traverses a tunnel or bridge eastbound in the process of picking up a disabled vehicle, the driver of the wrecker must pay a toll for the vehicle.

8. off-route vehicles which, due to a mistake, heavy traffic or other similar circumstances, use a vehicular crossing in an eastbound direction contrary to the intent of the operator;

9. military convoys rendering aid pursuant to the terms of the New Jersey - New York Mutual Military Assistance Pact;

book at a time by the custodian who checks the date the previous book was issued to control misuse. The employee inserts his/her name on the receipt (first page of book) and the custodian inserts his/her name and the date issued on the receipt which is filed. These receipts should be retained in accordance with the Port Authority Record Retention Schedule or until examined by the Audit Department.

C. Personal Passes

1. Passes are issued, one book at a time, by the custodian who checks the employee's allowance and the number of books previously issued to insure that the allowance is not exceeded. The employee signs the receipt and the custodian inserts his/her name and the date on the receipt which is filed. These receipts should be retained in accordance with the Port Authority Record Retention Schedule or until examined by the Audit Department.

2. Passes for retired employees and employees on military leave are issued by the Administrative and Employee Benefits Division of the Personnel Department upon request of such individuals.

D. Official Business Passes

The custodian inserts the bearer's name, date and reason for issuance on the stub. The stub remains attached to the book.

Books of passes may be issued to a Port Authority contractor when passes are required by the contractor and operational conditions do not permit the issuance of passes, one at a time. The custodian issuing the book should note the contractor's name and date of issuance in a log. The contractor receiving the book should issue passes to drivers on an as needed basis and complete the stub portion of the book. Depleted books should be returned to the custodian. If the contractor fails to properly complete the stubs or return the depleted book, additional books should not be issued.

VII. General

A. Employee Leaving Port Authority Services

The organizaton unit head is responsible for obtaining unused passes from employees leaving the Port Authority for reason other than retirement.

# NON-REVENUE TOLL PROGRAMS FOR EMPLOYEES AT PORT AUTHORITY TUNNEL AND BRIDGE CROSSINGS

## I. Introduction

This Administrative Instruction sets forth guidelines governing the non-revenue use of Port Authority tunnels and bridges by employees, including the use of Employee E-ZPass® tags.

Employees represented for purposes of collective bargaining are governed by the terms and conditions of their respective collective bargaining agreements.

## II. *E-ZPass Program*

### A. Description

E-ZPass is an electronic toll collection system that makes traveling more convenient and helps reduce traffic congestion. Motorists prepay their tolls and have their accounts electronically debited, without tendering cash or tickets. An antenna at the toll plaza reads an electronic tag affixed to the vehicle for this purpose.

### B. Employee Non-Revenue E-ZPass Program

The Employee Non-Revenue E-ZPass Program allows for non-revenue passage for commutation and official agency business travel for eligible Port Authority employees at tunnels and bridges operated by the Port Authority. The Employee E-ZPass tag may only be used in a vehicle occupied by the employee to whom it was issued. The privilege of non-revenue passage applies only to commuting trips to and from the employee's primary employment location and approved travel for agency business purposes. Any toll for personal travel at Port Authority bridges and tunnels incurred with an Employee E-ZPass tag must be paid by the employee to the Port Authority. The Employee E-ZPass tag may not be used in return for payment or other form of compensation such as driving a delivery vehicle, taxi, or limousine.

If an employee's E-ZPass account is funded with a prepaid toll balance, the Employee E-ZPass tag may also be used for the personal travel at non-Port

Authority toll facilities that accept E-ZPass. The employee is responsible for maintaining sufficient funds in the account at all times.

Non-represented employees and retirees must discontinue the use of any paper passes for personal travel at the Port Authority bridges and tunnels.

1. Eligibility

   The Employee Non-Revenue E-ZPass Program is available to active non-represented staff employed on or before September 11, 2001 and continuously employed by the Port Authority since then. At such time as the Port Authority's headquarters are re-established at the World Trade Center site, the Employee Non-Revenue E-ZPass Program will no longer be available to such employees.

2. Employee Responsibilities

   a. Eligible employees are required to follow all E-ZPass rules and regulations, the New York E-ZPass Customer Agreement Terms and Conditions, Port Authority Addendum to Agreement, and this Administrative Instruction.

   b. Eligible employees are responsible for reimbursing the Port Authority for tolls associated with all travel at Port Authority tunnel and bridges not related to commutation and official business travel. Reimbursement for any personal use of a Non-Revenue E-ZPass Tag by an eligible employee is made by completing Form PA3269B no later than 45 days after the date of travel.

   c. Eligible employees using Employee E-ZPass tags for non-revenue business travel at the bridges and tunnels must document the transaction as a non-revenue toll in a business expense reimbursement submission, such as petty cash voucher (Form PA 618) or expense account submissions filed via the Business Expense Account Management (BEAM) application and covered in AI 30-3.51.

   d. The Port Authority may pursue tolls and related fees from employees through all appropriate means.

3. Misuse of Employee E-ZPass Tags

   The misuse of an Employee E-ZPass tag, and/or failure to comply with the terms of E-ZPass rules and regulations, the New York E-ZPass Customer Agreement Terms and Conditions, Port Authority Addendum to Agreement, and this Administrative Instruction, may result in formal disciplinary action, the cancellation of non-revenue passage privileges, and appropriate penalties.

4. Vehicle Class

   For eligible employees that fund their account, the Port Authority orange E-ZPass tag may only be used on Class 1 vehicles (i.e., private vehicles such as automobiles, sport utility vehicles [SUVs], minivans, or personal-use vans) with two-axles and single rear wheels, at non-Port Authority toll facilities that accept E-ZPass.

5. Lost, Stolen or Retained Employee E-ZPass Tags

   Eligible employees must immediately report a lost, stolen or retained Employee E-ZPass tag to the New York Customer Service Center and pay the prevailing fee to replace the tag.

6. Identification

   Eligible employees must be prepared to show Port Authority photo identification when using the Employee E-ZPass tag at Port Authority tunnels and bridges.

7. Audit

   All use of E-ZPass tags issued under the Employee Non-Revenue E-ZPass Programs are subject to audit for compliance with the guidelines established in this Administrative Instruction, the E-ZPass Customer Service Agreement, and the Port Authority Addendum to the Agreement.

8. Employee Separation

   An Employee E-ZPass account is deactivated upon separation (including retirement) from active Port Authority service. The tag must be returned to the department / office business manager upon leaving or the employee is charged the prevailing fee for the tag.

9. Port Authority Property

   E-ZPass tags are Port Authority property.

III. Port Authority Pool Vehicle E-ZPass Program

A. Departmental and Unit Coordinators

Each department designates a Departmental Coordinator to be responsible for the oversight of the department's Vehicle E-ZPass Program. The Departmental Coordinator maintains a list of Unit Coordinators, who are in turn responsible for the administration of the E-ZPass Program for their respective units. The

Director, Tunnels, Bridges and Terminals Department (TB&T), is advised of the name and contact information of the Departmental Coordinator and any related staffing changes.

Unit Coordinators are responsible for opening through TB&T's E-ZPass Programs Division and properly maintaining Port Authority Vehicle E-ZPass accounts. All assigned Port Authority vehicles are to be equipped with a Port Authority Vehicle E-ZPass tag, and an account funded with a Procurement Card specifically designated for E-ZPass account management only. Statements from the New York E-ZPass Customer Service Center are to be e-mailed to the Unit Coordinator listed on the E-ZPass account on a monthly basis. The Unit Coordinator is responsible for reviewing the statements for accuracy and contacting the E-ZPass New York Customer Service Center to address any discrepancies.

B. Department Responsibilities

1. Control of E-ZPass Tags and Tag Usage

   Individual Departments are responsible for proper control of all E-ZPass tags and tag usage assigned to the Department.

   a. An inventory of all assigned E-ZPass tags and related license plates must be maintained.

   b. A physical inventory of tags is performed annually and reconciled to the vehicle list and to tags listed on the E-ZPass account. Physical inventories should be performed and reconciled more frequently if significant changes are made.

   c. Generally, a non-revenue tag should be assigned to a specific vehicle. However, departments may maintain a supply of non-revenue tags for business related usage, including Central Pool vehicles covered in AI 15-3.02.

2. E-ZPass Account Information and Maintenance

   Individual Departments and their Departmental and Unit Coordinators are responsible to ensure the accuracy of all E-ZPass account information.

   a. All requests for tags must be made, in writing, to TB&T's E-ZPass Programs Division.

   b. License plate and tag information must be kept current on the account.

c. All other account demographic and administrative updates should be made by the requesting Unit Coordinator via the E-ZPass website (www.e-zpassny.com). This includes license plate information, credit card updates, lost or stolen tags, etc.

3. Safe Use

Employees should refer to AI 15-3.02 regarding safe vehicle operations. Speeding through toll lanes may result in speed notices being issued and/or account suspension at Port Authority and non-Port Authority facilities. An account that is invalid due to speed suspension is invalid at all toll facilities, including Port Authority facilities.

C. Employee Responsibilities

Employees are responsible for use of E-ZPass tags in Assigned Vehicles and Executive Cars as defined in AI 15-3.02. Employees must reimburse the Port Authority for all personal use of a Non-Revenue Vehicle Tag in a Pool Vehicle by submitting Form PA3269A within 45 days of such personal travel.

THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
OFFICE OF INSPECTOR GENERAL
*Office of Investigations*

# CLOSING MEMORANDUM

CASE NO: 08-019 | LOG NO: 725 | PREPARED BY: | DATE: 5/16/11

TO: FILE

## ORIGIN AND NATURE OF CASE:

On February 21, 2008, and , assigned to the Office of Inspector General ("OIG") responded to 225 Park Ave, NYC, and spoke with Port Authority ("PA") Law Department Attorney Barbara Smith concerning an allegation that PA Employee Oswald Newman allowing his son, Christopher Newman, to use his PA issued non-revenue EZ-Pass tag at the Central Terminal Parking lots at Newark Airport on a regular basis for approximately six months. Christopher Newman is a Federal Transportation Security Administration ("TSA") employee assigned to Newark Airport and was not authorized to use his father's EZ-Pass tag.

## INVESTIGATIVE FINDINGS:

## CONCLUSIONS AND RECOMMENDATIONS:

Base upon the above, it is recommended that this case be closed.

APPROVED: DATE: 5/16/11

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# OIG CLOSURE FORM

| Log Number: | Case Number: | Last Name: | First Name: | Status: |
|---|---|---|---|---|
| 659 | 07068 | Fitzgerald | John | C |

**Allegation:**

*MISUSE OF A PA ISSUED EZ PASS-Wanda Rodriquez, aka Wanda Ramos*

**Request to Close Investigation:**

ORIGIN AND NATURE OF CASE:

On May 14, 2007, at 0335 hours, Metropolitan Transportation Authority ("MTA") Bridge and Tunnel Officer Murray observed Miguel RODRIGUEZ attempting to use a Port Authority issued orange EZ Pass at the Bronx Whitestone Bridge, tag #00500914131. Miguel RODRIGUEZ was driving his tractor at the time. The Officer confiscated the tag. and an EZ Pass customer agreement violation notice #008864 was issued. The orange EZ Pass that was in the possession of Miguel RODRIGUEZ is the EZ Pass that was issued to his wife, Wanda RODRIGUEZ, and is authorized for class 1 vehicles, not tractor/trailers. Also, the employee EZ Pass tag may only be used in a vehicle occupied by the employee to whom it is issued. Wanda RODRIGUEZ is a Port Authority ("PA") employee assigned to the Procurement Department, Employee #34429.

INVESTIGATIVE FINDINGS:

# OIG CLOSURE FORM

# OIG CLOSURE FORM

Based upon the above, it is recommended that this case be closed.

Approved: ☑ Date Closed: 4/29/2009 Not Approved: ☐

Closure Approved By: _____ Date:_____

(For Official Use Only)

PANYNJ - Office of Inspector General

THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
OFFICE OF INSPECTOR GENERAL
Office of Investigations

# CLOSING MEMORANDUM

CASE NO: 10-018 | LOG NO: 1097 | DATE: 4/28/10

TO: FILE

## ORIGIN AND NATURE OF CASE:

An audit performed by the Port Authority's ("PA") Audit Department, of non-revenue EZ Pass tags, revealed an unusual amount of transactions on two EZ Pass tags, which are assigned to two different retired Port Authority employees.

## INVESTIGATIVE FINDINGS:

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CLOSING MEMORANDUM
CASE NO:

## CONCLUSIONS AND RECOMMENDATIONS:

Based upon the above, it is recommended this case be closed.

APPROVED: _____ DATE: 4/30/10

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THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
OFFICE OF INSPECTOR GENERAL
Office of Investigations

# CLOSING MEMORANDUM

CASE NO: 08115 | LOG NO: 873 | PREPARED BY: | DATE: 5/6/2010

TO: FILE

## ORIGIN AND NATURE OF CASE:

On October 28, 2008, Port Authority ("PA") Audit Department contacted the Office of Inspector General ("OIG") regarding an audit performed on PA NON-Revenue EZ Pass tags for Police vehicles at Newark Liberty International Airport. ("NLIA").

## INVESTIGATIVE FINDINGS:

## CONCLUSIONS AND RECOMMENDATIONS:

Based upon these findings, it is recommended that this case be closed.

APPROVED: DATE: 5/6/10

This report is the property of the Office of Inspector General. It contains confidential law enforcement information, and is For Official Use Only. This information may not be copied or disseminated without the written permission of the OIG. Any unauthorized or unofficial use or dissemination of this information will be penalized.

**THE PORT AUTHORITY** OF NY & NJ

# MEMORANDUM

**TUNNELS, BRIDGES AND TERMINALS DEPARTMENT**

**TO:** Assistant To's
**FROM:** John Riccardi – Policy Manager, Regional E-ZPass Programs
**DATE:** May 14, 2007
**SUBJECT:** Issuance of Employee Personal and Commutation Passes
**CC:** V. Kelly, M. Mattei, M. Muriello, K. Raymond

The E-ZPass electronic toll collection system is accepted at all Port Authority bridges and tunnels, as well as at specified airport parking lots where E-ZPass Plus is accepted. All these facilities also accept the orange Employee E-ZPass tag for non-revenue transactions for employees eligible for this program. A list of eligible airport parking lots and regulations is attached and is also available on the Aviation Department's E-Net site.

Effective June 30, 2007, the issuance of Employee Personal and Commutation passes will be discontinued for non-represented employees, retirees and members of the following unions, all of whom are eligible for Employee E-ZPass.

| | |
|---|---|
| ▪ **BTU** – Building Trades Union | ▪ **DEA** – Detectives Endowment Assoc. |
| ▪ **C32** – Communications Workers 1032<br>▪ **C77** – Communications Workers 1177 | ▪ **LBA** – Lieutenants Benevolent Assoc. |
| ▪ **IUOE** – Int'l Union of Operating Engineers | ▪ **PBA** – Police Benevolent Assoc. |
| ▪ **FS - IUJAT** – Operations Supervisors | ▪ **SBA** – Sergeants Benevolent Assoc. |

The June 30, 2007 date for discontinuing Employee Personal and Commutation passes will allow sufficient time for employees interested in obtaining an Employee E-ZPass to open an account and receive a tag.

**The FM – IUJAT Maintenance Supervisors'** union is participating in a pilot test of Employee E-ZPass until December 31, 2007. As FM employees enroll in Employee E-ZPass, TB&T staff will notify administrators to cease issuing passes to those employees. Those FM employees who do not opt to enroll in the Employee E-ZPass Pilot Program may continue to receive Personal and Commutation Passes until the end of 2007; at which time the union will decide whether all FM employees will convert to Employee E-ZPass or revert to Personal and Commutation Passes.

The following unions **have not** enrolled in Employee E-ZPass and are entitled to receive personal or commutation passes.

- **TWU** – Transport Workers Union
- **UOAT** – Union of Automotive Technicians
- **IBEW** – International Brotherhood of Electrical Workers

Please distribute passbooks in accordance to the established procedures until June 30, 2007. We would like to prevent hoarding of Employee Personal and Commutation passes. If you or any of your departmental staff has any questions, please feel free to call Marilyn Mattei in TB&T's Regional E-ZPass Division at (212) 435-4964. Thanks for your cooperation through this transition.

**THE PORT AUTHORITY** OF NY & NJ

# MEMORANDUM

**TUNNELS, BRIDGES AND TERMINALS DEPARTMENT**

**TO:** Assistant To's
**FROM:** John Riccardi – Policy Manager, Regional E-ZPass Programs
**DATE:** May 6, 2008
**SUBJECT:** **Update** – Issuance of Employee Personal and Commutation Passes
**CC:** R. Croneberger, C. Fausti, C. Fulton, V. Kelly, M. Mattei, M. Muriello, B. Oberheim

The **FM-IUJAT** union recently accepted the Employee E-ZPass program on behalf of its members. Therefore, effective June 1, 2008, do not issue Employee Personal or Commutation Passes to any FM-IUJAT members. The June 1, 2008 date for discontinuing Employee Personal and Commutation passes will allow sufficient time for FM- IUJAT members to obtain an Employee E-ZPass Non-Revenue account and receive a tag. As you know, all non-represented employees, retirees and members of the other unions listed below are already eligible for Employee E-ZPass. The issuance of Employee Personal and Commutation passes to these individuals was discontinued effective June 30, 2007.

| **Eligible for an Employee E-ZPass Account (Not Tickets/Passes)** | |
|---|---|
| ▪ **BTU** – Building Trades Union | ▪ **DEA** – Detectives Endowment Assoc. |
| ▪ **C32** – Communications Workers 1032 | ▪ **LBA** – Lieutenants Benevolent Assoc. |
| ▪ **C77** – Communications Workers 1177 | ▪ **PBA** – Police Benevolent Assoc. |
| ▪ **IUOE** – Int'l Union of Operating Engineers | ▪ **SBA** – Sergeants Benevolent Assoc. |
| ▪ **FS - IUJAT** – Operations Supervisors | ▪ Port Authority Active Employees |
| ▪ **FM - IUJAT** – Maintenance Supervisors* | ▪ Port Authority Retirees |

* no tickets/passes issued as of June 1, 2008

The following unions **have not** enrolled in Employee E-ZPass and are therefore the only ones **entitled to receive personal or commutation passes.**

| **Eligible for Personal / Commutation Passes — (Not Employee E-ZPass)** | |
|---|---|
| • **TWU** – Transport Workers Union | • **UOAT** – Union of Automotive Technicians |
| • **IBEW** – International Brotherhood of Electrical Workers | |

You many distribute passbooks to FM members who have not yet enrolled in Employee E-ZPass in accordance to the established procedures until June 1, 2008. We would like to prevent over accumulating of Employee Personal and Commutation passes. If you or any of your departmental staff has any questions, please feel free to call Marilyn Mattei in TB&T's Regional E-ZPass Division at (212) 435-4964. Thanks for your cooperation through this transition.

The E-ZPass electronic toll collection system is accepted at all Port Authority bridges and tunnels, as well as at specified airport parking lots where E-ZPass Plus is accepted. All of these facilities also accept the orange Employee E-ZPass tag for non-revenue transactions for employees eligible for this program. A list of eligible airport parking lots and regulations is attached and is also available on the Aviation Department's E-Net site.

**THE PORT AUTHORITY** OF NY & NJ

# MEMORANDUM

**TUNNELS, BRIDGES AND TERMINALS DEPARTMENT**

**TO:** Assistant To's
**FROM:** John Riccardi – Policy Manager, Regional E-ZPass Programs
**DATE:** May 15, 2008
**SUBJECT:** **Update** – Issuance of Employee Personal and Commutation Passes
**CC:** R. Croneberger, C. Fausti, C. Fulton, V. Kelly, M. Mattei, M. Muriello, B. Oberheim

The **FM-IUJAT** union recently accepted the Employee E-ZPass program on behalf of its members. Therefore, effective June 15, 2008, do not issue Employee Personal or Commutation Passes to any FM-IUJAT members. The June 15, 2008 date for discontinuing Employee Personal and Commutation passes will allow sufficient time for FM- IUJAT members to obtain an Employee E-ZPass Non-Revenue account and receive a tag. As you know, all non-represented employees, retirees and members of the other unions listed below are already eligible for Employee E-ZPass. The issuance of Employee Personal and Commutation passes to these individuals was discontinued effective June 30, 2007.

| Eligible for an Employee E-ZPass Account (Not Tickets/Passes) | |
|---|---|
| ▪ **BTU** – Building Trades Union | ▪ **DEA** – Detectives Endowment Assoc. |
| ▪ **C32** – Communications Workers 1032 | ▪ **LBA** – Lieutenants Benevolent Assoc. |
| ▪ **C77** – Communications Workers 1177 | ▪ **PBA** – Police Benevolent Assoc. |
| ▪ **IUOE** – Int'l Union of Operating Engineers | ▪ **SBA** – Sergeants Benevolent Assoc. |
| ▪ **FS - IUJAT** – Operations Supervisors | ▪ Port Authority Active Employees |
| ▪ **FM - IUJAT** – Maintenance Supervisors* | ▪ Port Authority Retirees |

* no tickets/passes issued as of June 15, 2008

The following unions **have not** enrolled in Employee E-ZPass and are **entitled to personal or commutation passes.**

| Eligible for Personal / Commutation Passes — (Not Employee E-ZPass) | |
|---|---|
| • **TWU** – Transport Workers Union | • **UOAT** – Union of Automotive Technicians |
| • **IBEW** – International Brotherhood of Electrical Workers | |

You many distribute passbooks to FM members who have not yet enrolled in Employee E-ZPass in accordance to the established procedures until June 15, 2008. We would like to prevent over accumulating of Employee Personal and Commutation passes. If you or any of your departmental staff has any questions, please feel free to call Marilyn Mattei in TB&T's Regional E-ZPass Division at (212) 435-4964. Thanks for your cooperation through this transition.

The E-ZPass electronic toll collection system is accepted at all Port Authority bridges and tunnels, as well as at specified airport parking lots where E-ZPass Plus is accepted. All of these facilities also accept the orange Employee E-ZPass tag for non-revenue transactions for employees eligible for this program. A list of eligible airport parking lots and regulations is attached and is also available on the Aviation Department's E-Net site.

**THE PORT AUTHORITY** OF NY & NJ

# MEMORANDUM

**TUNNELS, BRIDGES AND TERMINALS DEPARTMENT**

**TO:** Assistant To's
**FROM:** John Riccardi, Policy Manager, E-ZPass Programs Division
**DATE:** October 9, 2008
**SUBJECT:** **Update** – Issuance of Employee Personal and Commutation Passes - **UOAT**
**CC:** R. Croneberger, C. Fausti, C. Fulton, V. Kelly, M. Mattei, M. Muriello, B. Oberheim

The **UOAT** union recently accepted the Employee E-ZPass Program on behalf of its members. Therefore, effective October 31, 2008, do not issue Employee Personal passes or Commutation tickets to any UOAT members. In early September, all UOAT members were sent employee E-ZPass applications and notified of this change. This allowed sufficient time for UOAT members to open an Employee E-ZPass non-revenue account and receive a tag. If needed, Employee E-ZPass applications and related materials are available on ENet.

As you know, all non-represented employees, retirees and members of the other unions listed below are already eligible for Employee E-ZPass. The issuance of Employee Personal and Commutation passes to these individuals was previously discontinued.

| **Eligible for an Employee E-ZPass (Not Eligible for Personal Passes & Commutation Tickets)** | |
|---|---|
| ▪ **BTU** – Building Trades Union | ▪ **DEA** – Detectives Endowment Assoc. |
| ▪ **C32** – Communications Workers 1032 | ▪ **LBA** – Lieutenants Benevolent Assoc. |
| ▪ **C77** – Communications Workers 1177 | ▪ **PBA** – Police Benevolent Assoc. |
| ▪ **IUOE** – Int'l Union of Operating Engineers | ▪ **SBA** – Sergeants Benevolent Assoc. |
| ▪ **FS - IUJAT** – Operations Supervisors | ▪ Active Non-Represented Employees |
| ▪ **FM - IUJAT** – Maintenance Supervisors | ▪ Port Authority Retirees |
| ▪ **UOAT** – Union of Automotive Technicians — no tickets/passes issued as of October 31, 2008 | |

The following unions have not enrolled in the Employee E-ZPass Program and are entitled for Personal passes and Commutation tickets.

| **Eligible for Personal Passes & Commutation Tickets (Not Eligible for Employee E-ZPass)** | |
|---|---|
| • **TWU** – Transport Workers Union | • **IBEW** – International Brotherhood of Electrical Workers |

You may distribute passbooks to UOAT members who have not yet enrolled in the Employee E-ZPass Program in accordance with established procedures until October 31, 2008. As always, effort should be made to prevent the over-accumulation of Employee Personal passes and Commutation tickets. If you or any of your departmental staff has any questions, please feel free to call Marilyn Mattei in TB&T's E-ZPass Programs Division at (212) 435-4964. Thanks for your cooperation through this transition.

E-ZPass is accepted at all Port Authority bridges and tunnels, as well as at specified airport parking lots where E-ZPass Plus is accepted. These facilities also accept the orange Employee E-ZPass tag for eligible non-revenue transactions. A list of eligible airport parking lots and regulations is attached and is also available on the Aviation Department's ENet site.

(Gen. Res. 129. See Page 114, Board Minutes, May 8, 1947 as amended by Resolutions, Page 35, Board Minutes, February 10, 1948, Page 6, Board Minutes, January 12, 1950, Page 212, Board Minutes, June 14, 1951 and Page 245, Board Minutes, August 9, 1951).

RESOLVED, that for the purpose of establishing, levying and collecting tolls for the use of vehicular crossings, vehicles and animals shall be classified as follows:

Class I: Shall include the following vehicles having two axles: Passenger automobiles unless they form parts of combinations included in Class 7, hearses, ambulances, commercial limousines, taxicabs and animal drawn vehicles.

Class 2: Shall include motorcycles, with or without side cars, unless such motorcycles form parts of combinations included in Class 7; and ~~animals ridden, led or herded and not drawing~~ vehicles.

Class 3: Shall include omnibuses.

Class 4: Shall include the following vehicles having no more than two axles unless such vehicles form parts of combinations included in Classes 7, 8 and 9: Trucks with capacity not in excess of 2 tons, having one wheel at each end of the rear axle; tractors; chassis; and trailers or semi-trailers with a capacity not in excess of 2 tons.

Class 5: Shall include the following vehicles having no more than two axles, unless such vehicles form parts of combinations included in Classes 7, 8 and 9: Trucks with a capacity in excess of 2 tons but not in excess of 5 tons; trucks with a capacity not in excess of 2 tons, having more than one wheel at each end of the rear axle; and trailers or semi-trailers with a capacity in excess of 2 tons but not in excess of 5 tons.

Class 6: Shall include the following vehicles having no more than two axles, unless they form parts

of combinations included in Classes 7, 8 and 9; trucks with a capacity in excess of 5 tons; and trailers or semi-trailers with a capacity in excess of 5 tons.

Class 7: Shall include combinations consisting of motorcyles or passenger automobiles having two axles and trailers or semi-trailers.

Class 8: Shall include all vehicles other than omnibuses having three axles, unless they form parts of combinations included in Class 9.

Class 8 shall also include combinations consisting of trucks or tractors and semi-trailers, the combination having three axles.

Class 9: Shall include all vehicles other than omnibuses having four axles.

Class shall also include all combinations consisting of trucks or tractors and trailers or semi-trailers, the combination having four axles.

and be it further

RESOLVED, that (except as hereafter provided in the case of commutation or combination tolls) the following tolls shall be charged per trip for the use of vehicular crossings:

| | | |
|---|---|---|
| (a) | Vehicles included in Class I ..... | .50 each |
| (b) | Vehicles and animals included in Class 2 ..... | .25 each |
| (c) | Vehicles included in Class 3 ..... | 1.00 each |
| (d) | Vehicles included in Class 4 ..... | .50 each |
| (e) | Vehicles included in Class 5 ..... | .75 each |

(f) Vehicles included in Class 6 ..... 1.00 each

(g) Combinations of vehicles included in Class 7 ..... .75 per combination

(h) Vehicles included in Class 8 ..... 1.00 each

(i) Combinations of vehicles included in Class 8 ..... 1.00 per combination

(j) Vehicles included in Class 9 ..... 1.50 each

(k) Combinations of vehicles included in Class 9 ..... 1.50 per combination

and be it further

RESOLVED, that the Executive Director is hereby authorized to arrange for the sale of commutation tickets for vehicles and combinations of vehicles in Classes I, 3, 4, 5, 6 and 8, good only for passage over Port Authority Staten Island bridges, at the following rates and upon the following conditions and that such commutation tickets shall be accepted in lieu of the tolls above provided for single trips over the Staten Island bridges:

Commutation tickets for vehicles of Class I shall be valid for 26 trips; the charge for such ticket shall be $6.00.

Commutation tickets for vehicles of Class 3 shall be valid for 300 trips; the charge for such ticket shall be $180.00.

Commutation tickets for vehicles or combinations of vehicles included in Classes 4, 5, 6 and 8 shall be valid for 25 trips; the charge for such tickets in the case of vehicles or combinations of vehicles included in each said class shall be:

| | |
|---|---|
| Class 4 | 10.00 |
| Class 5 | 15.00 |
| Class 6 | 18.75 |
| Class 8 | 18.75 |

Commutation tickets for vehicles of Classes 1 and 3 which are purchased on any calendar day shall be invalid after midnight at the close of the same calendar day of the succeeding calendar month, provided, however, that tickets purchased on January 29th, or 30th, or on the 31st day of any calendar month shall be invalid after the close of the succeeding calendar month.

Commutation tickets for vehicles or combinations of vehicles included in Classes 4, 5, 6 and 8 shall be invalid after the close of the calendar month succeeding the calendar month in which purchased;

and be it further

RESOLVED, that the Executive Director is hereby authorized to arrange for the sale of combination tickets good for one passage consecutively over two vehicular crossings, at the following charges and upon the following conditions and such combination tickets shall be accepted in lieu of the toll above provided for single trips.

The charges for combination tickets, in the case of vehicles or combinations of vehicles included in each class herein established shall be:

| | |
|---|---|
| Class 1 | $ .75 |
| Class 2 | .35 |
| Class 3 | 1.40 |
| Class 4 | .75 |
| Class 5 | 1.00 |
| Class 6 | 1.25 |
| Class 7 | 1.00 |
| Class 8 | 1.25 |
| Class 9 | 2.50 |

Combination tickets shall be valid until 8 A.M. of the day following the day of purchase, the time to be the official time prevailing in the municipality in which the ticket is presented.

Combination tickets shall be valid only for the following:

(a) Passage to New Jersey over or through any Hudson River vehicular crossing fol-

lowed by passage to New York over any Staten Island Bridge;

(b) Passage to New Jersey over any Staten Island bridge followed by passage to New York over or through any Hudson River vehicular crossing;

(c) Passage to New York over the Bayonne Bridge followed by passage to New Jersey over either of the Arthur Kill bridges; or

(d) Passage to New York over either of the Arthur Kill bridges followed by passage to New Jersey over the Bayonne Bridge;

and be it further

RESOLVED, that the Executive Director be and he hereby is authorized to issue toll scrip in denominations of 25¢, 50¢, 75¢, $1.00 and $1.50, which may be purchased in lots of 25 per denomination, acceptable at bridges and tunnels at face value in payment of the single trip tolls above provided for any class of vehicle, said scrip to be sold at a reduction of 10%; said scrip will be accepted if detached but no change in any form will be given when scrip is tendered; and be it further

RESOLVED, that the effective date of this resolution shall be June 1, 1947, and that it shall supersede all previous resolutions providing for tolls to be charged for the use of vehicular crossings; and be it further

RESOLVED, that the Executive Director is hereby authorized to arrange for the sale of commutation tickets for passenger automobiles, good only for passage through the Holland and Lincoln Tunnels and over the George Washington Bridge, at the following rates and upon the following conditions, and that such commutation tickets shall be accepted in lieu of the tolls provided for single trips for passenger automobiles using the

said vehicular crossings:

Said commutation tickets for passenger automobiles shall be valid for 40 single trips; the charge for such ticket shall be $10.00.

Said commutation tickets shall be valid only during the 30 days immediately succeeding the date of issue thereof.

and be it further

RESOLVED, that the foregoing amendment shall be effective as of July 1, 1950, or at such earlier date as the Committee on Operations shall determine that physical facilities and other necessary arrangements are adequate to put the same into effect; and be it further

RESOLVED, that the Executive Director is hereby authorized to arrange for the sale of books containing 25 coupons, good for passage over or through any bridge or tunnel for Class I vehicles, at the following rates and upon the following conditions, and that such coupons shall be acceptable in lieu of the tolls provided for single trips for Class I vehicles using the said bridges and tunnels:

The charge for such book shall be $10.00.

The coupons shall be valid to and including December 31 of the second year following the calendar year during which issued.

Said coupons are usable by any person in possession thereof, but shall be detached from the book in the presence of the toll collector only, and shall not be transferred between two or more vehicles on the tolls plazas.

**THE PORT AUTHORITY OF NY & NJ**

225 PARK AVENUE SOUTH, 18TH FLOOR
NEW YORK, NY 10003
(212) 435-7000

August 19, 2002

Dear Fellow Employee/Retiree:

The Port Authority is pleased to introduce ***Employee/Retiree E-ZPass***℠, which will replace existing employee commutation, personal, and annual passes now used for free passage at Port Authority tunnels and bridges for non-represented employees and retirees. You should discontinue your use of personal, commutation and annual passes at Port Authority Tunnel & Bridge facilities as soon as the program is fully implemented.

Under the ***Employee/Retiree E-ZPass*** program you will be issued one orange E-ZPass tag for your exclusive personal use that will provide free (non-revenue) passage at Port Authority tunnels and bridges. **An *Employee E-ZPass* Enrollment Form,** and other related information are enclosed. The Q&A brochure should be helpful in answering any questions you may have, including how you may handle existing E-ZPass accounts you may currently have in your household. In addition, for assistance you may call the Tunnels, Bridges & Terminals' Customer Connection at 1-800-221-9903, between 10 am and 4 pm on weekdays. Please press 00 to speak with a Customer Relations Representative.

Thank you for your cooperation.

Sincerely,

Louis J. LaCapra
Chief Administrative Officer

Ernesto L. Butcher
Chief Operating Officer

Attachments

Note in NY kindly
Employee E-ZPass
began in Summer
of 2002.

E-ZPass

New York Service Center

Mail To: *E-ZPass* Customer Service Center
New York Service Center
P.O. Box 149006
Staten Island, NY 10314-9006
(No faxes accepted)

**NR**

*E-ZPass* Information
(to be filled out by Customer Service Center)

*E-ZPass* Account Number: _____

*E-ZPass* Tag Number: _____

Clerk No.: _____

Date Opened: _____

Approved: _____ Exception: _____

# Port Authority Employee/Retiree E-ZPass℠ Enrollment Form

**If you choose to fund the account for your personal use at non-PA crossings, you must also complete the purple sections below.**

Name: _____ Employee Number: _____
Last First M.I.

Address: _____ Daytime Telephone: ( ) _____

City: _____ State: _____ Zip Code: _____

License Plate: _____ State: _____ PIN Number: ____ ____ ____ ____
(Select any four numbers that you will remember)

License Plate: _____ State: _____

Vehicle Make, Model and Year: _____

Vehicle Make, Model and Year: _____

If your vehicle is not a Class 1, (a Class 1 vehicle is typically an automobile, SUV or van) with two axles and single rear wheels, you may not use the tag at any non-Port Authority crossings.

If you choose to use the Port Authority *Employee/Retiree E-ZPass* tag at Port Authority crossings ONLY (Holland and Lincoln tunnels, George Washington, Bayonne and Goethals bridges and Outerbridge Crossing), and do not want to fund the account, skip to Customer Agreement and sign.

**Please remember to review E-ZPass Customer Agreement Terms and Conditions, Employee/Retiree E-ZPass Addendum and AP 40-1.01, "Port Authority E-ZPass Programs at Tunnel and Bridge Crossings," (attached), and sign form below.**

**Instructions:** Refer to the plan descriptions and requirements on the back of this form prior to completing it. Select the plan(s) you would like to add to your E-ZPass account. In the right column, enter the required pre-payment for each plan you select. Add up the payment amounts for each plan you have selected and enter the total on line 6 (this amount will be added to your monthly replenishment.)

| | | | Fill in amount or check to enroll |
|---|---|---|---|
| 1 | Basic Plan (for all facilities) Select this plan if you do not select any of the prepaid plans below. | $25.00 | $ |
| 2 | MTA Staten Island Resident Discount Plan (Proof of residency required) This plan is not available on two accounts simultaneously. | $ 0.00 | Check here to enroll ( ) |
| 3 | MTA Rockaway Resident Discount Plan (Proof of residency required) This plan is not available on two accounts simultaneously. | $ 0.00 | Check here to enroll ( ) |
| 4 | Thruway Tappan Zee Commuter Plan | $25.00 | $ |
| 5 | Thruway Tappan Zee Carpool Commuter Plan | $25.00 | $ |
| 6 | (Add lines 1-5) TOTAL PREPAID AMOUNT DUE | $ | |

**Payment Information:** To add most plans to your *Employee/Retiree E-ZPass* New York account, you must submit payment for the plan(s) selected above. You may either provide credit card information or include a check or money order with this form.

☐ Credit Card Payment with Automatic Replenishment* ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Credit Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date: __ __ / __ __

I authorize *E-ZPass* to immediately charge my credit card for the total amount shown on line 6. Whenever my prepaid balance is $10.00 or below, I authorize *E-ZPass* to charge my credit card an amount that reflects my average monthly usage. I authorize *E-ZPass* to, on a continuing basis, obtain updated information about my credit card from the financial institution that issued the credit card, including but not limited to changes in account number and/or expiration date. I understand and agree that such charges will continue until my *E-ZPass* account is terminated or I revoke this authorization in writing. Should I fail to return my tag, require a replacement or incur an administrative fee, I authorize *E-ZPass* to charge my credit card the appropriate amount incurred under the terms of my agreement.

* _____ _____/_____/_____
Cardholder Signature (Required) Date

☐ Check or Money Order Payment (Please sign the customer agreement below and attach to this form a check or money order made payable to *E-ZPass*.)

**Customer Agreement:** My completion of this form, payment of the required deposits, and signature below constitute my agreement to use *E-ZPass* subject to all applicable terms and conditions. I understand and agree that by using *E-ZPass* facilities, the resulting charges will be deducted from my prepaid *E-ZPass* account. I understand and agree that I have read, understand, and accept the terms and conditions set forth in this form, all of which are part of my agreement.

By signing below, I agree to the Terms and Conditions outlined on the attached "*E-ZPass* Customer Agreement Terms and Conditions," "*Employee/Retiree E-ZPass* Addendum," and Port Authority AP 40-1.01 Port Authority *E-ZPass* Programs at Tunnel and Bridge Crossings.

* _____ _____
Employee Signature (Required for All Account Types) Date

**THE PORT AUTHORITY** OF NY & NJ

# Port Authority Employee/Retiree Addendum to *E-ZPass*℠ Customer Agreement Terms and Conditions

- Upon request via an *Employee/Retiree E-ZPass* Enrollment Form, an *Employee/Retiree E-ZPass* account ("*Employee E-ZPass account*") will be opened for the employee/retiree ("employee"), who will receive one orange non-revenue tag.

- There is no deposit required for this tag.

- The tag is issued for the employee's personal or commutation use in accordance with AP 40-1.01, Port Authority E-ZPass Programs at Tunnel and Bridge Crossings. It provides for free passage at Port Authority tunnel and bridge crossings when the employee is in the vehicle.

- Employees who choose to fund the *Employee E-ZPass* account with a prepaid toll balance for their own personal use at non-Port Authority crossings:

  – authorize E-ZPass to debit their account for such use

  – authorize E-ZPass to deduct any applicable administrative fees incurred pursuant to this Agreement from prepaid toll balance

  – must obey all laws and regulations at all E-ZPass toll plazas

  – must maintain a sufficient prepaid toll balance

- Whether or not you choose to fund the account, all *Employee E-ZPass* Enrollment Forms must be sent to the New York Customer Service Center at Staten Island by mail. If you fund the account, initial payment can be made using credit card, check, money order or cashier's check. Subsequent replenishments can be made using cash, if necessary, or by other means, at a NY Customer Service Center.

- In addition to the provisions of AP 40-1.01, the account is subject to all the rules and regulations established by the E-ZPass Customer Agreement. If an *Employee E-ZPass* account is deemed invalid due to speeding violations, insufficient funds, or other reasons, the account will be invalid everywhere and the free passage feature at Port Authority crossings will be suspended until the *Employee E-ZPass* account is reinstated.

- Employees should be prepared to show Port Authority identification at Port Authority toll plazas upon request.

- Non-revenue trips on Port Authority *Employee E-ZPass* account are subject to audit.

- Upon separation (other than retirement) from Port Authority service, the *Employee E-ZPass* account will be deactivated and tag must be returned to Customer Service Center.

- Inquiries and correspondence, payments, tag returns, or violation inquiries regarding *Employee E-ZPass* account can be sent to:

  E-ZPass Customer Service Center
  Port Authority Employee E-ZPass
  P.O. Box 149006
  Staten Island, NY 10314-9006

# How to Sign Up for Employee/Retiree *E-ZPass*SM:

*Complete the enclosed* **Employee/Retiree E-ZPass Enrollment Form** *and mail it in the pre-*addressed envelope. The home mailing address you include on the enrollment form must match the home address on file in the Port Authority's PeopleSoft system; otherwise the application will be rejected and returned to you. Contact your administrator to update your home address on PeopleSoft.

By submitting the Enrollment Form, you will have a special **Employee/Retiree E-ZPass** account established for your personal use, and you agree to comply with all regulations as detailed in the "E-ZPass Customer Agreement Terms and Conditions" and Port Authority Employee/Retiree Addendum," (see attached).

**You may Fund the Account for your Personal Use at Non-PA Toll Plazas, or Not Fund the Account and Use it Exclusively at PA Crossings:**

- ✓ On the Enrollment Form, you have an option to fund the account with a prepaid toll balance for your personal use at other agencies' toll plazas, in addition to your non-revenue use at PA crossings (Holland and Lincoln tunnels, George Washington, Bayonne and Goethals bridges and Outerbridge Crossing). To fund the account, fill out the entire Enrollment Form, including the purple section, and sign the Customer Agreement.

- ✓ If you do not fund the **Employee/Retiree E-ZPass** account, you will only be able to use the tag at PA crossings. The tag is not valid at other agencies' toll facilities unless it is funded with a prepaid toll balance. Remember, use of an unfunded tag at other agencies' toll facilities will result in the issuance of violations, administrative fees, and/or confiscation of the tag by toll plaza personnel. If you choose not to fund the Employee E-ZPass account, please fill out the black sections of the Enrollment Form only and sign the Customer Agreement. Make sure the tag is in the silver bag to prevent it from reading.

- ✓ If your vehicle is not a Class 1 (typically an automobile, SUV or van) with two axles and single rear wheels, **you may not use the tag at any non-Port Authority crossings.**

**Please remember that the use of this tag for free passage at PA crossings is restricted to active and retired PA employees and can be used only if the employee is in the vehicle traveling through PA crossings. The tag is not transferable to other individuals. Random checks may be conducted at PA crossings to confirm that the employee is in the vehicle. Mis-use of the tag may result in discipline and loss of benefit**

For assistance, you may call the Tunnels, Bridges and Terminals' Regional E-ZPass Program Unit at 1-800-221-9903 and leave a message. Staff will return your call within two business days.

**THE PORT AUTHORITY** OF NY & NJ

*E-ZPass* Customer Services
One Madison Ave. - 5th Floor
New York, NY 10010

Dear Fellow Employee:

I am pleased to inform you that you are eligible for the **Employee/Retiree E-ZPass Program.** This program replaces existing employee commutation, personal and annual passes currently used for free passage at Port Authority tunnels and bridges.

Under the Program you will be issued one orange E-ZPass tag for your exclusive personal use for free (non-revenue) passage at Port Authority tunnels and bridges. Please discontinue your use of passes as soon as you receive your orange E-ZPass tag. An Employee E-ZPass Enrollment Form and other related information are enclosed. The Q&A brochure should be helpful in answering any questions you have, including how to handle existing E-ZPass accounts you may currently have in your household. Please e-mail any additional questions to sggonzalez@panynj.gov.

Thank you for your cooperation.

Sincerely,

John Riccardi

John Riccardi
Policy Manager, E-ZPass Customer Service Center
Regional E-ZPass Programs
Tunnels, Bridges and Terminals

sg
Enclosures
1. Customer Agreement Terms and Conditions
2. E-ZPass Non-Revenue Application
3. Envelope
4. Instructions
5. Questions and Answers

# How to Sign Up for Employee/Retiree *E-ZPass*:

Complete the enclosed **Employee/Retiree E-ZPass Enrollment Form** and mail it in the pre-addressed envelope. The mailing address you include on the enrollment form must match the mailing address on file in the Port Authority's PeopleSoft system; otherwise the application will be rejected and returned to you. Contact your administrator to update your mailing address on PeopleSoft.

By submitting the Enrollment Form, you will have a special **Employee/Retiree E-ZPass** account established for your personal use, and you agree to comply with all regulations as detailed in the "E-ZPass Customer Agreement Terms and Conditions" and Port Authority Employee/Retiree Addendum," (see attached).

**You may Fund the Account for your Personal Use at Non-PA Toll Plazas, or Not Fund the Account and Use it Exclusively at PA Crossings:**

- ✓ *On the Enrollment Form, you have an option to fund the account with a prepaid toll* balance for your personal use at other agencies' toll plazas, in addition to your non-revenue use at PA crossings (Holland and Lincoln tunnels, George Washington, Bayonne and Goethals bridges and Outerbridge Crossing). To fund the account, fill out the entire Enrollment Form, including the purple section, and sign the Customer Agreement.

- ✓ If you do not fund the **Employee/Retiree E-ZPass** account, you will only be able to use the tag at PA crossings. The tag is not valid at other agencies' toll facilities unless it is funded with a prepaid toll balance. Remember, use of an unfunded tag at other agencies' toll facilities will result in the issuance of violations, administrative fees, and/or confiscation of the tag by toll plaza personnel. If you choose not to fund the Employee E-ZPass account, please fill out the black sections of the Enrollment Form only and sign the Customer Agreement. Make sure the tag is in the silver bag to prevent it from reading at other agency toll plazas.

- ✓ If your vehicle is not a Class 1 (typically an automobile, SUV or van) with two axles and single rear wheels, **you may not use the tag at any non-Port Authority crossing.**

**Please remember that the use of this tag for free passage at PA crossings is restricted to active and retired PA employees and can be used only if the employee is in the vehicle traveling through PA crossings. The tag is not transferable to other individuals. Random checks may be conducted at PA crossings to confirm that the employee is in the vehicle. Mis-use of the tag may result in discipline and loss of the non-revenue benefit.**

For assistance, you may call the Tunnels, Bridges and Terminals' Regional E-ZPass Program at 1-800-221-9903 and leave a message. Staff will return your call within two business days.

New York Service Center

Mail To: *E-ZPass* Customer Services
One Madison Ave., 5th Floor
New York, NY 10010

NR

***E-ZPass* Information** (to be filled out by Customer Service Center)

*E-ZPass* Account Number: _____

*E-ZPass* Tag Number: _____

Clerk No.: _____

Date Opened: _____

Approved: _____ Exception: _____

# Port Authority Employee/Retiree E-ZPass® Enrollment Form

**If you choose to fund the account for your personal use at non-PA crossings, you must also complete the purple sections below.**

NAME: _____ (Last / First / M.I.) EMPLOYEE NUMBER: _____

ADDRESS: _____ DAYTIME TELEPHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LICENSE PLATE: _____ STATE: _____ PIN NUMBER: _____
(Select any four numbers that you will remember)

LICENSE PLATE: _____ STATE: _____

VEHICLE MAKE, MODEL AND YEAR: _____

VEHICLE MAKE, MODEL AND YEAR: _____

If your vehicle is not a Class 1, (a Class 1 vehicle is typically an automobile, SUV or van) with two axles and single rear wheels, you may not use the tag at any non-Port Authority crossings.

If you choose to use the Port Authority *Employee/Retiree E-ZPass* tag at Port Authority crossings ONLY (Holland and Lincoln tunnels, George Washington, Bayonne and Goethals bridges and Outerbridge Crossing), and do not want to fund the account, skip to Customer Agreement and sign.

**Please remember to review *E-ZPass* Customer Agreement Terms and Conditions and Employee/Retiree *E-ZPass* Addendum (attached), and sign form below. In addition, review AP 40-1.01 which can be found on eNet or requested from *E-ZPass* Customer Services at the address listed above.**

**Instructions:** Discount plans are available. Visit www.ezpassny.com or request a copy from E-ZPass Customer Services at the address listed above. Select the plan(s) you would like to add to your *E-ZPass* account. In the right column, enter the required pre-payment for each plan you select. Add up the payment amounts for each plan you have selected and enter the total in Box D (this amount will be added to your monthly replenishment).

| | | |
|---|---|---|
| BOX A | MINIMUM AMOUNT OF PREPAID TOLLS<br>If you select the GIC or GIR plans, you may enter $0.00 in Box A (refer to *E-ZPass* Plans for plan descriptions). | BOX A $ 25.00 |
| BOX B | ADDITIONAL AMOUNT OF PREPAID TOLLS<br>(If you would like to add more money to your initial prepaid tolls) | BOX B $ |

| FREQUENT USERS/RESIDENCY PLANS (OPTIONAL) – Complete this section only if you want a Commuter/Resident Discount Plan. Refer to *E-ZPass* Discount Plans at www.ezpassny.com | PLAN CODE | DISCOUNT PLAN AMT. |
|---|---|---|
| | | |
| | | |
| | | |

*COMMUTER/RESIDENT DISCOUNT PLANS*
The dollar amount included on www.ezpassny.com under *E-ZPass* Discount Plans is the required prepaid amount for that plan.

**TOTAL $ AMOUNT OF DISCOUNT PLANS SELECTED** — BOX C $

**INITIAL PAYMENT - Total of Boxes A, B and C** $ — BOX D $

**Payment Information:** To add discount plans to your *Employee/Retiree E-ZPass* New York account, you must submit payment as indicated above. You may either provide credit card information or include a check or money order with this form.

## PAYMENT METHOD/REPLENISHMENT OPTIONS - Select option 1 or option 2

☐ OPTION 1 - Credit Card with Automatic Replenishment - **The easiest way to pay.**
When your prepaid balance reaches a certain level, your *E-ZPass* account will automatically be replenished.

Credit Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date: __ __ / __ __

☐ Credit Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

I authorize *E-ZPass* to immediately charge my credit card for the total amount shown in the "Initial Payment" Box D. Whenever my prepaid amount decreases to or below the replenishment point for my account, I authorize *E-ZPass* to charge my credit card my replenishment amount. I understand and agree that such charges will continue until my *E-ZPass* account is terminated or I revoke this authorization in writing. Should I fail to return my Tag(s) or require a replacement, or incur an administrative fees or *E-ZPass Plus* charge, I authorize *E-ZPass* to charge my credit card the appropriate amount incurred under the terms of my agreement. I understand that the replenishment amount may be adjusted to reflect actual usage. I authorize *E-ZPass* in its discretion to receive updated information about my credit card, including new account numbers and expiration dates, from the financial institution issuing my credit card.

* _____ _____/_____/_____
**Cardholder Signature (Required)** Date

☐ OPTION 2 - Check or Cash Replenishment

- Once your account is opened, you can replenish your account by mailing a check made payable to "E-ZPass" or by making a cash payment at one of our eight convenient walk-in centers listed in the Q&A brochure.
- You are responsible for monitoring your account and maintaining a positive balance. Failure to do so may cause violations/confiscation and a loss of the non-revenue benefit.
- Do not mail cash.

**Customer Agreement:** My completion of this form, payment of the required deposits, and signature below constitute my agreement to use *E-ZPass* subject to all applicable terms and conditions. I understand and agree that by using E-ZPass facilities, the resulting charges will be deducted from my prepaid *E-ZPass* account. I understand and agree that I have read, understand, and accept the terms and conditions set forth in this form, all of which are part of my agreement.

By signing below, I agree to the Terms and Conditions outlined on the attached "*E-ZPass* Customer Agreement Terms and Conditions," "Employee/Retiree *E-ZPass* Addendum". I also agree to be bound by AP 40-1.01 Port Authority *E-ZPass* Programs at Tunnel and Bridge Crossings, which can be viewed on eNet or requested from *E-ZPass* Customer Services at the address listed above.

* _____ _____/_____/_____
**Employee Signature (Required for All Account Types)** Date

**THE PORT AUTHORITY** OF NY & NJ

# Port Authority Employee/Retiree Addendum to *E-ZPass*® Customer Agreement Terms and Conditions

1. Upon request via an *Employee/Retiree E-ZPass* Enrollment Form, an *Employee/Retiree E-ZPass* account ("*Employee E-ZPass account*") will be opened for the employee/retiree ("employee"), who will receive one orange non-revenue tag.

2. There is no deposit required for this tag. If the tag is lost, stolen or damaged, the employee must pay for the tag at the prevailing rate.

3. The tag is issued for the employee's personal or commutation use in accordance with AP 40-1.01, Port Authority E-ZPass Programs at Tunnel and Bridge Crossings. It provides for free passage at Port Authority tunnel and bridge crossings **when the employee is in the vehicle.**

4. Employees who choose to fund the *Employee E-ZPass* account with a prepaid toll balance for their own personal use at non-Port Authority crossings:

   - authorize E-ZPass to debit their account for such use

   - authorize E-ZPass to deduct any applicable administrative fees incurred pursuant to this Agreement from prepaid toll balance

   - must obey all laws and regulations at all E-ZPass toll plazas

   - must maintain a sufficient prepaid toll balance

5. Whether or not the account is funded, all *Employee E-ZPass* Enrollment Forms must be mailed to *E-ZPass* Customer Service at the address listed below. If funding the account, initial payment can be made using credit card, check, money order or cashier's check. Subsequent replenishments can be made using cash, if necessary, or by other means, at a NY *E-ZPass* Customer Service Center.

6. In addition to the provisions of AP 40-1.01 which can be found on eNet or requested from TB&T *E-ZPass* Customer Services, the account is subject to all Terms and Conditions established by the *E-ZPass* Customer Agreement. If an *Employee E-ZPass* account is deemed invalid due to speeding violations, insufficient funds, or other reasons, the account is invalid everywhere and the free passage feature at Port Authority crossings will be suspended until the *Employee E-ZPass* account is reinstated. Use of the *E-ZPass* tag during suspension will result in violations / confiscation.

7. Employees should be prepared to show Port Authority identification at Port Authority toll plazas upon request.

8. Non-revenue trips on Port Authority *Employee E-ZPass* account are subject to audit.

9. Upon separation (other than retirement) from Port Authority service, the *Employee E-ZPass* account will be deactivated and the tag must be returned to the Unit Administrator. Failure to return the tag results in the tag cost being debited from the account.

10. Inquiries and correspondence, payments, tag returns, or violation inquiries regarding *Employee/Retiree E-ZPass* account can be sent to:

    E-ZPass Customer Services
    One Madison Ave., 5th Floor
    New York, NY 10010

# Customer Agreement Terms and Conditions

These terms and conditions, together with your E-ZPass application ("Application"), constitute your E-ZPass Agreement ("Agreement"). E-ZPass is an electronic toll collection system that allows you to pre-pay charges incurred at E-ZPass facilities. New York E-ZPass is operated under the auspices of the Triborough Bridge and Tunnel Authority ("TBTA"), the New York State Thruway Authority ("NYSTA"), and the Port Authority of New York and New Jersey ("PANYNJ"). *Your E-ZPass account ("Account") will be operable on all E-ZPass facilities, regardless of location. Your Account will be assigned to one of the* above-mentioned New York entities and your Agreement is with that particular entity. Identification of the New York entity to which your Account has been assigned and with which you have your Agreement appears on your E-ZPass tag(s) ("Tag"). Please read these terms and conditions and keep them for your records. When you open your Account and use your E-ZPass Tag, you agree as follows:

**1) GENERAL**

a. Failure to comply with this Agreement may result in termination of your Account.
b. You may not assign the obligations or benefits of this Agreement.
c. Failure to pay charges to your Account may result in penalties as provided by law.
d. You must approach and pass through E-ZPass toll lanes at the posted speed limit. Failure to obey the posted speed limit may result in suspension or revocation of your Account.
e. You must comply with all applicable traffic laws, regulations, signs and signals, and the directions of toll collectors and law enforcement officers.

**2) TAG USE**

a. Tag Deposit. Cash or check customers must pay a deposit of $10 for each Tag. The deposit will be refunded when you close your Account and return the Tag in good condition as determined solely by E-ZPass. The Tag deposit is waived for customers authorizing Account replenishment via automatic charge to a credit card.
b. *You may use the Tag on the vehicle(s) specifically listed on your Application.*
c. In accordance with Section 5 herein, you must surrender a Tag immediately upon request.
d. When you use the Tag at any E-ZPass facility, you authorize E-ZPass to debit your Account for charges incurred.
e. If you use the Tag on E-ZPass facilities other than New York E-ZPass facilities, you are subject to the laws and regulations governing such use.
f. You must maintain a sufficient balance in your Account, and may not permit Tag use unless a sufficient balance is maintained.

**3) YOUR ACCOUNT**

a. You must maintain a prepaid amount in your Account to cover applicable charges to your Account. Applicable charges, if any, will be deducted from your Account each time the Tag is used.
b. E-ZPass may deduct from your Account applicable administrative fees incurred pursuant to this Agreement.
c. Your Account may be suspended based upon outstanding violations and/or for failure to pay administrative fees.
d. No interest will be paid on balances in your Account or on refundable Tag deposits.
e. You will receive a periodic statement unless there are no transactions and no financial activity in your Account during the applicable period covered by such statement.
f. You will be charged a fee for any request to retrieve a statement previously provided.
g. You may, no more than four times per year, suspend the following monthly use plans for a minimum of one week and extend the monthly period for calculating the minimum commuter trip charge by calling 1-800-333-TOLL (8655): Tappan Zee Bridge Commuter (TZC), Tappan Zee Bridge Carpool Commuter (TZPL), Grand Island Commuter (GIC), New Rochelle Commuter (NRC), Yonkers Commuter (YKC), Harriman Commuter (HAC), Bridge Authority Discount (NYSBA). The first Tag use at the applicable bridge after the minimum one-week period will reactivate the monthly use plan.
h. E-ZPass, in its discretion, may receive updated information about your credit card, including new account numbers and expiration dates, from the financial institution issuing the card.

**4) ACCOUNT PRE-PAYMENT**

a. You must pay a minimum prepaid amount sufficient to pay charges to your Account for a one-month period.
b. Your Account must be replenished by your prepaid amount when your Account balance decreases to or below the replenishment point specific to your Account plan. You may choose to replenish your Account in one of the following ways:
   1. Authorizing E-ZPass to automatically charge your credit card for all charges to your Account.
   2. Checks (or Money Orders) made payable to E-ZPass. A returned check fee of $25 will be charged for each check returned to E-ZPass unpaid by your bank.
   3. Cash payments made at an E-ZPass Customer Service Center only in U.S. dollars, or in Canadian dollars at the exchange rate E-ZPass may determine. DO NOT SEND CASH BY MAIL.
c. An Account analysis is performed on all new Accounts 35 days from the first Tag use and every 90 days thereafter. If your monthly use is consistently above or below your prepaid amount, E-ZPass will adjust your prepaid amount to approximate a one-month level of use.
d. If you have chosen to replenish your Account with a credit card, you may be enrolled in the E-ZPass Plus program. This Program allows you to use your Tag at authorized E-ZPass Plus facilities. If your Tag is used to incur E-ZPass Plus charges, then E-ZPass may charge your credit card that amount. Such credit card charges may be different from your replenishment amount and charged to your credit card at any time. By participating in E-ZPass Plus, you consent to the release of your name and address to E-ZPass Plus facility operators for collection purposes. If you choose not to participate in E-ZPass Plus, you must notify the E-ZPass Customer Service Center.
e. Depending on usage or other charges to your Account, there may be more than one replenishment transaction within one statement period.

**5) VIOLATIONS**

a. If you use the Tag when your Account is in a negative balance, suspended or revoked, or after the Tag has been reported lost or stolen, you may: incur *administrative fees of up to $50 per occurrence; be charged the full, undiscounted charge; and/or be asked to surrender the Tag to E-ZPass via certified* mail or to plaza personnel.
b. If you use the Tag in a vehicle other than one of the class for which the Tag is designated, you may incur administrative fees of up to $50 per occurrence and/or be asked to surrender the Tag to E-ZPass via certified mail or to plaza personnel. Such continued misuse may result in revocation of your Account.

(continued on reverse)

**6) DISPUTES**
You hereby authorize E-ZPass to decide in the first instance every question or dispute arising from, under, in connection with or related to this Agreement, including, without limitation, the imposition of tolls, fees, or other charges incurred, applied or stated for the use or misuse of your Tag or Account. All disputes must be submitted in writing to the E-ZPass Customer Service Center within 180 days of notice that a toll, fee, or other charge has been made to your Account. You agree that the mailing or emailing to the address you state on your Application or to an address which you subsequently provide to the E-ZPass Customer Service Center constitutes notice to you of the tolls, fees and charges contained therein and of any determination by E-ZPass of your submitted dispute. The imposition of claims against PANYNJ, NYSTA and TBTA arising from, under, in connection with or in any way related to this Agreement including, without limitation, the imposition of tolls, fees, or other charges incurred, applied or stated for the use or misuse of your Tag or Account, are governed as follows:

- PANYNJ – the provisions of New York State Unconsolidated Laws, Sections 7101 through 7136 and New Jersey Statutes Annotated, Sections 32:1-157 through 32:1-176.
- NYSTA - the provisions of Section 361-b of the New York State Public Authorities Law.
- TBTA – no action shall lie or be maintained unless such action shall be commenced within one year of notice of E-ZPass' determination regarding your dispute submitted pursuant to this Agreement.

**7) LOST/STOLEN OR NON-OPERATIONAL TAGS**
You will not be liable for unauthorized Tag use that occurs after you notify E-ZPass, orally or in writing, of loss, theft or possible unauthorized use. However, if a Tag is reported lost, or stolen, or is defaced or damaged, you will be charged $23.00 for interior Tags and $33.00 for exterior Tags. If a Tag is non-operational for reasons other than abuse or improper use, and the Tag is returned to an E-ZPass Customer Service Center, E-ZPass will replace it at no charge.

**8) DISCLAIMER**
You acknowledge that E-ZPass and all entities providing E-ZPass services have not made, and expressly disclaim any representation or warranty, express or implied relating to the Tag including, without limitation, any implied or express warranty of merchantability, fitness for a particular purpose or conformity to models or samples. You agree that E-ZPass and all entities providing E-ZPass services will have no obligation or liability whatsoever to you with respect to your use of or the performance of the Tag. You agree to indemnify and hold harmless E-ZPass and all entities providing E-ZPass services from and against all damage, loss, cost, expense or liability relating to, arising from, or as a result of, the use or performance of the Tag.

**9) TERMINATION**
You may terminate this Agreement at any time by requesting such termination in writing and returning the Tag(s) to E-ZPass. Tags should be returned to an E-ZPass Customer Service Center in person or by certified mail. Tags remain the property of the entities providing E-ZPass services. Upon termination and return of the Tag(s), once all outstanding charges have been deducted from your Account, any remaining balance and Tag deposit will be refunded to you. Such refund will be made in the form of a check or credit to your credit card, depending on the manner in which you have chosen to replenish your Account balance.

**10) COLLECTION OF EXPENSES**
You agree to pay all costs, including attorneys' fees, incurred by E-ZPass and all entities providing E-ZPass services to collect any monies due under the terms of this Agreement.

**11) MODIFICATIONS**
E-ZPass may change the terms of this Agreement at any time by advance written notice. Such modified terms shall take effect on the date specified therein. The invalidity of any term or terms of this Agreement shall not affect any other term of this Agreement, which shall remain in full force and effect.

**12) GOVERNING LAW**
This Agreement shall be governed by and construed in accordance with the laws of the State of New York.

**13) CHANGES**
You agree to inform E-ZPass of any changes to the information provided by you in your Application, such as:

- Address,
- Vehicle information,
- Credit card account status (i.e., closed account, maximum credit use),
- Expiration date of credit card account, or
- Payment method.

**14) NON-DISCLOSURE**
E-ZPass respects the privacy of all Account holders. Account information will not be disclosed to third parties without your consent except as permissible by law and the policies of E-ZPass and the entities providing E-ZPass services.

**15) INQUIRIES AND CORRESPONDENCE**
Please send all correspondence, payments, Tag returns, or violation inquiries to:

**E-ZPass CUSTOMER SERVICE CENTER**

| APPLICATIONS AND RETURNED TAGS: | VIOLATIONS: | PAYMENTS: | CORRESPONDENCE: |
|---|---|---|---|
| PO Box 149001 | PO Box 149003 | PO Box 149002 | PO Box 149004 |
| Staten Island, NY | Staten Island, NY | Staten Island, NY | Staten Island, NY |
| 10314-9001 10314-9003 | 10314-9003 | 10314-9002 | 10314-9004 |

**16) SCHEDULE OF DEPOSITS/ADMINISTRATIVE FEES**

| | | |
|---|---|---|
| Per Tag deposit (cash and check customers) | | $10.00 |
| Per Tag deposit (credit card customers) | | waived |
| Cost of Tag if defaced, damaged, lost or stolen | Interior | $23.00 |
| | Exterior | $33.00 |
| Returned check fee | | $25.00 |
| Monthly statement by mail, annual fee | | $6.00 |
| Duplicate copy of Statement | | $2.00 |
| PANYNJ monthly Account service fee | | $1.00 |
| Account revocation fee | | $25.00 |
| Tag retention fee | | Up to $25.00 |
| Other Tag misuse/violation administrative fees | | Up to $50.00 |

E-ZPass and the entities providing E-ZPass services reserve the right to assess additional fees.

**PLEASE RETAIN FOR YOUR RECORDS.**

# Employee E-ZPass Program
# What to Expect from the Recent Change in Port Authority Policy

## Non-Represented Employees Hired On or Before September 11, 2001

As an active Port Authority employee qualifying for the temporary Non-Revenue Employee E-ZPass Program relating to commutation and business travel, you can expect the following:

- Effective January 1, 2011, your orange E-ZPass tag will no longer be accepted for non-revenue airport parking. *If your Employee E-ZPass account is automatically replenished* by a credit card, you can use the E-ZPass Plus option for payment of all applicable airport parking charges. Please see www.e-zpassny.com for details on E-ZPass Plus.
- Effective January 1, 2011, your orange E-ZPass tag will no longer provide for non-revenue passage at the Port Authority tunnels and bridges, except for employee commutation to and from your primary work location and for travel associated with official Port Authority business. As the orange E-ZPass tag will still be maintained as "non-revenue" status for all Port Authority bridge and tunnel transactions, you will be required to reimburse the Port Authority for all other use of Port Authority tunnels and bridges. Employees who have elected not to obtain or use an orange Employee E-ZPass tag will continue to be reimbursed for business travel. All reimbursement will be through existing administrative mechanisms.
- Employees who violate the established procedures will permanently forfeit their Non-Revenue Employee E-ZPass commutation and business travel privileges and be subject to other disciplinary action.
- If an employee's commutation pattern changes, he or she may apply for a Non-Revenue (orange) E-ZPass tag for commutation and business travel as long as the program is offered and the employee meets the eligibility requirements.

If you have questions about orange E-ZPass tags, your E-ZPass account or any other E-ZPass transitional issue, please write via email to E-ZPass@panynj.gov or call 212-435-4820.

# Employee E-ZPass Program
# What to Expect from the Recent Change in Port Authority Policy

## Non-Represented Employees Hired After September 11, 2001

The Port Authority Non-Revenue Employee E-ZPass Program is being discontinued for all active, non-represented Port Authority employees hired or rehired after September 11, 2001, for all purposes, whether for commutation, business travel or personal use. You can expect the following:

- Effective January 1, 2011, your orange E-ZPass tag will no longer be accepted for non-revenue passage at the Port Authority tunnels and bridges. Initially, posting of Port Authority toll charges may be delayed, but will be correctly deducted from your account as soon as practical.
- If you currently fund this account for travel at other toll facilities, you may continue to use your tag. However, your account will also be charged the appropriate toll for travel at Port Authority tunnels and bridges and be subject to the $1.00 monthly private account fee applicable to all Port Authority private account holders.
- If you do not currently fund your account, your orange E-ZPass tag will be deactivated effective January 1, 2011 and you will need to open a new E-ZPass account for travel at Port Authority bridges and tunnels and other toll facilities. Holders of orange E-ZPass tags associated with unfunded accounts will be provided with postage-paid envelopes to return their deactivated tags to the Port Authority.
- Effective January 1, 2011, your orange E-ZPass tag will no longer be accepted for non-revenue airport parking. If you have opted to fund your Employee E-ZPass account with a credit card, you may continue to use the E-ZPass Plus payment option for airport parking. Please see www.e-zpassny.com for details about E-ZPass Plus.

If you have questions about orange E-ZPass orange tags, your E-ZPass account or any other E-ZPass transitional issue, please write via email to E-ZPass@panynj.gov or call 212-435-4820.

## For Non-Represented Eligible Employees Hired Prior to or on 9/11/2001

# Port Authority Employee Addendum to *E-ZPass*® Customer Agreement Terms and Conditions

1. Upon request via an Employee E-ZPass Enrollment Form, an Employee E-ZPass account will be opened for the employee ("employee"), who will receive one orange non-revenue tag. Employees must obey all laws and regulations at all E-ZPass toll plazas.

2. There is no deposit required for this tag. If the tag is lost, stolen or damaged, the employee must pay for the tag at the prevailing rate.

3. The tag is issued for the employee's commutation or business-related use in accordance with AP 40-1.01, Port Authority E-ZPass Programs at Tunnel and Bridge Crossings. It provides for free passage at Port Authority tunnel and bridge crossings when the employee is in the vehicle and commuting to his/her primary work site or traveling for business.

   - Personal use of the tag at Port Authority crossings must be reimbursed using PA form 3269B within 45 days of the transaction.

4. Employees who choose to fund the Employee E-ZPass account with a prepaid toll balance for their own personal use at non-Port Authority crossings:

   - authorize E-ZPass to debit their account for such use

   - authorize E-ZPass to deduct any applicable administrative fees incurred pursuant to this Agreement from prepaid toll balance

   - must obey all laws and regulations at all E-ZPass toll plazas

   - must maintain a sufficient prepaid toll balance

5. Whether or not the account is funded, all Employee E-ZPass Enrollment Forms must be mailed to E-ZPass Customer Service at the address listed below. If funding the account, initial payment can be made using credit card, check, money order or cashier's check. Subsequent replenishments can be made using cash, if necessary, or by other means, at a NY E-ZPass Customer Service Center.

6. In addition to the provisions of AP 40-1.01 which can be found on enet or requested from TB&T E-ZPass Customer Services, the account is subject to all Terms and Conditions established by the E-ZPass Customer Agreement. If an Employee E-ZPass account is deemed invalid due to speeding violations, insufficient funds, or other reasons, the account is invalid everywhere and the free passage feature at Port Authority crossings will be suspended until the Employee E-ZPass account is reinstated. Use of the E-ZPass tag during suspension will result in violations / confiscation.

7. Employees should be prepared to show Port Authority identification at Port Authority toll plazas upon request.

8. Non-revenue trips on Port Authority Employee E-ZPass account are subject to audit.

9. Upon separation from Port Authority service, the Employee E-ZPass account will be deactivated and the tag must be returned to the Unit Administrator. Failure to return the tag results in the tag cost being debited from the account.

10. Inquiries and correspondence, payments, tag returns, or violation inquiries regarding Employee E-ZPass account can be sent to:

    E-ZPass Customer Services
    One Madison Ave., 5th Floor
    New York, NY 10010

**For Non-Represented Eligible Employees Hired Prior to or on 9/11/2001**

2/2011

*New York Service Center*

Mail To: *E-ZPass* Customer Services
One Madison Ave., 5th Floor
New York, NY 10010

Non-revenue for commutation and business related travel only

*E-ZPass* **Information** (to be filled out by Customer Service Center)

*E-ZPass* Account Number: _____

*E-ZPass* Tag Number: _____

Clerk No.: _____

Date Opened: _____

Approved: _____ Exception: _____

# *Port Authority Non-Represented Eligible Employee E-ZPass Enrollment Form*

**If you choose to fund the account for your personal use at non-PA crossings, you must also complete the purple sections below.**

NAME: _____ (Last / First / M.I.) EMPLOYEE NUMBER: _____

ADDRESS: _____ DAYTIME TELEPHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LICENSE PLATE: _____ STATE: _____ PIN NUMBER: _____
(Select any four numbers that you will remember)

LICENSE PLATE: _____ STATE: _____

VEHICLE MAKE, MODEL AND YEAR: _____

VEHICLE MAKE, MODEL AND YEAR: _____

If your vehicle is not a Class 1, (a Class 1 vehicle is typically an automobile, SUV or van) with two axles and single rear wheels, you may not use the tag at any non-Port Authority crossings.

If you choose to use the Port Authority *Employee E-ZPass* tag at Port Authority crossings ONLY (Holland and Lincoln tunnels, George Washington, Bayonne and Goethals bridges and Outerbridge Crossing), and do not want to fund the account, skip to Customer Agreement and sign.

**Please remember to review *E-ZPass* Customer Agreement Terms and Conditions and Non-Represented Employee *E-ZPass* Addendum (attached), and sign form below. In addition, review AP 40-1.01 which can be found on eNet or requested from *E-ZPass* Customer Services at the address listed above.**

**Instructions:** Discount plans are available. Visit www.ezpassny.com or request a copy from E-ZPass Customer Services at the address listed above. Select the plan(s) you would like to add to your *E-ZPass* account. In the right column, enter the required pre-payment for each plan you select. Add up the payment amounts for each plan you have selected and enter the total in Box D (this amount will be added to your monthly replenishment).

| | | |
|---|---|---|
| BOX A | MINIMUM AMOUNT OF PREPAID TOLLS<br>If you select the GIC or GIR plans, you may enter $0.00 in Box A (refer to *E-ZPass* Plans for plan descriptions). | BOX A $ 25.00 |
| BOX B | ADDITIONAL AMOUNT OF PREPAID TOLLS<br>(If you would like to add more money to your initial prepaid tolls) | BOX B $ |

| FREQUENT USERS/RESIDENCY PLANS (OPTIONAL) – Complete this section only if you want a Commuter/Resident Discount Plan. Refer to E-ZPass Discount Plans at www.ezpassny.com | PLAN CODE | DISCOUNT PLAN AMT. |
|---|---|---|
| COMMUTER/RESIDENT DISCOUNT PLANS<br>The dollar amount included on www.ezpassny.com under *E-ZPass* Discount Plans is the required prepaid amount for that plan. | | |
| | | |
| | | |
| TOTAL $ AMOUNT OF DISCOUNT PLANS SELECTED | | BOX C $ |
| INITIAL PAYMENT - Total of Boxes A, B and C $ | | BOX D $ |

**Payment Information:** To add discount plans to your *Employee E-ZPass* New York account, you must submit payment as indicated above. You may either provide credit card information or include a check or money order with this form.

**PAYMENT METHOD/REPLENISHMENT OPTIONS** - Select option 1 or option 2

☐ OPTION 1 - Credit Card with Automatic Replenishment - **The easiest way to pay.** When your prepaid balance reaches a certain level, your *E-ZPass* account will automatically be replenished.

Credit Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date: __ __ / __ __

☐ Credit Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

I authorize *E-ZPass* to immediately charge my credit card for the total amount shown in the "Initial Payment" Box D. Whenever my prepaid amount decreases to or below the replenishment point for my account, I authorize *E-ZPass* to charge my credit card my replenishment amount. I understand and agree that such charges will continue until my *E-ZPass* account is terminated or I revoke this authorization in writing. Should I fail to return my Tag(s) or require a replacement, or incur an administrative fees or *E-ZPass Plus* charge, I authorize *E-ZPass* to charge my credit card the appropriate amount incurred under the terms of my agreement. I understand that the replenishment amount may be adjusted to reflect actual usage. I authorize *E-ZPass* in its discretion to receive updated information about my credit card, including new account numbers and expiration dates, from the financial institution issuing my credit card.

* _____ _____/_____/_____
**Cardholder Signature (Required)** Date

☐ OPTION 2 - Check or Cash Replenishment

- Once your account is opened, you can replenish your account by mailing a check made payable to "E-ZPass" or by making a cash payment at one of our eight convenient walk-in centers listed in the Q&A brochure.
- You are responsible for monitoring your account and maintaining a positive balance. Failure to do so may cause violations/confiscation and a loss of the non-revenue benefit.
- Do not mail cash.

**Customer Agreement:** My completion of this form, payment of the required deposits, and signature below constitute my agreement to use *E-ZPass* subject to all applicable terms and conditions. I understand and agree that by using E-ZPass facilities, the resulting charges will be deducted from my prepaid *E-ZPass* account. I understand and agree that I have read, understand, and accept the terms and conditions set forth in this form, all of which are part of my agreement.

By signing below, I agree to the Terms and Conditions outlined on the attached "*E-ZPass* Customer Agreement Terms and Conditions," "Non-Represented Eligible Employee *E-ZPass* Addendum". I also agree to be bound by AP 40-1.01 Port Authority *E-ZPass* Programs at Tunnel and Bridge Crossings, which can be viewed on eNet or requested from *E-ZPass* Customer Services at the address listed above.

* _____ _____/_____/_____
**Employee Signature (Required for All Account Types)** Date

**THE PORT AUTHORITY** OF NY & NJ

# Q&A

## Non-Represented Eligible Employees Questions and Answers about Port Authority

E-ZPass

THE PORT AUTHORITY OF NY & NJ

# Welcome to Port Author

**Q What is the new policy for Employee E-ZPass® accounts for non-represented employees hired on or before September 11, 2001?**

A Effective January 1, 2011, all non-represented employees hired on or before September 11, 2001 may continue to use his/her orange E-ZPass tag for free commutation trips to and from their primary work location and travel associated with official Port Authority business. This will be in effect until the Port Authority returns to its headquarters at the World Trade Center.

**Q Does the employee hired on or before September 11, 2001 get free personal usage of their E-ZPass tag at Port Authority tunnels and bridges?**

A No. The employee must reimburse the Port Authority for all personal travel (non-commutation and non-business related) at Port Authority tunnels and bridges using Form 3269A no later than 45 days after the date of travel.

**Q What will happen if non-represented employees hired on or before September 11, 2001 decide not to obtain an orange E-ZPass tag?**

A If the non-represented employee hired on or before September 11, 2001 elects not to obtain an E-ZPass tag at this time, the employee will continue to be reimbursed for expenses related to non-commutation business travel through administrative procedures already established by the Port Authority. These procedures include petty cash and expense accounts.

**Q What happens if an employee hired on or before September 11, 2001 changes his/her commutation pattern?**

A If an employee's commutation pattern changes, he/she may apply for an E-ZPass tag enabled with commutation and business travel privileges as long as the program is offered and the employee meets eligibility requirements.

**Q Can active non-represented employees hired on or before September 11, 2001 use personal or commutation passes they still have?**

A No. Eligible active non-represented employees hired on or before September 11, 2001 cannot use personal or commutation passes according the Administrative Instruction (AI) 40-1.01.

# ty E-ZPass for Non-Repre

**How do I close my account?**

Send a signed letter asking to close the account and include the tag and mail to:

E-ZPass
P.O. BOX 149001
Staten Island, New York 10314-9001

**What penalties will be accessed to employees that do not adhere to the new E-ZPass policies?**

Employees who do not comply with the established procedures will permanently forfeit their E-ZPass Employee commutation and business travel privileges and be subject to other disciplinary action.

**What is the new policy for airport parking using E-ZPass for non-represented employees hired before or on September 11, 2001?**

If the non-represented employee hired before or on September 11, 2001 funds their Employee E-ZPass account with a credit card, they may automatically use E-ZPass Plus for airport parking where offered.

All non-revenue airport parking has been discontinued effective Saturday, January 1, 2011.

**Can I add a Port Authority–specific discount plan to my Employee Non-Revenue E-ZPass account so that I can reimburse the Port Authority at a lower rate for personal travel?**

No. If you want to take advantage of PA-specific discounts, you must open and maintain a private E-ZPass account.

**Can I request more than one tag on my Employee E-ZPass account?**

No. Only one tag will be issued under the Employee E-ZPass account. If your family requires additional tags, you will need to open or maintain another E-ZPass account.

# sented Eligible Employees

**Q How do I fund my Employee E-ZPass account using cash?**

A Initial funding of the Employee E-ZPass account must be done *through the mail using a credit card, personal check, money* order or cashier's check. To replenish your account once it is established you may pay cash in person at any NY CSC.

**Q Can I pick up my Employee E-ZPass tag at a Customer Service Center?**

A No. An Employee E-ZPass tag may only be requested through *the mail.*

**Q Can I use my Employee E-ZPass at other agency facilities?**

A If you want to use your Employee E-ZPass tag at other agencies' facilities, you must fund the Employee E-ZPass account. Keep in mind that use of the orange Employee E-ZPass tag at other agencies' toll facilities without funds will result in violations, *administrative fees and/or confiscation of the tag.*

**Q What is the simplest way to fund my Employee E-ZPass account?**

A The account may be funded using a Visa, MasterCard, Discover or AMEX-credit card or a debit card with a Visa or Master Card logo. Using a credit card or debit card helps ensure that the account has funds in it because replenishment is automatically done when your account balance falls below your established threshold. Remember to update your credit or debit card expiration date.

**Q Why do I have to include a PIN number?**

A Anytime you contact the CSC for information regarding your account, you will need to supply a PIN number for auto identification purposes. This is for your security.

**Q I do not own a car. Can I still use a tag? How does that work?**

A Your orange Employee E-ZPass tag can be used in any passenger vehicle as long as you are in the vehicle and commuting to your primary workspace or traveling for business. To ensure your tag is read, remember to mount it on the windshield in advance of your trip. The tag cannot be used by anyone other than the person to whom it is issued. Random checks may be conducted at Port Authority facilities to confirm that the employee is in the vehicle.

**What happens if I receive a speed warning?**

If you do not abide by the speed limits posted at toll plazas, you run the risk of being issued speed violations and having your account suspended or revoked. If your tag is suspended due to speeding, you cannot use it at any toll plaza, including Port Authority crossings, and you may lose your free passage benefit.

**What happens if my account has insufficient funds?**

Using your tag when your account has insufficient funds may result in violations, administrative fees, and/or confiscation of the tag. You may also lose your free passage benefit.

**If I use my Employee E-ZPass tag in another person's vehicle and the tag is not read in a Port Authority toll plaza, what will happen?**

The toll will be charged to the other person's vehicle in the form of an E-ZPass deduction (if they have an E-ZPass account), or a toll violation. The Employee who attempted to use the tag that did not work properly will need to dispute the transaction in writing to the Tunnels, Bridges and Terminal Department's Regional E-ZPass Division. To ensure that your tag is read, mount it on the windshield of the vehicle in which you are traveling. Extra self-adhesive strips are available from the CSC.

**I have more than one vehicle and would like to add more license plates onto the account?**

You may include up to two license plates on the enrollment form. Attach an additional sheet of paper to include all license plates that may be used with the Employee E-ZPass tag. Make sure you also include vehicle type, model, year and the registration state.

**Do I have to sign up for the Basic Plan if I only want one of the MTA Discount Plans?**

Yes, if you want to use your employee E-ZPass tag anywhere besides Port Authority crossings, you must enroll in the Basic Plan, with a minimum payment of $25.00.

**Q: Can I update my personal information online?**

A: Yes, you can update the following information as long as you know your account or tag# and your PIN:

- Change your credit card/or credit card expiration date
- Update license plates (delete or add information)
- Receive account information
- Obtain Service Center locations and hours of operation

**Q: Who should I contact to remove an incorrect charge on my E-ZPass account?**

A: Call the E-ZPass Customer Service Center at 1-800-333-8655.

**Q: Where are the E-ZPass Customer Service Centers (CSCs) located?**

A: The locations of all New York Customer Service Centers are listed below. Please remember, you cannot open an Employee E-ZPass account at a CSC, but you can replenish, if you have chosen not to fund your account with a credit card.

Albany
4 Executive Park Drive
Albany, NY
12203-3717

Queens
19-02 Whitestone
Expwy. Suite 301
College Point, NY
11357

Yonkers
730 McLean Avenue
Yonkers, NY 10704

Grand Island
2293 Grand Island Blvd.
Grand Island, NY
14072-1819

Staten Island
1150 South Avenue
Staten Island, NY
10314

Nanuet
27 Rockland Plaza
Corner of Route 59 &
Middletown Road
Nanuet, NY 10954

Syracuse
Lakeshore Dr.-In Plaza
911 Old Liverpool Rd.
Liverpool, NY
13088

E-ZPass

**1-800-333-TOLL (8655)**

ezpassny.com

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2/2011

## For Active Represented Employees

# Port Authority Active Represented Employee Addendum to *E-ZPass*® Customer Agreement Terms and Conditions

1. Upon request via an Employee E-ZPass Enrollment Form, an Employee E-ZPass account ("Employee E-ZPass account") will be opened for the employee ("employee"), who will receive one orange non-revenue tag.

2. There is no deposit required for this tag. If the tag is lost, stolen or damaged, the employee must pay for the tag at the prevailing rate.

3. The tag is issued for the employee's personal or commutation use in accordance with their Memorandum of Agreement. It provides for free passage at Port Authority tunnel and bridge crossings when the employees is in the vehicle.

4. Employees who choose to fund the Employee E-ZPass account with a prepaid toll balance for their own personal use at non-Port Authority crossings:

   - authorize E-ZPass to debit their account for such use

   - authorize E-ZPass to deduct any applicable administrative fees incurred pursuant to this Agreement from prepaid toll balance

   - must obey all laws and regulations at all E-ZPass toll plazas

   - must maintain a sufficient prepaid toll balance

5. Whether or not the account is funded, all Employee E-ZPass Enrollment Forms must be mailed to E-ZPass Customer Service at the address listed below. If funding the account, initial payment can be made using credit card, check, money order or cashier's check. Subsequent replenishments can be made using cash, if necessary, or by other means, at a NY E-ZPass Customer Service Center.

6. In addition to the provisions of the Memorandum of Agreement, the account is subject to all Terms and Conditions established by the E-ZPass Customer Agreement. If an Employee E-ZPass account is deemed invalid due to speeding violations, insufficient funds, or other reasons, the account is invalid everywhere and the free passage feature at Port Authority crossings will be suspended until the Employee E-ZPass account is reinstated. Use of the E-ZPass tag during suspension will result in violations / confiscation.

7. Employees should be prepared to show Port Authority identification at Port Authority toll plazas upon request.

8. Non-revenue trips on Port Authority Employee E-ZPass account are subject to audit.

9. Upon separation from Port Authority service, the Employee E-ZPass account will be deactivated and the tag must be returned to the Unit Administrator. Failure to return the tag results in the tag cost being debited from the account.

10. Inquiries and correspondence, payments, tag returns, or violation inquiries regarding Employee E-ZPass account can be sent to:

    E-ZPass Customer Services
    One Madison Ave., 5th Floor
    New York, NY 10010

**For Active Represented Employees**

2/2011

*New York Service Center*

Mail To: *E-ZPass* Customer Services
One Madison Ave., 5th Floor
New York, NY 10010

| *E-ZPass* Information (to be filled out by Customer Service Center) |
|---|
| *E-ZPass* Account Number: _____ |
| *E-ZPass* Tag Number: _____ |
| Clerk No.: _____ |
| Date Opened: _____ |
| Approved: _____ Exception: _____ |

# *Port Authority Active Represented Employee E-ZPass® Enrollment Form*

**If you choose to fund the account for your personal use at non-PA crossings, you must also complete the purple sections below.**

NAME: _____ (Last / First / M.I.) EMPLOYEE NUMBER: _____

ADDRESS: _____ DAYTIME TELEPHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LICENSE PLATE: _____ STATE: _____ PIN NUMBER: _____
(Select any four numbers that you will remember)

LICENSE PLATE: _____ STATE: _____

VEHICLE MAKE, MODEL AND YEAR: _____

VEHICLE MAKE, MODEL AND YEAR: _____

If your vehicle is not a Class 1, (a Class 1 vehicle is typically an automobile, SUV or van) with two axles and single rear wheels, you may not use the tag at any non-Port Authority crossings.

If you choose to use the Port Authority *Employee E-ZPass* tag at Port Authority crossings ONLY (Holland and Lincoln tunnels, George Washington, Bayonne and Goethals bridges and Outerbridge Crossing), and do not want to fund the account, skip to Customer Agreement and sign.

**Please remember to review *E-ZPass* Customer Agreement Terms and Conditions and Employee *E-ZPass* Addendum (attached), and sign form below. In addition, review AP 40-1.01 which can be found on eNet or requested from *E-ZPass* Customer Services at the address listed above.**

**Instructions:** Discount plans are available. Visit www.ezpassny.com or request a copy from E-ZPass Customer Services at the address listed above. Select the plan(s) you would like to add to your *E-ZPass* account. In the right column, enter the required pre-payment for each plan you select. Add up the payment amounts for each plan you have selected and enter the total in Box D (this amount will be added to your monthly replenishment).

| | | |
|---|---|---|
| BOX A | MINIMUM AMOUNT OF PREPAID TOLLS<br>If you select the GIC or GIR plans, you may enter $0.00 in Box A (refer to *E-ZPass* Plans for plan descriptions). | BOX A $ 25.00 |
| BOX B | ADDITIONAL AMOUNT OF PREPAID TOLLS<br>(If you would like to add more money to your initial prepaid tolls) | BOX B $ |

| FREQUENT USERS/RESIDENCY PLANS (OPTIONAL) – Complete this section only if you want a Commuter/Resident Discount Plan. Refer to *E-ZPass* Discount Plans at www.ezpassny.com | PLAN CODE | DISCOUNT PLAN AMT. |
|---|---|---|
| COMMUTER/RESIDENT DISCOUNT PLANS<br>The dollar amount included on www.ezpassny.com under *E-ZPass* Discount Plans is the required prepaid amount for that plan. | | |
| TOTAL $ AMOUNT OF DISCOUNT PLANS SELECTED | | BOX C $ |
| INITIAL PAYMENT - Total of Boxes A, B and C $ | | BOX D $ |

**Payment Information:** To add discount plans to your *Employee E-ZPass* New York account, you must submit payment as indicated above. You may either provide credit card information or include a check or money order with this form.

**PAYMENT METHOD/REPLENISHMENT OPTIONS** - Select option 1 or option 2

☐ OPTION 1 - Credit Card with Automatic Replenishment - **The easiest way to pay.**
When your prepaid balance reaches a certain level, your *E-ZPass* account will automatically be replenished.

Credit Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date: __ __ / __ __

☐ Credit Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

I authorize *E-ZPass* to immediately charge my credit card for the total amount shown in the "Initial Payment" Box D. Whenever my prepaid amount decreases to or below the replenishment point for my account, I authorize *E-ZPass* to charge my credit card my replenishment amount. I understand and agree that such charges will continue until my *E-ZPass* account is terminated or I revoke this authorization in writing. Should I fail to return my Tag(s) or require a replacement, or incur an administrative fees or *E-ZPass Plus* charge, I authorize *E-ZPass* to charge my credit card the appropriate amount incurred under the terms of my agreement. I understand that the replenishment amount may be adjusted to reflect actual usage. I authorize *E-ZPass* in its discretion to receive updated information about my credit card, including new account numbers and expiration dates, from the financial institution issuing my credit card.

* _____ _____/_____/_____
**Cardholder Signature (Required)** Date

☐ OPTION 2 - Check or Cash Replenishment

- Once your account is opened, you can replenish your account by mailing a check made payable to "E-ZPass" or by making a cash payment at one of our eight convenient walk-in centers listed in the Q&A brochure.
- You are responsible for monitoring your account and maintaining a positive balance. Failure to do so may cause violations/confiscation and a loss of the non-revenue benefit.
- Do not mail cash.

**Customer Agreement:** My completion of this form, payment of the required deposits, and signature below constitute my agreement to use *E-ZPass* subject to all applicable terms and conditions. I understand and agree that by using E-ZPass facilities, the resulting charges will be deducted from my prepaid *E-ZPass* account. I understand and agree that I have read, understand, and accept the terms and conditions set forth in this form, all of which are part of my agreement.

By signing below, I agree to the Terms and Conditions outlined on the attached "*E-ZPass* Customer Agreement Terms and Conditions," and the "Port Authority Active Represented Employee E-ZPass Addendum." I also agree to be bound by the applicable Memorandum of Agreement.

* _____ _____/_____/_____
**Employee Signature (Required for All Account Types)** Date

**THE PORT AUTHORITY** OF NY & NJ

# Q&A

## Active Represented Employees Questions and Answers about Port Authority

E-ZPass

THE PORT AUTHORITY OF NY & NJ

# Welcome to Port Authority

**Q: I already have an E-ZPass® account. Do I have to close it and only use the Employee E-ZPass account?**

A: Your orange Employee E-ZPass tag is the only tag that will allow free passage at Port Authority facilities. If you require additional E-ZPass tags for family members, you must maintain a separate account.

**Q: Can I request more than one tag on my Employee E-ZPass account?**

A: No, only one tag will be issued under the Employee E-ZPass account. If your family requires additional tags, you will need to open or maintain another E-ZPass account.

**Q: We have only one family vehicle and someone will be using it while I am at work. Should I keep my existing E-ZPass account?**

A: The orange Employee E-ZPass tag can only be used at Port Authority facilities when the employee is in the vehicle. If other family members use E-ZPass for travel across Port Authority facilities when you are not in the vehicle, a separate account must be maintained.

**Q: I do not want to maintain two accounts, but I have two cars. What can I do?**

A: The orange Employee E-ZPass tag may be moved from car to car. However, please remember that the Port Authority employee to whom the tag is issued must be in the vehicle at the time of use. To ensure your tag is read in toll lanes, remember to mount it on the windshield in advance of your trip. Extra self-adhesive strips are available from the NY Customer Service Center (CSC). Please list all vehicles, which may be used, on the enrollment form and remember to keep the vehicle list up-to-date.

**Q: How do I fund my Employee E-ZPass account using cash?**

A: Initial funding of the Employee E-ZPass account must be done through the mail using a credit card, personal check, money order, or cashier's check. To replenish your account once it is established, you may pay cash in person at any NY CSC.

**Q: Can I pick up my Employee E-ZPass tag at a Customer Service Center?**

A: No, an Employee E-ZPass tag may only be requested through the mail.

# E-ZPass for Active Repr

**Q If I close my current E-ZPass account, can my balance be applied to the Employee E-ZPass account?**

A No, you cannot transfer funds from an existing E-ZPass account to your Employee E-ZPass account. If you close an existing account, the remaining balance will be refunded separately.

**Q Can I use my Employee E-ZPass at other agency facilities?**

A If you want to use your Employee E-ZPass tag at other agencies' facilities, you must fund the Employee E-ZPass account. Fill out the entire application. Keep in mind that use of the orange Employee E-ZPass tag at other agencies' toll facilities without funds will result in violations, administrative fees and/or confiscation of the tag.

**Q What's the simplest way to fund my Employee E-ZPass account?**

A The account may be funded using a Visa, MasterCard, Discover or AMEX-credit card or a debit card with a Visa or MasterCard logo. Using a credit or debit card helps ensure that the account has funds in it because replenishment is automatically done when your account balance falls below your established threshold. Remember to update your credit or debit card expiration date.

**Q Why do I have to include a PIN number?**

A Anytime you contact the CSC for information regarding your account, you will need to supply a PIN number for auto identification purposes. This is for your security.

**Q I do not own a car. Can I still use a tag? How does that work?**

A Your orange Employee E-ZPass tag can be used in any passenger vehicle as long as you are in the vehicle. To ensure your tag is read, remember to mount it on the windshield in advance of your trip. The tag cannot be used by anyone other than the person to whom it is issued. Random checks may be conducted at Port Authority facilities to confirm that the employee is in the vehicle.

**Q What happens if I receive a speed warning?**

A If you do not abide by the speed limits posted at toll plazas, you run the risk of being issued speed violations and having your account suspended or revoked. If your tag is suspended due to speeding, you cannot use it at any toll plaza, including Port Authority crossings, and you may lose your free passage benefit.

# esented Employees

**Q What happens if my account has insufficient funds?**

A Using your tag when your account has insufficient funds may result in violations, administrative fees, and/or confiscation of the tag. You may also lose your free passage benefit.

**Q If I use my Employee E-ZPass tag in another person's vehicle and the tag is not read in a Port Authority toll plaza, what will happen?**

A The toll will be charged to the other person's vehicle in the form of an E-ZPass deduction (if they have an E-ZPass account), or a toll violation. The employee who attempted to use the tag that did not work properly will need to dispute the transaction in writing to the Tunnels, Bridges and Terminal Department's Regional E-ZPass Division. To ensure that your tag is read, mount it on the windshield of the vehicle in which you are traveling. Extra self-adhesive strips are available from the CSC.

**Q I have more than one vehicle and would like to add more license plates onto the account.**

A You may include up to two license plates on the enrollment form. Attach an additional sheet of paper to include all license plates that may be used with the Employee E-ZPass tag. Make sure you also include vehicle makes, models, years and the state where each vehicle is registered.

**Q Do I have to sign up for the Basic Plan if I only want one of the MTA Discount Plans?**

A Yes, if you want to use your Employee E-ZPass tag anywhere besides Port Authority crossings, you must sign up for the Basic Plan, with a minimum payment of $25.00.

**Q Can I update my personal information online?**

A Yes, you can update the following information as long as you know your account or tag # and your PIN:

- Change your credit card/or credit card expiration date
- Update license plates (delete or add information)
- Receive account information
- Obtain Service Center locations and hours of operation

**Q: Can I use my Employee E-ZPass tag for parking at Port Authority airports?**

A: Employee E-ZPass tags are accepted for parking at JFK, EWR, and LGA.

You may leave your car in any lot for up to 4 hours (short term). Beyond 4-hours, you are required to pay the rate for the entire duration in which the vehicle was parked.

Free Long Term Parking is available in the following lots:

- John F. Kennedy Lot #9
- Newark Liberty Lot #P6
- LaGuardia Lot #5

For further information please contact the Aviation Department at (212) 435-3729 or visit the Aviation Department's Website on enet.

**Q: Who should I contact to remove an incorrect charge on my E-ZPass account?**

A: Call the E-ZPass Customer Service Center at 1-800-333-8655.

**Q: Where are the E-ZPass Customer Service Centers (CSCs) located?**

A: The locations of all New York Customer Service Centers are listed below. Please remember, you cannot open an Employee E-ZPass account at a CSC, but you can replenish, if you have chosen not to fund your account with a credit card.

Albany
4 Executive Park Drive
Albany, NY
12203-3717

Queens
19-02 Whitestone
Expwy. Suite 301
College Point, NY
11357

Yonkers
730 McLean Avenue
Yonkers, NY 10704

Grand Island
2293 Grand Island Blvd.
Grand Island, NY
14072-1819

Staten Island
1150 South Avenue
Staten Island, NY
10314

Nanuet
27 Rockland Plaza
Corner of Route 59 &
Middletown Road
Nanuet, NY 10954

Syracuse
Lakeshore Dr.-In Plaza
911 Old Liverpool Rd.
Liverpool, NY
13088

E-ZPass

**1-800-333-TOLL (8655)**

ezpassny.com

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2/2011

**Audit Department Tip: Proper Use of Your Employee E-ZPass**

When using your employee non-revenue (orange) E-ZPass tag, keep in mind the following:

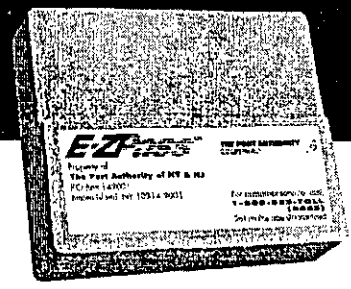
- Your employee tag should only be used at PA facilities when you are in the vehicle as either a passenger or driver for commutation or personal (non-commercial) use.
- Carry your Port Authority ID card when you plan to use your E-ZPass. Be aware that random spot checks are conducted at Port Authority facilities to confirm that the PA employee is in the vehicle. When this occurs, please show your Port Authority ID card when requested.
- Your Employee E-ZPass account can only have one tag on the account.
- Your E-ZPass tag can be used for free passage at the George Washington Bridge, Lincoln Tunnel, Holland Tunnel, Goethals Bridge, Outerbridge Crossing and Bayonne Bridge.
- With the installation of E-ZPass Plus at the airports, free parking is available to Port Authority employees. Please refer to the links below for specific details on time limitations by parking lot.

    - JFK - http://enet/aviation/html/jfk_parking.html
    - LGA - http://enet/aviation/html/lga_parking.html
    - EWR - http://enet/aviation/html/ewr_parking.html

- If you fund your account and your vehicle is a class 1 (i.e. private two-axle single rear wheel vehicle), you may utilize your employee E-ZPass tag at non-Port Authority crossings or other toll roads that accept E-ZPass.
- To help ensure that your tag is properly read and to avoid receiving violation notices, make sure to mount your E-ZPass tag just below the rear view mirror on your windshield. Additional self-adhesive strips are available at Customer Service Centers or by calling (800) 333-8655.
- To avoid violations, ensure that your license plates are kept up-to-date on your Employee E-ZPass account. Visit www.E-ZPassny.com to update license plate information on your account.
- *Review your monthly statements to ensure that charges are appropriate.*
- Obey posted speed limits when driving through all toll lanes to avoid violations and possible account suspension.

# Welcome to Port Authority Employee

E-ZPass®



*A benefit you have as a PA employee is free passage across PA-operated tunnels and bridges with Port Authority E-ZPass, a remarkable toll collection technology that makes traveling more convenient, helps you save money through discount plans offered by many toll facilities, and helps reduce traffic congestion for everyone. You must request and return an enrollment application to take advantage of this benefit.*

---

- Call 1-800-221-9903 and leave a message or email Sylvia Gonzalez at sggonzalez@panynj.gov to request a package. When making your request, include your:
  - Name
  - Employee #
  - Home Address
  - Telephone #
- Application and related information also available on eNet (the PA employee web site)

**THE PORT AUTHORITY** OF NY & NJ

## *To obtain an Employee E-ZPass enrollment form via eNet:*

- Type enet in browser (can only be accessed via PA computer)
- Departments → TB&T
- E-ZPass → Employee/Retiree E-ZPass Enrollment Form

*Please be sure that the address on your application matches the address on file with Human Resources.*

*If you do not fund your account, your orange Employee E-ZPass tag is only valid at PA facilities listed below:*

- Lincoln Tunnel
- Holland Tunnel
- George Washington Bridge
- Goethals Bridge
- Bayonne Bridge
- Outerbridge Crossing

*Remember: You must be in the vehicle to use your Employee E-ZPass. Your orange tag is not transferable to anyone else.*

Additional information regarding the *Employee E-ZPass* program, including the *E-ZPass* Q&A brochure, is also available on eNet.

For Commuter/Resident Discount Plans and general *E-ZPass* info, visit ezpassny.com.

# Retiree Benefits Informational Sheets

Applicable to: International Union of Operating Engineers, AFL-CIO
Locals 15, 30 and 68 (IUOE) &
The Maintenance Division of the Building and
Construction Trades Council of Greater NY (BTU)

Over 25 years of service

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies to only those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

## UNITED HEALTHCARE PLAN (PPO)
## OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

## UNITED HEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, United Healthcare's out-of-network benefits provided for 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" is sent to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees for each individual up to $5,000 and at 100% thereafter during the calendar year. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt out of the Port Authority prescription plan.

**NOTE:** If you travel outside the Continental United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to United Healthcare for reimbursement (as per your out-of-network plan of benefits).

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

1. **HOW WILL MY PRESCRIPTIONS BE FILLED?**

   Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

   The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

2. **HOW CAN I OBTAIN A PROVIDER DIRECTORY?**

   You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

3. **DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?**

   No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

4. **WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?**

   In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

   Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

5. **HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?**

   If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

   If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

***Medicare Part D and Prescription Drug Coverage:*** *Port Authority/PATH retirees and their* eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has *been determined to provide coverage that, in most cases, is better than the standard Medicare Part D* coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

NOTE: If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement *(as per your out-of-network plan of benefits).*

BTU & IUOE (Over 25 Years)

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of $20,000, the amount of the ICP will continue (at no cost) until your death.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of$50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of$50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

**Retiree Benefits Informational Sheets**

Applicable to: International Union of Operating Engineers, AFL-CIO
Locals 15, 30 and 68 (IUOE) &
The Maintenance Division of the Building and
Construction Trades Council of Greater NY (BTU)

Under 25 years of service

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies to only those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- *Unlimited Lifetime Major Medical Maximum.*
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

1. **HOW WILL MY PRESCRIPTIONS BE FILLED?**

   Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

   The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

2. **HOW CAN I OBTAIN A PROVIDER DIRECTORY?**

   You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

3. **DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?**

   No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

4. **WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?**

   In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

   Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

5. **HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?**

   If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

   If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required *hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day* annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

***Medicare Part B:*** *Covers medical expenses for such things as doctors' charges, out-patient hospital* care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

*Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred* during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** *If you travel outside the United States and require medical treatment, Medicare will not pay* for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

**BTU & UOE (Under 25 Years)**

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. The current monthly cost per $1,000 of coverage is *$0.318* and is subject to change annually. Required contributions will be deducted from your pension check.

In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan (which becomes effective when you are both retired and age 65) you will be required to make contributions towards the cost of this coverage. The face value of the Insurance Continuation Plan (ICP) coverage is $20,000 and the current monthly contribution (if enrolled) is *$0.59* and is subject to change annually.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of $20,000, the amount of the ICP will continue (at no cost) until your death.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1 ,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

**THE PORT AUTHORITY OF NY & NJ**

April 2002

Dear PBA, SBA, DEA, LBA and UOAT Employee:

The Aetna Reasonable & Customary Dental Plan was revised to provide you with the following *enhancements*:

*Effective July 1, 2000:*

* 100% reimbursement of R&C charges for preventative dental services that include two (2) cleanings annually (and the accompanying exams), x-rays and fluoride applications (under the same terms and conditions as previously applied). You do not need to first satisfy a deductible.

* 100% reimbursement of R&C charges for sealants (one application per permanent molar every three years for children under the age of 19). You do not need to first satisfy a deductible.

* $2,000 lifetime benefit for orthodontic services (reimbursed at 80% of R&C charges).

*Effective January 1, 2001:*

* 100% reimbursement of R&C charges for up to four (4) cleanings annually (and the accompanying exams). You do not need to first satisfy a deductible.

* 80% reimbursement of R&C charges for dental implants (under the same terms and conditions as previously applied for restorative dental services) after satisfaction of an individual/family deductible.

In order to (re) process any affected claims retroactively, the following administrative procedures have been established:

- Aetna has initiated re-processing of all submitted claims related to preventative care services (to include sealants and additional cleanings) noted above. Aetna has advised that **previously submitted claims through February 2002 will be reprocessed and adjusted reimbursements will be mailed to affected employees over the next 3 months. Claims submitted after February will be reprocessed and reimbursements should be received over the next 4 months.** Employees with both preventative and restorative claims in a calendar year must

continue to satisfy the appropriate individual/family deductible (under the same terms and conditions as previously applied for restorative dental services).

- Employees who never submitted claims for those preventative care services noted above (e.g., sealants, additional cleanings) must mail claim forms to Aetna immediately for review and processing. Attached is a copy of a claim form with the appropriate address.

- With respect to adjusting the orthodontic benefit and/or processing reimbursement for dental implants, employees must call Aetna Customer Service at 1-800-772-4683 and Aetna will work with you on a case-by-case basis to process reimbursements.

If you have any general questions concerning these dental enhancements, please feel free to contact Employee Benefits Customer Service at 201-595-4537.

Sincerely,

Rosetta A. Jannotto

Rosetta A. Jannotto
Employee Benefits Manager

INFORMATION SERVICES NEWS BULLETIN

THE PORT AUTHORITY OF NEW YORK AND NEW JERSEY
Office of the Executive Director

OFFICE MEMORANDUM ~~15-96~~ 6-96

March 22, 1996

In mid-February, I asked Department Directors to develop specific cost saving proposals in order to fund 1996 merit increases for non-represented staff. To date, we have received promising proposals from a number of departments, and we are awaiting final proposals from others. We are in the process of analyzing these submissions and will communicate the results shortly.

In addition, in an effort to provide increased quality health care options while controlling the rising cost of health care benefits, we are implementing, for non-represented employees, changes to our health benefits. In addition to the indemnity and HMO options, employees will now be offered a new option, at no cost to them, known as a "Point of Service" Plan (POS). This plan combines the best features of a Health Maintenance Organization (HMO) plan with the flexibility of traditional indemnity insurance as employees decide which physicians and hospitals to use for medical care.

The POS plan we've chosen is through Oxford Health Plans. It includes one of the most extensive and best qualified networks of service providers, involves no paperwork for services obtained in-network, and in-network physicians including specialists, hospitals and surgical services are generally covered at virtually 100%. In addition to covering medical treatments for illness or injury, this plan also covers well care visits and annual examinations, as well as prescription drugs with a small co-payment. The Point of Service Plan has the added feature of allowing participants the flexibility to choose service providers outside of the plan network; as with the traditional indemnity plan, out-of-network services are subject to deductibles and a co-payment. Employees who remain in the current indemnity health plan offered through The Prudential Insurance Company of America and hospital service through Empire Blue Cross will be required to contribute to this plan. Since retired employee benefits also represent a considerable and growing cost to the Port Authority, retiree contributions for benefits based on a new vesting schedule will be implemented for employees who retire on or after July 1, 1996.

Complete details concerning the above benefit changes will also be forwarded to you shortly in an announcement from the Director of Human Resources, Louis J. LaCapra.

ORIGINAL SIGNED BY:

George J. Marlin
Executive Director

**THE PORT AUTHORITY OF NY & NJ** **MEMORANDUM**

Memorandum to Chief of Staff
HR Policy – Retiree Benefits

TO: Louis J. LaCapra, Chief of Staff
FROM: Rosetta A. Jannotto, Employee Benefits Manager
DATE: February 14, 2002
SUBJECT: HUMAN RESOURCES POLICY – RETIREE BENEFITS

COPY TO: L. Hofrichter, P. Segalini

Below for your review and concurrence is an update to the Human Resources Policy that resulted from approval of Office Memorandum 6-96, dated March 22, 1996 regarding retiree benefits for employees not represented for collective negotiations:

**Group Health Insurance**
Affected employees who retire after July 1, 1996 are eligible to participate in the Preferred Provider health option, with a separate prescription program. Employees will also have the option to be enrolled in the vision program. These benefits are provided both on an individual and family basis at no cost into retirement. The current indemnity health plan and any health maintenance organizations are not available options into retirement. Affected employees who retire on or after July 1, 2000 will also be reimbursed Medicare Part B premiums for themselves and their spouse.

**Group Life Insurance**
Affected employees retiring on or after July 1, 1996 who have 25 or more years of Port Authority service will be eligible to continue their group life insurance into retirement with no required contributions. Affected employees retiring with less than 25 years of Port Authority service will be eligible to continue their group life insurance into retirement, however, they will be required to contribute 50% of the retiree cost of providing that insurance benefit.

Effective April 1, 2001 there is an additional death benefit for staff who are Tier I members with the New York State and Local Employees' Retirement System and have attained 55 years of age with at least 30 years of Port Authority service. Effective January 1, 2002 this benefit may be continued into retirement without the declining balance provision of the group term life insurance program.

**Group Dental Benefit**
Affected employees who retire on or after July 1, 1996 may be enrolled in the Reasonable and Customary group dental insurance plan. This benefit is provided on an individual and family basis for employees with 25 or more years of Port Authority service with no required contributions. Affected employees with less than 25 years of Port Authority service will be required to contribute 50% of the retiree cost of providing that insurance. All affected employees may be enrolled in the Schedule of Allowances Plan or Dentcare, with no required contribution.

Concurrence:
Louis J. LaCapra
Chief of Staff

# MEMORANDUM

## *Human Resources Department*

*To:* Louis J. LaCapra

*From:* Mary Lee Hannell

*Date:* January 3, 2011

***Subject:*** **RETIREE VESTING AND CONTRIBUTIONS**

***Ref.:*** Office Memorandum 6-96; dated March 22, 1996

*Copy To:* J. Basile, R. Cherkis

After conducting research in response to New Jersey's request for information concerning employee benefits, I have reviewed historical documents and have found that an earlier authorization describing vesting of retiree benefit contributions has been inconsistently applied over the years. More specifically, non-represented employees retiring with less than 25 years of Port Authority service would remain eligible for health, dental and life insurance benefits provided they contributed 50% of the Port Authority's benefit costs.

This memorandum serves to affirm with you the original intent of the 1996 authorization and, effective immediately, implement the retiree vesting and contribution schedule, as noted below:

- Non-represented employees who retire with less than twenty-five years of Port Authority service remain eligible for Port Authority medical, dental and life insurance benefits provided they contribute 50% of the full benefits costs to the Port Authority.
- Non-represented employees who retire with twenty-five or more years of Port Authority service remain eligible to receive medical, dental and life insurance benefits without contribution.

Mary Lee Hannell
Director

Concurred: _____ Date: 3 Jan 2011
Louis J. LaCapra
Chief Administrative Officer

# MEMORANDUM

*Human Resources Department*

***To:*** Christopher O. Ward
***From:*** Mary Lee Hannell
***Date:*** January 25, 2011
***Subject:*** **Retiree Vesting and Contributions**

***Copy To:*** D. Buchbinder, L. LaCapra

The Port Authority policy regarding costs for retiree benefits (other than pensions) for employees not represented for collective negotiations is continuously subject to review. While prior cost containment measures have helped us to continue to provide a competitive package that both attracts and retains career service staff, economic and corporate realities require that we modify our current program contribution levels for retirees.

Similarly to the New York State Local Employees' Retirement System (NYSLERS) vesting schedule for Tier 5 members which requires ten years of credited service to vest for pension benefits, all non-represented employees hired on or after Monday, January 3, 2011 who retire with less than ten years of Port Authority service may remain eligible for Port Authority medical, dental and life insurance benefits as retirees provided they contribute the full benefit costs to the Port Authority.

Mary Lee Hannell
Director

Approved: _____ Date: 28 Jan 11

Christopher O. Ward
Executive Director

THE PORT AUTHORITY OF NY & NJ

One World Trade Center
New York, N.Y. 10048

Human Resources Department
Louis J. LaCapra, Director
(212) 435-8140
(201) 622-6600 x 8140

March 25, 1996

Dear Fellow Employee:

In recent years both public and private sector employers have been challenged to provide high quality, comprehensive health benefits to their employees and dependents, while curtailing the increasing cost of these benefits. As a result, virtually all employers in our region have instituted changes which encourage employees to switch from traditional indemnity/hospital services plans, like our Prudential/Empire Blue Cross plan, to lower cost managed care options and require their employees to share a reasonable amount of the cost of their benefits.

Point of Service Plan and Coverage Changes

In addressing these challenges, I am very pleased to announce that in addition to the existing health benefit options, we are offering all non-represented employees a new option known as a "Point of Service" Plan (POS). This new plan, which will be provided through Oxford Health Plans, a leader in the health benefits field, offers comprehensive medical coverage with no employee contribution. This POS plan combines the best features of a Health Maintenance Organization (HMO) with the flexibility of traditional indemnity insurance as employees decide which physicians and hospitals to use for medical services. It includes one of the most extensive and best qualified networks of service providers, involves no paperwork for services obtained in-network, and in-network physicians (including specialists), hospitals and surgical services are generally covered at virtually 100%. In addition to covering medical services, this plan also covers well-care visits and annual examinations, as well as prescription drugs with a small co-payment. The Point of Service Plan has the added feature of allowing participants the complete flexibility to choose service providers outside of the plan network; as with the traditional indemnity plan, out-of-network services are subject to deductibles and co-payments.

I am also pleased to announce that in conjunction with the introduction of the Point of Service plan, employees will now be able to select the Prudential reasonable and customary dental plan in conjunction with the Point of Service plan or any of the HMO's.

Employees who elect to remain in the current indemnity health plan, offered through The Prudential Insurance Company of America, with hospital service provided through Empire Blue Cross, will be required to contribute

THE PORT AUTHORITY OF NY & NJ



through payroll deductions on a pre-tax basis toward their coverage as follows:

| Coverage | Bi-Weekly Contribution |
|---|---|
| Family | $40.00 |
| Single | $20.00 |

In order to hold the contribution rates to these levels and bring our benefits in line with prevailing practices in other organizations, it has been necessary to adjust the limits of our mental and nervous coverage provided under the Prudential indemnity plan, which is one of the most significant cost areas. For all exempt employees, the lifetime limit for mental and nervous in-patient and out-patient benefits will be $50,000, and the maximum amount of reimbursement for these outpatient charges will be 50%, with a per-visit maximum of $45 and a limit of 50 visits per year.

Vesting of Retiree Benefit Contributions

Our 5,000 retired employees and their dependents also represent considerable benefits costs to the Port Authority. Increases in our retiree population, coupled with the continually rising cost of these benefits, require us to introduce retiree contributions for benefits based on length of service. Accordingly, for employees retiring on or after July 1, 1996, the percentage of health, dental and life insurance costs which will be paid for by the Port Authority will be 50% for employees who retire with less than 25 years of service and 100% for employees who retire with at least 25 years of service with the Port Authority. For employees who retire and opt for health coverage under one of the HMO's or the Point of Service Plan, no contribution for health benefits will be required regardless of length of Port Authority service.

Benefit Election Procedures

An open enrollment period will be in effect from Thursday, March 28, 1996 to Tuesday, April 23, 1996, during which time you will have the opportunity to select a health plan from among a range of options including the Point of Service Plan. We expect these changes to be effective on May 19th with contributions to begin in pay period 11. To assist you in making this important decision, approximately 40 briefings will be scheduled for all eligible staff at convenient World Trade Center and facility locations during which you will receive more detailed information about all of your benefit options and have the opportunity to ask questions. Human Resources staff will work with departmental coordinators in arranging these briefings. A master schedule of the briefings for each location is attached, and you will

THE PORT AUTHORITY OF NY & NJ



be advised by your departmental coordinator where and when to attend. In addition, commencing on March 28th and extending through the entire Open Enrollment period, dedicated telephone lines at the following number will be in operation to answer employees' questions respecting these benefit changes and the Open Enrollment: 212-435-8001. I strongly encourage you to attend and participate in these meetings and to review the available materials carefully so that you can select the health benefit option which best meets your needs.

Sincerely,

Louis J. LaCapra
Director
Human Resources Department

Enclosure

September 2002

Dear TWU Retiree (since 7/1/00):

The Aetna Reasonable & Customary Dental Plan was revised to provide you with the following *enhancements*:

*(Retired) effective July 1, 2000:*

* 100% reimbursement of R&C charges for preventative dental services that include two (2) cleanings annually (and the accompanying exams), x-rays and fluoride applications (under the same terms and conditions as previously applied). You do not need to first satisfy a deductible.

* 100% reimbursement of R&C charges for sealants (one application per permanent molar every three years for children under the age of 19). You do not need to first satisfy a deductible.

* $2,000 lifetime benefit for orthodontic services (reimbursed at 80% of R&C charges).

*(Retired) effective January 1, 2001:*

* 100% reimbursement of R&C charges for up to four (4) cleanings annually (and the accompanying exams). You do not need to first satisfy a deductible.

* 80% reimbursement of R&C charges for dental implants (under the same terms and conditions as previously applied for restorative dental services) after satisfaction of an individual/family deductible.

In order to (re) process any affected claims retroactively, the following administrative procedures have been established:

- Aetna has initiated re-processing of all submitted claims related to preventative care services (to include sealants and additional cleanings) noted above. Aetna has advised that **previously submitted claims through August 2002 will be reprocessed and adjusted reimbursements will be mailed to affected retirees over the next 6 weeks.** Retirees with both preventative and restorative claims in a calendar year must continue to satisfy the appropriate individual/family deductible (under the same terms and conditions as previously applied for restorative dental services).

- Employees who never submitted claims for those preventative care services noted above (e.g., sealants, additional cleanings) must mail claim forms to Aetna immediately for review and processing. Attached is a copy of a claim form with the appropriate address.

- With respect to adjusting the orthodontic benefit and/or processing reimbursement for dental implants, employees must call Aetna Customer Service at 1-800-772-4683 and Aetna will work with you on a case-by-case basis to process reimbursements.

*If you have any general questions concerning these dental enhancements, please feel free* to contact Employee Benefits Customer Service at 212-435-2870.

Sincerely,

Rosetta A. Jannotto

Rosetta A. Jannotto
Employee Benefits Manager

**THE PORT AUTHORITY OF NY & NJ**

08/03 – Introduction of MetLife as Dental Administrator

August 2003

Dear Port Authority & PATH Employee/Retiree,

As part of its commitment to provide you with the highest quality and most cost-effective benefits possible, the Port Authority continuously evaluates the benefits marketplace. As a result, it has become apparent that improvements in the processing of your dental claims and associated customer services could be realized. Therefore, I am pleased to announce that effective October 1, 2003, the Metropolitan Life Insurance Company (MetLife) will administer the Port Authority's dental plans.

MetLife is one of the largest dental insurance carriers in the country, administering dental benefits to over 18 million participants. Its service and overall satisfaction levels are currently rated among the best in the industry. MetLife will provide Port Authority/PATH employees and retirees with a dedicated, toll-free telephone number, an Interactive Voice Response System and a self-service website where covered dependents and processed claims can be viewed.

In the next few weeks, you will receive a letter providing additional details on the transition and addressing questions you may have. Please be assured that the level of benefits you and your eligible dependents currently enjoy will remain the same but with an improved level of service.

If you have any questions regarding the information contained in this letter, please contact Employee Benefits Customer Service at (212) 435-2870.

Sincerely,

Louis J. LaCapra
Chief Administrative Officer

**THE PORT AUTHORITY OF NY & NJ**

September 2003

Dear Port Authority & PATH Employee/Retiree,

As we previously advised you, effective October 1, 2003, the Metropolitan Life Insurance Company (MetLife) will administer our dental plans. While the level of your benefits and the plan in which you are enrolled remain unchanged, customer service will be enhanced. Specifically, MetLife will provide a dedicated, toll-free customer service number, (888) 727-2317, that includes an Interactive Voice Response System. A self-service website will also be available for your convenience shortly. To address questions you may have and to help ensure a smooth transition, please note the following:

- ***Where should I submit my dental claims?*** All claims incurred on/before September 30, 2003 should be submitted to Aetna **in a timely manner**. Claims that are incurred on/after October 1, 2003 should be submitted to MetLife via the enclosed claim form. Additional claim forms can be obtained by contacting MetLife on/after October 1, 2003 or by copying the enclosed form. The claim form is also available to employees on the Human Resources Department's eNet site.

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- ***What is the new dental group number?*** The dental group number, located in Box 10 of the dental claim form, is 302043. It is the same for Port Authority and PATH.

- ***How will annual deductible(s) be affected?*** You will not be required to satisfy a new deductible for the remainder of 2003.

- ***What happens with dental work already in progress?*** Some major dental services (e.g., crowns, bridgework) may require more than one visit to your dentist's office. Your dentist will usually use the date of final service when submitting a claim. If the final treatment occurs on/before September 30, 2003, your dentist should submit the claim to Aetna. If the final date of treatment occurs on/after October 1, 2003, the claim should be submitted to MetLife.

- ***What happens with orthodontia work already in progress?*** When submitting your first orthodontic claim to MetLife, provide a copy of Aetna's latest *Explanation of Benefits* or have your dentist supply MetLife with the dates the original appliances were placed on, as well as the benefit and payment history.

Once again, let me assure you that your level of benefits will remain the same. If you have any questions, please contact Employee Benefits at (212) 435-2870.

Sincerely,

Rosetta A. Jannotto

Rosetta A. Jannotto
Assistant Director
Human Resources Department

Encl.

**MetLife®**
Metropolitan Life Insurance Company

# Dental Expense Claim

**To Be Completed by Employee** (You must review the important statements on page 2 and sign where indicated before completing this section of the form.)

| 1. Patient First Name / Middle / Last | 2. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other | 3. Sex ☐ Male ☐ Female | 4. Married? ☐ Yes ☐ No | 5. Patient Date of Birth Mo. / Day / Year | 6. For Office Use |
|---|---|---|---|---|---|

| 7. If Full Time Student (Age 19 or Over) School / City / State | 8. EMPLOYEE Social Security / ID Number | 9. If Disabled (Age 19 or Over) ☐ Yes ☐ No | 10. Name of Group Dental Program **Port Authority/PATH #302043** |
|---|---|---|---|

| 11. Employee First Name / Middle / Last | 12. Employee Date of Birth | 13. Office Phone (Area Code) |
|---|---|---|

| 14. Employee Residence Mailing Address | 15. City, State, Zip |
|---|---|

| 16. Are other Family Members Employed? ☐ Yes ☐ No Name / Social Security / ID Number | 17. Date of Birth | 18. Name and Address of Employer for Item 16 |
|---|---|---|

19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:)
Dental Plan Name / Group No. / Name and Address of Carrier

| 20. I Authorize Release of any Information Relating to this Claim | 21. I Certify that the Above Information is Correct. | 22. I Authorize Payment Directly to the Below Named Dentist. |
|---|---|---|
| (Signature of Patient or Signature of Authorized Representative if Minor) / Date | Employee Signature / Date | Employee Signature / Date |
| If Authorized Representative, Relationship to Minor | | |

**To Be Completed by Dentist**

| 23. Dentist Name | 24. Mailing Address / City / State / Zip |
|---|---|

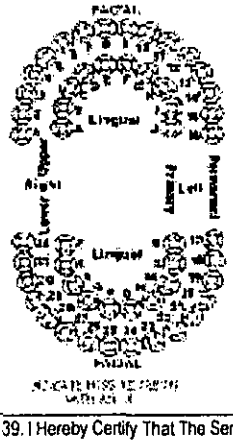
| 25. Dentist Social Security Number or T.I.N. | 26. Dentist License Number | 27. Dentist Phone Number |
|---|---|---|

| 28. First Visit Date Current Series | 29. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other _____ | 30. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many? _____ |
|---|---|---|

| 31. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) | 32. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) |
|---|---|
| 33. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) | 34. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) |

| 35. If Prosthesis, Is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement) | 36. Date of Prior Replacement? |
|---|---|
| 37. Is Treatment for Orthodontics? ☐ Yes ☐ No / If Services Already Commenced, Enter Date Appliance Placed | Months of Treatment Remaining |

**Dentist's** – ☐ Pretreatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)**




38. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

| Tooth # or Letter | Surface | Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.) | Date Service Performed Mo./ Day /Year | ADA Procedure Number | Fee | For Carrier Use Only |
|---|---|---|---|---|---|---|
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39. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed
*Signature of Dentist _____ Date _____ Total Fee Actually Charged

40. Address where treatment was performed
Street _____ City _____ State _____ Zip _____

If you are covered under a self-insured plan or insured under a policy issued in any state other than those listed below, **or** if you reside in any state other than those listed below, then the following warning may apply to you:

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

If you are insured under a policy issued in one of the following states, **or** if you reside in one of the following states, one of the following state warnings may apply to you:

**New York (only applies to Accident and Health Benefits (AD&D/Disability/Dental):** I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to $5,000 plus the value of the claim.

**Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Massachusetts:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Kansas and Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement may have violated state law.

Employee Signature _____ Date _____

**Please Review Before Submitting Claim**

**Information for Employee**

1. Complete your section of the claim form (Items 1 through 21) in full to assure positive identification and prompt payment. Please print or type. **Note:** Item 8 (Employee Social Security / ID Number) **must be completed** for the claim to be processed.
2. **Patient Consent.** By signing item 20 the patient (or parent or other authorized representative) consents to the use and disclosure of information relating to the services provided by the dentist or health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for dental benefits to a provider or administrator of dental benefit plans. This consent will be valid for as long as the patient is entitled to coverage under a dental plan. You are entitled to a copy of this consent. This consent may be revoked in writing delivered to your dentist or health care professional, but such revocation will not affect any action taken in reliance on this consent prior to revocation. Upon receipt of revocation or refusal to sign a consent, your dentist or health care professional may decline to provide or continue treatment. If this consent is signed by the authorized representative of the patient, the relationship of the authorized representative must be provided in Item 20.
3. You must sign the claim form in Item 21.
4. You can arrange for MetLife to make payment directly to the dentist by completing Item 22. If you wish benefits to be paid directly to yourself, do not complete Item 22. In either case, a statement of benefits paid will be sent to you.
5. If total charges for the planned course of treatment are expected to be $300 or more, a pre-treatment estimate of benefits is suggested. Please note that the pre-treatment estimate of benefits is only intended to avoid misunderstandings between the employee, dentist and insurance company concerning benefits payable. It is not intended to preclude a course of treatment agreed upon by you and your dentist.

   The form should be completed and submitted to MetLife prior to the commencement of the course of treatment for a pre-treatment estimate of benefits. MetLife will notify you of your benefits payable. (If you wish, a pre-treatment estimate may be requested for anticipated dental expenses of less than $300.)
6. If total charges for the planned course of treatment will be less than $300, the claim form should be completed when treatment is completed and mailed to the address shown below.

   **Dental Coverage is subject to specific limitations and exclusions. Please refer to your booklet for a description of covered services, schedule of benefits payable, limitations and exclusions.**

**Information for Attending Dentist**

1. Benefits are payable in accordance with four Classes of Services. It is therefore important that a separate fee is indicated for each item of service performed.
2. If total charges for the planned course of treatment are expected to be $300 or more, a pre-treatment estimate of benefits is suggested. Please note that the pre-treatment estimate of benefits is only intended to avoid misunderstandings between the employee, dentist and insurance company concerning benefits payable. It is not intended to preclude a course of treatment agreed upon by you and your patient.

   Check the box noted "Pre-treatment estimate" and complete items 23 through 39. The completed claim form should be sent to MetLife prior to the commencement of the course of treatment for a pre-treatment estimate of benefits. MetLife will notify your patient of benefits payable.
3. Generally, we do *not* request x-rays where standard filling materials are used. Pre-operative x-rays are requested *only* in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally we may request x-rays that relate to other dental services.

   In an effort to reduce your costs and inconvenience, we request your cooperation in submitting x-rays *only* in the above mentioned circumstances or when specifically requested. This will also enable us to expedite the processing of a pretreatment estimate.
4. If authorized by the employee, benefit payments will be made directly to you.

**Mail Completed form to:**
**MetLife Dental Claims**
**P.O. Box 981282**
**El Paso, TX 79998-1282**

**Employees: 1-888-727-2317**
**Dentists: 1-877-638-3379**

**MetLife®**
Metropolitan Life Insurance Company

# Dental Expense Claim

**To Be Completed by Employee** *(You must review the important statements on page 2 and sign where indicated before completing this section of the form.)*

| 1. Patient First Name / Middle / Last | 2. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other | 3. Sex ☐ Male ☐ Female | 4. Married? ☐ Yes ☐ No | 5. Patient Date of Birth Mo. / Day / Year | 6. For Office Use |
|---|---|---|---|---|---|

| 7. If Full Time Student (Age 19 or Over) School / City / State | 8. EMPLOYEE Social Security / ID Number | 9. If Disabled (Age 19 or Over) ☐ Yes ☐ No | 10. Name of Group Dental Program **Port Authority/PATH #302043** |
|---|---|---|---|

| 11. Employee First Name / Middle / Last | 12. Employee Date of Birth | 13. Office Phone (Area Code) |
|---|---|---|

| 14. Employee Residence Mailing Address | 15. City, State, Zip |
|---|---|

| 16. Are other Family Members Employed? ☐ Yes ☐ No<br>Name / Social Security / ID Number | 17. Date of Birth | 18. Name and Address of Employer for Item 16 |
|---|---|---|

19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:)
Dental Plan Name / Group No. / Name and Address of Carrier

| 20. I Authorize Release of any Information Relating to this Claim | 21. I Certify that the Above Information is Correct. | 22. I Authorize Payment Directly to the Below Named Dentist. |
|---|---|---|
| (Signature of Patient or Signature of Authorized Representative if Minor) / Date | Employee Signature / Date | Employee Signature / Date |
| If Authorized Representative, Relationship to Minor | | |

**To Be Completed by Dentist**

| 23. Dentist Name | 24. Mailing Address / City / State / Zip |
|---|---|

| 25. Dentist Social Security Number or T.I.N. | 26. Dentist License Number | 27. Dentist Phone Number |
|---|---|---|

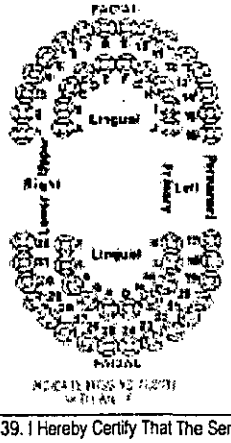
| 28. First Visit Date Current Series | 29. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other _____ | 30. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many? _____ |
|---|---|---|

| 31. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) | 32. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) |
|---|---|
| 33. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) | 34. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) |

| 35. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement) | 36. Date of Prior Replacement? |
|---|---|

| 37. Is Treatment for Orthodontics? ☐ Yes ☐ No | If Services Already Commenced, Enter Date Appliance Placed | Months of Treatment Remaining |
|---|---|---|

**Dentist's** – ☐ Pretreatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)**




38. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

| Tooth # or Letter | Surface | Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.) | Date Service Performed Mo./ Day /Year | ADA Procedure Number | Fee | For Carrier Use Only |
|---|---|---|---|---|---|---|
| | | | | | | |
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39. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed
*Signature of Dentist _____ Date _____ Total Fee Actually Charged

40. Address where treatment was performed
Street _____ City _____ State _____ Zip _____

If you are covered under a self-insured plan or insured under a policy issued in any state other than those listed below, **or** if you reside in any state other than those listed below, then the following warning may apply to you:

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

*If you are insured under a policy issued in one of the following states, or if you reside in one of the following states, one of the following state warnings* may apply to you:

**New York (only applies to Accident and Health Benefits (AD&D/Disability/Dental):** I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to $5,000 plus the value of the claim.

**Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Massachusetts:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil *penalties.*

**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Kansas and Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement may have violated state law.

Employee Signature _____ Date _____

**Please Review Before Submitting Claim**

**Information for Employee**

1. Complete your section of the claim form (Items 1 through 21) in full to assure positive identification and prompt payment. Please print or type. **Note:** Item 8 (Employee Social Security / ID Number) **must be completed** for the claim to be processed.
2. **Patient Consent.** By signing Item 20 the **patient** (or parent or other authorized representative) consents to the use and disclosure of information relating to the services provided by the dentist or health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for dental benefits to a provider or administrator of dental benefit plans. This consent will be valid for as long as the patient is entitled to coverage under a dental plan. You are entitled to a copy of this consent. This consent may be revoked in writing delivered to your dentist or health care professional, but such revocation will not affect any action taken in reliance on this consent prior to revocation. Upon receipt of revocation or refusal to sign a consent, your dentist or health care professional may decline to provide or continue treatment. If this consent is signed by the authorized representative of the patient, the relationship of the authorized representative must be provided in Item 20.
3. You must sign the claim form in item 21.
4. You can arrange for MetLife to make payment directly to the dentist by completing item 22. If you wish benefits to be paid directly to yourself, do not complete Item 22. In either case, a statement of benefits paid will be sent to you.
5. If total charges for the planned course of treatment are expected to be $300 or more, a pre-treatment estimate of benefits is suggested. Please note that the pre-treatment estimate of benefits is only intended to avoid misunderstandings between the employee, dentist and insurance company concerning benefits payable. It is not intended to preclude a course of treatment agreed upon by you and your dentist.

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6. If total charges for the planned course of treatment will be less than $300, the claim form should be completed when treatment is completed and mailed to the address shown below.

   **Dental Coverage is subject to specific limitations and exclusions. Please refer to your booklet for a description of covered services, schedule of benefits payable, limitations and exclusions.**

**Information for Attending Dentist**

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3. Generally, we do *not* request x-rays where standard filling materials are used. Pre-operative x-rays are requested *only* in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally we may request x-rays that relate to other dental services.

   In an effort to reduce your costs and inconvenience, we request your cooperation in submitting x-rays *only* in the above mentioned circumstances or when specifically requested. This will also enable us to expedite the processing of a pretreatment estimate.
4. If authorized by the employee, benefit payments will be made directly to you.

**Mail Completed form to:**
**MetLife Dental Claims**
**P.O. Box 981282**
**El Paso, TX 79998-1282**

**Employees: 1-888-727-2317**
**Dentists: 1-877-638-3379**

**THE PORT AUTHORITY OF NY & NJ**

November 2003

Dear Port Authority & PATH Employee/Retiree,

As you may know, National Prescription Administrators (NPA), our prescription drug benefit carrier, was recently purchased by Express Scripts, Inc. In conjunction with this purchase, Express Scripts has issued the enclosed new prescription identification card(s), which can be used effective November 15, 2003. Your level of benefits remains unchanged and Express Scripts has assured us that they will continue to provide the same level of service to which you were accustomed under NPA.

You will notice that the new card has an enhanced level of security and privacy. Specifically, your Social Security number has been removed from the card and replaced with a unique identifier provided by Express Scripts. In addition, the card has been issued with your name only. Your previously listed dependents are still eligible for benefits under the plan and will continue to be as long as they meet our eligibility criteria.

If you currently have a combination prescription/vision card or a vision only card from National Vision Administrators (NVA), you can continue to use it for vision care services. We are currently working with NVA on reissuing vision identification cards in the near future.

If you have any questions regarding your prescription benefit or the contents of this letter, please contact Express Scripts Customer Service at (800) 467-2006 or Employee Benefits at (212) 435-2870.

Sincerely,

Michael F. Cavalier

Michael F. Cavalier
Manager, Employee Benefits

THE PORT AUTHORITY OF NY & NJ

October 2004

Dear Port Authority & PATH Employee/Retiree,

As part of Port Authority's ongoing commitment to ensure the privacy of your health care information, protect you against identity theft and to comply with recent federal HIPAA (Health Insurance Portability and Accountability Act) legislation, National Vision Administrators (NVA) has issued new identification card(s).

You will notice that the new card has an enhanced level of security and privacy. Specifically, your Social Security number has been removed from the card and replaced with a unique identifier provided by NVA. The level of benefits for you and your eligible dependents remains unchanged and NVA has assured us that it will continue to provide the same level of service to which you are accustomed.

If you have any questions regarding your vision benefits or the contents of this letter, please contact NVA Customer Service at (800) 672-7723 or Employee Benefits at (212) 435-2870.

Sincerely,

Michael F. Cavalier
Manager, Employee Benefits

225 Park Avenue South, 10th Floor
New York, NY 10003
T: 212 435 7000

November 2004

Dear Port Authority & PATH Employee/Retiree:

Enclosed for your convenience is an additional National Vision Administrators (NVA) identification card. As you know, your social security number was replaced with an alternate identification number and, although both cards are issued in your name, all of your eligible family dependents are covered for vision benefits under this card.

If you have any questions regarding your vision benefits, covered dependents or need additional cards, please don't hesitate to call NVA at (800) 672-7723.

Sincerely,

Michael F. Cavalier

Michael F. Cavalier
Manager, Employee Benefits

225 Park Avenue South, 10th Floor
New York, NY 10003
T: 212 435 7000

January 2007

Dear Retiree/Medicare Enrollee,

Please find enclosed a copy of your *Evidence of Coverage* for the Port Authority of NY & NJ Retiree Prescription Drug Plan, an employer-sponsored Medicare Part D Prescription Drug Plan administered by Express Scripts. The *Evidence of Coverage* explains your benefits, services, co-payments/co-insurance, rights and responsibilities under this Plan. Also please complete the enclosed *Medicare Questionnaire for Beneficiaries with Prescription Drug Coverage* and return to:

The Port Authority of NY & NJ
Attention: Employee Benefits Division
225 Park Avenue South – 10th Floor
New York, NY 10003

If you have any questions, please contact Employee Benefits at (212) 435-2870.

Sincerely,

Michael F. Cavalier

Michael F. Cavalier
Manager, Employee Benefits

Encl.

# EVIDENCE OF COVERAGE

## Port Authority of New York & New Jersey
## (An Employer-Sponsored Medicare Part D Prescription Drug Plan)
## Exclusively for
## Medicare-Eligible Retirees and Their Medicare-Eligible Dependents

E1539


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### *How to contact Customer Service*

If you have any questions or concerns, Express Scripts' Customer Service will be happy to help you. Business hours are 24 hours a day/seven days a week.

**CALL:** 1-800-557-3949. Calls to this number are free.
**TTY/TDD:** 1-800-899-2114. This toll-free number requires special telephone equipment.
**WRITE:** Express Scripts, Inc. P.O. Box 66583, St. Louis, MO 63166

To contact Port Authority regarding eligibility issues and concerns about Express Scripts:

**CALL:** 212-435-2870
**WRITE:** The Port Authority of New York & New Jersey
225 Park Avenue South – 10th Floor
Attn: Employee Benefits
New York, NY 10003

## Section 1- Introduction

The Port Authority of New York & New Jersey (Port Authority) provides comprehensive prescription drug benefit coverage for its Medicare-eligible retirees and their Medicare-eligible dependents through The Port Authority Retiree Prescription Drug Plan, an employer-sponsored Medicare Part D Plan ("Plan") approved by the Centers for Medicare and Medicaid Services (CMS). This prescription drug coverage is currently administered by Express Scripts, Inc. The contract with CMS has no effect on your prescription drug coverage, or your ability to obtain the prescription drugs you and your eligible dependents need, when and where you need them.

This Evidence of Coverage (EOC) explains the benefits, services, co-pays/coinsurance, and guidelines you must follow to get your prescription drugs covered. It also explains the Plan's responsibilities to you.

The Plan covers only Medicare-eligible retirees and their Medicare-eligible spouses/dependents (collectively, eligible dependents). Dependents who qualify for Port Authority retiree health and prescription drug coverage, but are not eligible for Medicare, will continue their prescription drug coverage under the Port Authority's regular retiree prescription drug coverage. Both the prescription drug plan for Medicare-eligibles and the regular retiree prescription drug coverage provide comprehensive prescription drug coverage.

The information in this EOC is effective from January 1, 2007 until changed by the Port Authority. This EOC is intended to summarize the pertinent provisions of the Plan. However, in the event there is a conflict between this EOC and the governing Plan documents, the Plan documents will be controlling.

## Section 2 - Coverage and Plan Benefits

### *Coverage*

Eligible employees who retire from the Port Authority of New York & New Jersey or the Port Authority Trans-Hudson Corporation, and are eligible for Medicare, are automatically enrolled in the Plan. In addition, if your eligible spouse and/or dependent(s) are eligible for Medicare, they will also be automatically enrolled in the Plan. You will be notified, in writing, of your automatic enrollment. If you wish to decline Plan coverage, you will have 30 days to give the Port Authority written notice.

If you enroll in another Medicare Part D Prescription Drug Plan, please notify the Port Authority in writing. If you or your covered dependent(s) enroll in another Medicare Part D Prescription Drug Plan, the Port Authority will become secondary, and will not pay any claims until after the other Medicare Part D plan has paid what is owed under that plan. You will then have to submit a paper claim to Express Scripts (with a copy of your prescription drug receipt and Explanation of Benefits from the other plan) for a determination of any further reimbursement due you from the Port Authority.

If you (and, if applicable, your eligible dependents) are covered by another Medicare Part D Plan and later drop that coverage, you must notify the Port Authority's Employee Benefits Division if you want to join (or rejoin) the Port Authority's Plan.

The Port Authority handles all eligibility matters. If you have any questions about eligibility under the Plan, please contact the Port Authority at (212) 435-2870.

## *Plan Benefits*

**You pay no monthly or annual premiums for this prescription drug coverage.**

A description of your prescription drug benefit is shown in the table below.

| | |
|---|---|
| Deductible | None |
| Retail Pharmacy –<br>Up to a 30 day supply (90 day supply available at select participating pharmacies) | You pay 20% of the cost of each prescription |
| Mail Order Pharmacy –<br>Up to a 90 day supply | You pay 20% of the cost of each prescription |
| Annual Out-of-Pocket Maximum | $500 |

Below are some additional provisions of the Plan:

1. The Plan covers all legally prescribed drugs by a licensed medical practitioner that you or your eligible dependents purchase at legally authorized pharmacies. In some cases, the Plan covers drugs that a standard commercial Medicare Part D plan does not make available.
2. Insulin, insulin syringes, and needles are covered by prescription only.
3. Prescriptions will be dispensed as written by the licensed medical practitioner.
4. All refills will be dispensed according to your licensed medical practitioner's directions.
5. Contraceptives are available through mail order only.
6. Monthly dosage limits may apply to certain drugs. To find out if any dosage limitations, restrictions or other requirements apply to a drug that may be or has been prescribed, please contact Express Scripts.
7. Maintenance drugs used on a long-term basis can be filled through mail order to save you money.
8. There is no limit to the number of prescriptions allowable through the Plan.
9. Medications provided to eligible participants confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity where drugs are covered under either Medicare Part A or B; medication used for cosmetic purposes (e.g., Rogaine/Monoxidil for hair restoration and Retin-A for individuals over 25 years old).

The following drugs and drug devices or appliances are the principal, but not necessarily only, exclusions from coverage:

1. Medications lawfully obtainable without a prescription (excluding: insulin devices or appliances),
2. Support garments or other non-medicinal substances,
3. Administration charges for drugs or insulin,
4. Investigatory or experimental drugs,
5. Unauthorized or premature refills,

6. Prescriptions covered without charge under Federal, State or local programs including Workers' Compensation,
7. Medications or drugs prescribed while you are confined to a rest home, nursing home, sanitarium, extended care facility/ hospital or similar entity are covered under either Medicare Part A or B.
8. Medications (either type of medication or quantity) intended for unauthorized or unapproved use, and
9. Medication used for cosmetic purposes (*e.g.*, Rogaine, Monoxidil for hair restoration, and Retin-A for persons over age 25).

In addition, the Plan does not cover drugs that are covered under Medicare Part A or Part B or the Port Authority's medical coverage.

## *Where can I use the Express Scripts drug card?*

The Plan's service area is nationwide. Regardless of where you live, prescription drug coverage is provided. Most retail pharmacies accept the Express Scripts prescription drug card. A list of participating pharmacies is available from Express Scripts' website at www.express-scripts.com.

### *How do I fill a prescription through the Plan's network mail order pharmacy service?*

You can use the Plan's mail order service to fill any of your prescriptions. You can receive up to a 90-day supply through the Plan's mail order service. Contact Customer Service to obtain a mail order pharmacy form. You are not required to use mail order services to get an extended supply. You can also get an extended supply through some participating retail network pharmacies.

## *Filling prescriptions outside the network*

If you do not use a network pharmacy (*i.e.*, one that electronically accepts your Express Scripts prescription drug card), you can be reimbursed for a 30-day prescription filled at any pharmacy (90-day supplies will only be available from participating pharmacies or through mail order). To learn how to submit a paper claim, please refer to the paper claims process described next. **Note:** If we do pay for the drugs you get from an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

## *How do I submit a paper claim?*

When you go to a network pharmacy, your claim is automatically submitted by the pharmacy. However, if you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly. When that happens, you will have to pay the full cost of your prescription and request reimbursement (up to a 30-day supply) by submitting a claim form (together with the required information and documents), which you can get by calling Express Scripts' Customer Service. The claim form explains what you need to do and where to send the completed form.

## *Specialty pharmacies/Home infusion pharmacies*

### *Home infusion pharmacies*

The Plan will cover home infusion therapy if:

- Your prescription drug is covered or an exception has been granted for your prescription drug, and
- Your prescription is written by a doctor.

### *Long-term care pharmacies*

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the Plan's network of long-term care pharmacies. Please contact Customer Service to find out if your long-term care pharmacy is part of our network. If your long-term care facility does not participate in the Express Scripts network, you may submit your prescription for reimbursement to Express Scripts by using a paper claim (see above).

### *Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) Pharmacies*

Native Americans and Alaska Natives have access to I/T/U pharmacies through the Plan's pharmacy network. Please contact Customer Service for a Pharmacy Directory to find an I/T/U pharmacy in your area. If you use a non-network I/T/U pharmacy, you should submit a paper claim for reimbursement.

### *Some vaccines and drugs may be administered in your doctor's office*

The Plan covers vaccines that are preventive in nature but not the cost associated with administering the vaccine and are not already covered by Medicare Part B. In addition the Plan covers some drugs that may be administered in your doctor's office. (Please see "How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information).

## *Drug Management Programs*

### *Utilization management*

For certain prescription drugs, there may be additional requirements for coverage or limits on coverage. These requirements and limits ensure that our members use these drugs in the most effective way. Examples of utilization management tools are described below.

**Prior Authorization:** Prior authorization may be required for certain drugs.

If you want to appeal Express Scripts' denial of your request for prior authorization, contact Express Scripts as follows:

**By telephone:** 1-800-417-8164

**By fax:** 1-877-837-5922

**By Mail:** Express Scripts, Inc.
Prior Authorization – Part D
Mail Route BL0345
6625 West 78th Street
Bloomington, MN 55439

**Quantity Limits:** For certain drugs, the amount of the drug that the Plan will cover may be limited per prescription or for a defined period of time. You can find out if your drug is subject to these additional requirements or limits by looking up the medicine on the Express Scripts website or by calling Customer Service. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. (See Section 4 for appeal process.)

### *Drug utilization review*

Drug utilization reviews are conducted to ensure you are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. Drug utilization reviews are conducted each time you fill a prescription and on a regular basis by reviewing prior records. During these reviews, medication problems such as the following are looked at:

- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If a medication problem is identified during the drug utilization review, the Plan will work with your doctor to correct the problem.

### *Medication therapy management programs*

Medication therapy management programs are offered at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed by a team of pharmacists and doctors. We use these medication therapy management programs to help provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors. We offer a medication therapy management program for members that meet specific criteria. We may contact members who qualify for these programs. If Express Scripts contacts you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate. If you are selected to join a medication therapy management program Express Scripts will send you information about the specific program, including information about how to access the program.

## *How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?*

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you are enrolled in Medicare Parts A and B, and your medication is covered under either Part A or B, your drug will still be covered under Medicare Part A or B even though you are enrolled in this Plan. In addition, if your drug is covered by Medicare Part A or Part B, it cannot be covered by the Plan even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this Plan in other cases but never both at the same time.

## *Explanation of Benefits*

### *What is the Explanation of Benefits?*

The Explanation of Benefits is a document that summarizes your prescription drug coverage

under the Plan. You will be provided with an Explanation of Benefits whenever you request it, and at certain times determined by the Plan. To get a copy, please contact Customer Service. Your Explanation of Benefits will include a list of prescriptions you filled, the amount you paid for each prescription, and the amount the Plan paid.

### *How does your prescription coverage work if you go to a hospital or skilled nursing facility?*

**If you are admitted to a hospital for a Medicare-covered stay,** Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, the Plan will cover your prescription drugs as long as the drugs are not covered by Medicare Part A or Part B. The Plan will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

**If you are admitted to a skilled nursing facility for a Medicare-covered stay,** after Medicare Part A stops paying for your prescription drug costs, the Plan will cover your prescription provided the drug is not covered by Medicare Part B. The Plan will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process. When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. Please see Section 5 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan. However, since this Plan does not charge any monthly premium, you can remain on this Plan at no cost, even if you are not purchasing any drugs covered by this Plan.

### *Help us keep your membership record up-to-date*

The Plan has information about you as a Plan member, including your address and telephone number. It shows your specific Plan coverage and other information. Section 6 tells you how the Plan protects the privacy of your personal health information. Please keep your information up-to-date by letting the Port Authority know right away if there are any changes in your name, address, phone number or changes to your dependent's coverage. Also, let us know of any changes in prescription drug coverage you have from other sources, such as from your spouse's current or former employer. In addition, you should tell the Plan about any changes in coverage due to claims filed under liability insurance, such as workers' compensation claims or claims against another driver in an automobile accident.

## Section 3 - If You Have Other Prescription Drug Coverage

A coordination of benefits survey (*Medicare Questionnaire for Beneficiaries with Prescription Drug Coverage)* may be sent to you so that the Plan can know what other drug coverage you have in addition to the coverage you get through this Plan. CMS requires us to collect this information from you. The information you provide helps calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Customer Service to update your membership records.

**Veteran's Administration and TriCare Coverage**

Veteran's Administration Benefits - For individuals who have served in the military and are entitled to Veteran Administration (VA) pharmacy benefits, Medicare law does not permit coordination of benefits (COB) between two federally funded prescription plans such as the VA and any Medicare Part D Plan. You may receive coverage from either the VA or the Plan on a prescription-by-prescription basis, but you cannot COB between plans. For more information, *see* ***www.va.gov*** *on the web.*

TriCare - For individuals who have served in the military and receive a pension with TRICARE pharmacy benefits, by law, TRICARE pays only after all other health plans have paid. If you want TRICARE as your primary coverage, you must disenroll from the Port Authority's prescription drug plan. For more information, see **www.tricare.osd.mil** on the web.

## Section 4 - Appeals and Grievances: What To Do If You Have A Complaint

This section gives the rules for making complaints in different types of situations. If you make a complaint, the Plan must be fair in how it is handled. You cannot be disenrolled from the Plan or penalized in any way if you make a complaint.

If you have a complaint, you are encouraged to first call Customer Service to resolve it over the phone. If you request a written response to your phone complaint, the Plan will respond in writing to you. If the Plan cannot resolve your complaint over the phone, the formal process described below may apply. Customer Service can provide information on the next steps in the process.

The Port Authority has contracted with Express Scripts to administer this Plan. All decisions by Express Scripts are made for and on behalf of the Port Authority. If you have any problems with Express Scripts' service, please contact their Customer Service. If you are not satisfied with Express Scripts' handling of your case, please contact Port Authority directly as indicated on page 1.

There are two separate complaint procedures: (1) "coverage determinations," which deal with whether the Plan covers the drug you are requesting and how much you will pay for the requested drug, and (2) "grievances," which address any other types of complaints, including delays in receiving drugs and difficulties reaching someone who has information or control over your prescription drugs. These two procedures are explained in detail below.

### *How to request a coverage determination*

This section explains what you can do if you have problems getting the prescription drugs you believe the Plan should provide and want to request a coverage determination. The Plan uses the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that the Plan will not cover a prescription drug that is not excluded here, you should contact Customer Service and ask for a coverage determination. The following are examples of when you may want to ask us for a coverage determination:

- If you have received a prescription drug that you believe may be covered by the Plan while you were a member, but the Plan has refused to pay for the drug.

- If you disagree with the amount that the Plan requires you to pay for a prescription drug that your doctor has prescribed for you.

- If you are being told that coverage for a prescription drug that you have been getting will be reduced or stopped.

- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.

- If there is a requirement that you try another drug before the Plan will pay for the drug you are requesting and you believe the requirement is wrong or unfair.

- You bought a drug at a pharmacy that is not in the Plan network, you have filed a claim for payment with the Plan and you have not received the Plan's payment within a reasonable period of time.

The process for requesting a coverage determination is discussed in greater detail below.

### *What is a coverage determination?*

The coverage determination made by the Plan is the starting point for dealing with requests you may have about covering or paying for a prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact Customer Service and ask for a coverage determination. With this decision, the Plan explains whether it will provide the prescription drug you are requesting or pay for a drug you have already received. If the Plan denies your request (this is sometimes called an "adverse coverage determination"), you can "appeal" the decision by going on to Appeal Level 1 (see below). If the Plan fails to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

- You ask the Plan to pay for a drug you have already received. This is a request for a coverage determination about payment. You can call Customer Service to get help in making this request.

- You ask for an exception to the Plan's utilization management tools. Requesting an exception to a utilization management tool is a type of coverage exception. You can call Customer Service to ask for this type of exception. i

When the Plan makes a coverage determination, it is giving an interpretation of how the Plan's prescription drug benefits apply to your specific situation. This document and any amendments you may receive describe the prescription drug benefits covered by the Plan, including any limitations that may apply to these benefits. This document also lists exclusions (benefits that are "not covered" by the Plan).

### *Who may ask for a coverage determination?*

You can ask the Plan for a coverage determination yourself. Your prescribing doctor or someone you name may also do it for you. The person you name would be your appointed representative. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to Express Scripts at:

Express Scripts, Inc.
Attention: Prior Authorization – Part D
Mail Route BL0345
6625 West 78th Street
Bloomington, MN 55439

You can call Customer Service to learn how to name your appointed representative. You also have the right to have an attorney ask for a coverage determination on your behalf.

### *Asking for a "Standard" or "Fast" Coverage Determination*

A decision about whether the Plan will cover a prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours - see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours - see below). A fast decision is sometimes called an "expedited coverage determination." You can ask for a fast decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for prescription drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a prescription drug that you already received.)

### *Asking for a standard decision*

To ask for a standard decision you, or your appointed representative should refer to the Customer Service numbers listed on page 1 for assistance. Your physician can call Express Scripts Physician Line at 1-800-417-8164. You can also deliver a written request to the above address.

### *Asking for a fast decision*

You, your doctor, or your appointed representative can ask Express Scripts to give a fast decision (rather than a standard decision) by writing, calling or faxing Customer Service. Be sure to ask for a "fast," "expedited," or "24-hour" review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, Express Scripts will automatically give you a fast decision.

If you ask for a fast coverage determination without support from a doctor, Express Scripts will decide if your health requires a fast decision. If they decide that your medical condition does not meet the requirements for a fast coverage determination, they will send you a letter informing you that if you get your doctor's support for a fast review, they will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with the decision to deny your request for a fast review. If Express Scripts denies your request for a fast coverage determination, they will give you a decision within the 72-hour standard timeframe.

### *What happens when you request a coverage determination?*

What happens, including how soon Express Scripts must decide, depends on the type of decision.

1. *For a standard coverage determination about a prescription drug, which includes a request about payment for a prescription drug that you already received:*

Generally, Express Scripts must give you its decision no later than 72 hours after receiving your request, but the decision will be made sooner if your health condition requires. However, if your request involves a request for an exception (including a coverage exception, or an exception from utilization management rules – such as dosage or quantity limits, a decision will be made no later than 72 hours after receipt of your doctor's "supporting statement" explaining why the drug you are asking for is medically necessary. **If you are requesting an exception, you should submit your prescribing doctor's supporting statement with the request, if possible.**

Express Scripts will give you a decision in writing about the prescription drug you have requested. You will get this notification when a decision is made under the timeframe explained above. If Express Scripts does not approve your request, it must explain why, and tell you of your right to appeal the decision. The section "Appeal Level 1" explains how to file this appeal. If Express Scripts has not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

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2. *For a fast coverage determination about a prescription drug that you have not received:*

If you get a fast review, Express Scripts will give you a decision within 24 hours after you or your doctor ask for a fast review - sooner if your health requires. If your request involves a request for an exception, Express Scripts must make a decision no later than 24 hours after it gets your doctor's "supporting statement," which explains why the uncovered drug you are asking for is medically necessary.

Express Scripts will give you a decision in writing about the prescription drug you have requested. You will get this notification when Express Scripts makes its decision, under the timeframe explained above. If Express Scripts does not approve your request, it must explain why, and tell you of your right to appeal the decision. The section "Appeal Level 1" explains how to file this appeal.

If Express Scripts decides you are eligible for a fast review, and it has not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If Express Scripts does not grant your or your doctor's request for a fast review, it will give you its decision within the standard 72-hour timeframe discussed above. If Express Scripts tells you it will not provide a fast review by phone, it will send you a letter explaining the decision within three calendar days after it has called you. The letter will also tell you how to file a "grievance" if you disagree with the decision to deny your request for a fast review, and will explain that you will automatically receive a fast decision if you get your doctor's support for a fast review.

### *What happens if Express Scripts decides completely in your favor?*

If Express Scripts makes a coverage determination that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a prescription drug, which includes a request about payment for a prescription drug that you already received:*

Express Scripts must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after they received the request. If your request involves a request for an exception, Express Scripts must authorize or provide the benefit no later than 72 hours after it gets your doctor's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, Express Scripts must send payment to you no later than 30 calendar days after it gets the request.

2. *For a fast decision about a prescription drug that you have not received:*

Express Scripts must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, Express Scripts must authorize or provide the benefit no later than 24 hours after it gets your doctor's "supporting statement."

### *What happens if Express Scripts denies your request?*

If Express Scripts denies your request, it will send you a written decision explaining the reason why your request was denied. Express Scripts may decide completely or only partly against you. For example, Express Scripts denies your request for payment for a prescription drug that you have already received, or says that the Plan will pay nothing or only part of the amount you requested. If a coverage determination does not give you all that you requested, you have the right to appeal the decision. (See Appeal Level 1).

## *Appeal Level 1: If Express Scripts denies all or part of your request in their coverage determination, you may ask them to reconsider their decision. This is called an "appeal" or "request for redetermination."*

Please call Customer Service if you need help with filing your appeal. You may ask Express Scripts to reconsider their coverage determination, even if only part of its decision is not what you requested. When Express Scripts gets your request to reconsider the coverage determination, it gives the request to people at their organization who were not involved in making the coverage determination. This helps ensure that Express Scripts will give your request a fresh look.

If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

### *What kinds of decisions can be appealed?*

You can generally appeal the decision not to cover a drug, vaccine, or other prescription drug benefit. You may also appeal the decision not to reimburse you for a prescription drug that you paid for. You can also appeal if you think the Plan should have reimbursed you more than you

received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. A coverage determination may be appealed if you disagree with the decision.

***How does the appeals process work?***

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

**Moving from one level to the next.** At each level, the Plan will issue its decision to you. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied. If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

**Who makes the decision at each level?** You make your request for coverage or payment of a prescription drug directly to Express Scripts. They review this request and make a coverage determination. If Express Scripts denies your request (in whole or in part), you can go on to the first level of appeal by asking it to review its coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of this Plan, where people who are not connected to Express Scripts or the Port Authority conduct the review and make the decision. After the first level of appeal, someone who is connected to the Medicare program or the Federal court system will decide all subsequent levels of appeal. This will help ensure a fair, impartial decision.

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Each appeal level is discussed in greater detail below in the section titled "Detailed information about how to request a coverage determination and an appeal."

How you make your appeal depends on whether you are requesting reimbursement for a prescription drug you already received and paid for, or authorization of a prescription drug benefit (that is, a prescription drug that you have not yet received). If your appeal concerns a decision Express Scripts made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and "Asking for a fast decision."

To file an appeal (for both standard and fast appeals), contact Express Scripts as follows:

**By mail:** Express Scripts, Inc.
Attention: Pharmacy Appeals – Part D
Mail Route BL0390
6625 West 78th Street
Bloomington, MN 55439

**By fax:** 1-877-852-4070

For appeals made outside of weekday business hours, please call 1-800-344-3405, extension 2373022 or fax the request to 1-877-852-4070.

### *Getting information to support your appeal*

Express Scripts must gather all the information they need to make a decision about your appeal. If your assistance in gathering this information is needed, it will contact you. You have the right to get and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information. You can give Express Scripts your additional information by mail or fax, using the address or fax number above.

You also have the right to ask us for a copy of information regarding your appeal. Contact Customer Service for copies of your information. The Plan is allowed to charge a fee for copying and sending this information to you.

### *Who may file your appeal of the coverage determination?*

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. You, your appointed representative, or your prescribing doctor may file a fast appeal.

### *How soon must you file your appeal?*

Your appeal must be filed within 60 calendar days from the date listed on the notice of coverage determination. The Plan can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, call or write the Express Scripts Appeals Department.

### *What if you want a fast appeal?*

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by contacting Customer Service. Be sure to ask for a "fast," "expedited," or "72-hour" review. If your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, Express Scripts will automatically treat you as eligible for a fast appeal.

### *How soon must Express Scripts decide on your appeal?*

*How quickly Express Scripts decides on your appeal depends on the type of appeal:*

1. *For a standard decision about a prescription drug, which includes a request for reimbursement for a prescription drug you already paid for and received.*

After Express Scripts gets your appeal, the Plan has up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If Express Scripts does not give you a decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

2. *For a fast decision about a prescription drug that you have not received.*

After Express Scripts gets your appeal, they have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If Express Scripts does not give you its decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

### *What happens next if Express Scripts decides completely in your favor?*

1. *For a decision about reimbursement for a prescription drug you already paid for and received.* Express Scripts must send payment to you no later than 30 calendar days after it gets your request to reconsider their coverage determination.
2. *For a standard decision about a prescription drug you have not received.* Express Scripts must authorize or provide you with the prescription drug you have asked for as quickly as your health requires, but no later than 7 calendar days after it gets your appeal.
3. *For a fast decision about a prescription drug you have not received.* Express Scripts must authorize or provide you with the prescription drug you have asked for within 72 hours of receiving your appeal – or sooner, if your health would be affected by waiting this long.

### *What happens next if Express Scripts denies your appeal?*

If Express Scripts denies any part of your appeal, you or your appointed representative has the right to ask an independent organization, to review your case. This independent review organization contracts with the Federal government and is not part of the Plan.

## *Appeal Level 2: If Express Scripts denies any part of your first appeal, you may ask for a review by a government-contracted independent review organization*

### *What independent review organization does this review?*

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with CMS. The independent review organization has no connection to the Plan, the Port Authority or Express Scripts. You have the right to ask Express Scripts for a copy of your case file. The Plan is allowed to charge you a fee for copying and sending this information to you.

### *How soon must you file your appeal?*

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the Independent Review Organization whose name and address is included in the redetermination notice you get from Express Scripts.

### *What if you want a fast appeal?*

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing doctor cannot file the request for you – only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under "Asking for a Fast Decision." If your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, the independent review organization will automatically treat you as eligible for a fast appeal.

### *How soon must the independent review organization decide?*

After the independent review organization gets your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For a standard request about a prescription drug, which includes a request about reimbursement for a prescription drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it gets your request to give you a decision.*
2. *For a fast decision about a prescription drug that you have not received, the independent review organization has up to 72 hours from the time it gets the request to give you a decision.*

### *If the independent review organization decides completely in your favor:*

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about reimbursement for a prescription drug you already paid for and received.* Express Scripts must pay within 30 calendar days from the date it gets notice reversing the coverage determination. Express Scripts will also send the independent review organization a notice that it has abided by the decision.
2. *For a standard decision about a prescription drug you have not received.* Express Scripts must authorize or provide you with the prescription drug you have asked for within 72 hours from the date it receives notice reversing their coverage determination. Express Scripts will also send the independent review organization a notice that it has abided by the decision.
3. *For a fast decision about a prescription drug you have not received.* Express Scripts must authorize or provide you with the prescription drug you have asked for within 24 hours from the date it gets notice reversing their coverage determination. Express Scripts will also send the independent review organization a notice that it has abided by the decision.

### *What happens next if the review organization decides against you (either partly or completely)?*

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested prescription drug benefit meets the minimum requirement provided in the independent review organization's decision.

## *Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge*

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge (ALJ). You must make a request for review by an ALJ in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the ALJ extend this deadline for good cause. You will be notified how to send your appeal to the proper ALJ.

During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel. The ALJ will not review your appeal if the dollar value of the requested prescription drug benefit meets the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

### *How is the dollar value of the "amount remaining in controversy" calculated?*

If the Plan refused to provide prescription drug benefits, the dollar value for requesting an ALJ hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes all amounts you may be expected to pay for the drugs, including costs paid by other entities.

You may also combine multiple prescription drug claims under the Plan to meet the dollar value if:

1. The claims involve the delivery of prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the ALJ.

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### *How soon does the Judge make a decision?*

The ALJ will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

### *If the Judge decides in your favor:*

The ALJ will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a prescription drug you already received.* The Plan must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.
2. *For a standard decision about a prescription drug you have not received.* The Plan must authorize or provide you with the prescription drug you have asked for within 72 hours from the date Express Scripts gets notice reversing their coverage determination.
3. *For a fast decision about a prescription drug you have not received.* The Plan must authorize or provide you with the prescription drug you have asked for within 24 hours from the date Express Scripts gets notice reversing their coverage determination.

### *If the Judge rules against you:*

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the ALJ will tell you how to request this review.

## *Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council*

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at

Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

### *How soon will the Council make a decision?*

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

### *If the Council decides in your favor:*

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a prescription drug you already received:* The Plan must send payment to you no later than 30 calendar days from the date Express Scripts gets notice reversing their coverage determination.
2. *For a standard decision about a prescription drug you have not received:* The Plan must authorize or provide you with the prescription drug you have asked for within 72 hours from the date Express Scripts gets notice reversing their coverage determination.
3. *For a fast decision about a prescription drug you have not received:* The Plan must authorize or provide you with the prescription drug you have asked for within 24 hours from the date Express Scripts gets notice reversing their coverage determination.

### *If the Council decides against you:*

If the amount involved meets the minimum requirement, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than the minimum requirement, the Council's decision is final and you may not appeal any further.

## *Appeal Level 5: Your case may go to a Federal Court*

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement, you may ask a Federal Court Judge to review the case.

### *How soon will the Judge make a decision?*

The Federal judiciary is in control of the timing of any decision.

### *If the Judge decides in your favor:*

Once we get notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a prescription drug you already received.* The Plan must send payment to you within 30 calendar days from the date Express Scripts gets notice reversing their coverage determination.
2. *For a standard decision about a prescription drug you have not received.* The Plan must authorize or provide you with the prescription drug you have asked for within 72 hours from the date Express Scripts gets notice reversing their coverage determination.
3. *For a fast decision about a prescription drug you have not received.* The Plan must authorize or provide you with the prescription drug you have asked for within 24 hours from the date Express Scripts gets notice reversing their coverage determination.

### *If the Judge decides against you:*

The Judge's decision is final and you may not take the appeal any further.

### *How to file a grievance*

A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below).

### *What types of problems might lead to you filing a grievance?*

- You feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone or in the network pharmacy.
- Disrespectful or rude behavior by network pharmacists or other staff.
- Cleanliness or condition of a network pharmacy.
- If you disagree with a decision not to expedite your request for an expedited coverage determination or redetermination.
- You believe notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if the Plan does not give you a decision within the required timeframe.
- Failure by the Plan sponsor to provide required notices.
- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. These fast-track grievances are discussed in more detail below.

If you have a grievance, you are encouraged to first call Customer Services and try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, the Plan will respond in writing to you. If the Plan cannot resolve your complaint over the phone, a formal procedure to review your complaints exists.

The Express Scripts' Medicare Grievance Team is available Monday – Friday, from 8:00 a.m. to 5:00 p.m. CST. During non-business hours, you may leave a message and your call will be returned on the next business day. You may submit your grievance to Express Scripts as follows:

**By Mail:** Express Scripts, Inc.
Attn: Director of Grievances
PO Box 66517
St. Louis, MO 63166-6517
**By Telephone:** 1-866-533-8512
**By Fax:** 1-800-305-1686

The Plan must notify you of its decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. The Plan may extend the timeframe by up to 14 calendar days if you request the extension, or if a need for additional information is justified and the delay is in your best interest.

### *For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)*

Complaints concerning the quality of care received under the Plan may be acted upon under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the Plan's grievance process. For any complaint filed with the QIO, the Plan must cooperate with the QIO in resolving the complaint.

### *How to file a quality of care complaint with the QIO*

Quality of care complaints filed with the QIO must be in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period.

## Section 5 - Terminating Plan Coverage and Your Choices for Continuing Prescription Drug Coverage after You Terminate Coverage

You are not required to use the Plan to obtain prescription drugs, and because you do not pay any premium, there is no cost to you if you do not use the Plan. However, if you want to enroll in another Medicare Part D Prescription Drug Plan, you will need to disenroll from the Port Authority's Plan first. Generally, you can enroll in a Medicare Part D Prescription Drug Plan during the annual open enrollment period (November 15 – December 31), but if you qualify for a Special Enrollment Period, you may be able to switch Part D plans during the Special Enrollment Period. You may terminate Plan coverage at any time by giving written notice to the Port Authority. Generally, coverage will terminate the last day of the month you notify the Port Authority of your request to terminate.

If you terminate your prescription drug coverage under this Plan, you will have the opportunity to enroll in another Medicare Part D plan, a Medicare Advantage plan, or a Medicare Cost Plus plan with prescription drug coverage provided that: those plans are available in your area, they are accepting new members, and you meet the eligibility requirements. For more information on

joining one of these plans in your area, contact 1-800-MEDICARE (TTY/TDD users call 1-877-486-2048) or visit **www.medicare.gov**. Refer to the next section, "When Can You Disenroll/Switch Medicare Prescription Drug Plans" for information on when you can make this change. You should contact the new plan that you are interested in for information on how and when you are able to join it.

For Medicare Part D, Medicare Advantage, or Medicare Cost Plus coverage for 2007 and afterwards, the annual coordinated election period runs from November 15 through December 31 of each year.

Please remember that, if during this election period you disenroll from this Plan and do not promptly enroll in another Medicare Part D Prescription Drug Plan or Medicare Advantage Plan with prescription drug coverage during this election period, you may be required to pay an extra premium for Medicare prescription drug coverage in the future.

If you join another Medicare Part D Prescription Drug Plan during the annual coordinated election period, your enrollment in this Plan will end on December 31 and your enrollment in the new Plan will be effective on January 1st of the following year.

### *Special Enrollment Period*

Generally, you may not enroll in a new Medicare Part D Prescription Drug Plan during other times of the year unless you qualify for a Special Enrollment Period. In order to qualify for a Special Enrollment Period, one of the following must apply to you:

- Your enrollment in this Plan was unintentional, inadvertent, or a mistake, because of the error, misrepresentation or inaction of a Federal employee, or a person acting upon the Federal government's behalf.

- You are able to demonstrate that this Plan has substantially violated a material provision in its contract. This includes, but is not limited to: If this Plan failed to provide you with prescription drug coverage in a timely manner; if this Plan failed to provide your prescription drug coverage with applicable quality standards; or you are able to demonstrate that this Plan misrepresented itself in its marketing.

- The Port Authority ceases to provide retiree prescription drug coverage.

- In certain cases, if this Plan were to be sanctioned by CMS.

- You move into, live in, or move out of certain medical facilities, including a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital or unit, rehabilitation hospital or unit, long-term care hospital, or certain other hospitals.

In the event that you are eligible for a Special Enrollment Period, CMS will determine the time frame for you to enroll in another Plan. If you feel you qualify for a Special Enrollment Period, please call Customer Service for assistance.

## How do you disenroll?

*If you wish to leave this Plan, and you are not enrolling in another Medicare Part D Prescription* Drug Plan, you will need to submit a disenrollment request. Your request should include your name, address, telephone number, email address (if you have one), Medicare number, Social Security number, date of birth, and requested disenrollment date, and (if applicable) the name and contact information for your new prescription drug plans. (Please note that the Plan may not be able to disenroll you on the date you request.) Remember to sign and date the request. You should mail the request to: The Port Authority of NY & NJ, 225 Park Avenue South – 10 Floor, Attn: Employee Benefits, New York, NY 10003 or fax it to (212) 435-2871. You may also disenroll by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you are enrolling in another Medicare Part D Prescription Drug Plan, you must contact that Plan to request enrollment information. Once you are enrolled in your new Medicare Part D plan, your membership in this Plan will *automatically* end with no action required on your part. Your new Plan will tell you, in writing, the date when your prescription drug coverage in that Plan begins. When changing plans without interruption of coverage, your prescription drug coverage with this Plan will end on that same day (this will be your "disenrollment date") as your new coverage begins. Remember, you are still a member of this Plan until your disenrollment date.

## When can the Plan disenroll you?

### *If you are no longer eligible for Medicare prescription drug coverage*

If you lose your eligibility for Medicare Part D prescription drug coverage, you usually will be transferred to the Port Authority's non-Medicare retiree plan.

### *When the Plan is no longer contracting with Medicare*

The Plan has a contract with CMS. This contract may be renewed each year. If, for any reason, the CMS contract terminates, it will not, in itself, have any adverse effect on your prescription drug benefits. However, if the CMS contract terminates, you will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS ends the contract in the middle of the year.

### *You materially misrepresent third-party reimbursement*

If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires the Plan to disenroll you.

You may be asked to leave the Plan in the following circumstances:

If you behave in a way that seriously affects the Plan's ability to arrange or provide services for you or for others who are members of the Plan. The Plan cannot make you leave (i.e., disenroll) the Plan for this reason unless permission is received from CMS.

If you give the Plan information that you know is false or deliberately misleading, and it affects whether or not you are eligible for the Plan.

If you let someone else use your prescription card to get prescription drugs for themselves or for others. Before asking you to leave (i.e., disenroll) the Plan for this reason, your case must first be referred to the Inspector General, and this may result in criminal prosecution.

### *You cannot be asked to leave the Plan because of your health*

You cannot be asked to leave the Plan for any health-related reasons or for the number of prescriptions a member takes. If you ever feel that you are being encouraged or asked to leave the Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227) or if a TTY/TDD user call 1-877-486-2048, the national Medicare help lines.

## Section 6 - Your Rights and Responsibilities as a Member of the Plan

### *Introduction*

Since you are enrolled in Medicare, you have certain rights to help protect you. In this first part of Section 6, your Medicare rights and protections as a member of the Plan are explained. You will be told what you can do if you think you are being treated unfairly or your rights are not being respected. If you would like Medicare publications on your rights, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

### *Your right to be treated with fairness and respect*

You have the right to be treated with dignity, respect, and fairness at all times. The Plan must obey laws against discrimination that protect you from unfair treatment. These laws say that the Plan cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let the Plan know. You can also reach the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call the Office for Civil Rights in your area. If you need help with communication, such as help from a language interpreter, please contact Customer Service.

### *Your right to the privacy of your medical records and personal health information*

There are Federal and State laws that protect the privacy of your medical records and personal health information. The Plan keeps your personal health information private as protected under these laws. The Plan will make sure that unauthorized people do not see or change your records. Generally, the Plan must get written permission from you (or from someone you have given legal power to make decisions for you) before it can give your protected health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. The Plan is required to provide you with a notice that tells about these rights and explains how it protects the privacy of your health information. For

example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask the Plan to make additions or corrections to your medical records (if you ask to do this, your request will be reviewed and a determination made as to whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call Customer Service.

**NOTE: As a member of The Port Authority of NY & NJ Retiree Prescription Drug Plan personal information, including prescription drug event data, will be released to Medicare, who may release it to researchers pursuant to all applicable privacy laws, for research purposes.**

### *Your right to get your prescriptions filled within a reasonable period of time*

As explained in this document, you are urged to get all of your prescriptions filled from a network pharmacy, that is, from pharmacies that contract with the Plan. You have the right to go to any network pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time.

### *Your right to know your treatment choices and participate in decisions about your health care*

You have the right to know about the different Medication Management Treatment Programs offered and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 4.

### Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and grievances are discussed in Section 4. If you make a complaint, the Plan must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that members have filed *against* the Plan in the past. To get this information, call Customer Service.

### *Your right to get information about your drug coverage and costs*

This EOC tells you what you have to pay for prescription drugs as a member of the Plan. If you need more information, please call Customer Service. You have the right to an explanation about any bills you may get for drugs not covered by the Plan. The Plan must tell you in writing why it will not pay for a drug, and how you can file an appeal to ask the Plan to change the decision. See Section 4 for more information about filing an appeal.

### *How to get more information about your rights*

If you have questions or concerns about your rights and protections, please call Customer Service. In addition, the Medicare program has a booklet called *Your Medicare Rights and Protections.* To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

### *What can you do if you think you have been treated unfairly or your rights are not being respected?*

For concerns or problems related to your Medicare rights and protections described in this section, you can call Customer Service.

### *What are your responsibilities as a member of our Plan?*

Along with the rights you have as a member of the Plan, you also have some responsibilities. Your responsibilities include the following:

Become familiar with your coverage and the rules you must follow to get care as a member. You can use this EOC and other information the Plan gives you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service if you have any questions.

Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.

Pay the portion of the prescription drug costs you may owe for the covered drugs you get.

Let the Plan know if you have any questions, concerns, problems, or suggestions.

## Section 7 - Legal Notices

### *Notice about governing law*

Many different laws apply to this EOC. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by CMS. In addition, other Federal laws may apply and, under certain situations, the laws of your State may apply.

### *Notice about nondiscrimination*

When the Plan makes decisions about the provision of health care services, it does not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Prescription Drug Plans under Medicare Part D, like this Plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

## Section 8 - Medicare and Extra Help with Drug Plan Costs for Those with Limited Income and Resources

### *How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) help line*

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. "CMS" stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Part D Prescription Drug Plans (including this Plan).

**Here are ways to get help and information about Medicare from CMS:**
Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare help line 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free. Use a computer to look at www.medicare.gov, the official government Web site for Medicare information.

**Other sources of information and assistance:**
"SHIP" stands for State Health Insurance Assistance Program. SHIPs are organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on where they are located. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare Health Plans, and about Medigap (Medicare supplement insurance) policies. You can also find the Web site for your local SHIP at www.medicare.gov.

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state or territory. QIOs have different names, depending on which state or territory they are in. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in the QIO review written quality of care complaints made by Medicare patients. See Section 4 for more information about complaints. Contact Customer Service for the QIO in your state.

**Medicaid agency – a state government agency that handles health care programs for people with low incomes**
Medicaid is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact your state's Medicaid agency.

### *What extra help is available?*

Medicare provides "extra help" to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not you home or

car. If you qualify, you will get help paying for your Medicare drug plan's prescription co-payments or co-insurance.

## *Do you qualify for extra help?*

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. You automatically qualify for extra help and don't need to apply. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people whom automatically qualify for extra help.
2. You apply and qualify. You may qualify if your yearly income is less than $14,700 (single) or $19,800 (married and living with your spouse), and your resources are less than $11,500 (single) or $23,000 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medicaid Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are 2006 and will change in 2007. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

## *How do you apply for extra help?*

Medicare mailed letters to people who automatically qualify for extra help. If you did not automatically qualify, the Social Security Administration (SSA) sent an application for this extra help to people with certain incomes. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

## Section 9 - Definitions

**Appeal** – A type of complaint you make when you want a reconsideration and a change to a decision the Plan has made about what drugs are covered for you or what the Plan will pay for a drug.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that runs the Medicare program.

**Coverage Determination** – The decision the Plan makes about the prescription drug benefits you are entitled to get under the Plan, and the amount that you are required to pay for a drug.

**Covered Drugs** – The general term we use to mean all of the prescription drugs covered by the Plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is as good as the standard Medicare prescription drug coverage. that expects to pay out, on average, as much as or more than Medicare's standard prescription drug coverage.

**Customer Service** – A department responsible for answering your questions about your membership, benefits, grievances, and appeals. See the Introduction about how to contact Customer Service.

**Disenroll or Disenrollment** – The process of ending your membership in the Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice).

**Evidence of Coverage (EOC)** – This document is called the Evidence of Coverage, or EOC. Included as part of this EOC are any other attachments that explain your coverage, define the Plan's obligations, and explain your rights and responsibilities as a member of the Plan.

**Exception** – A type of coverage determination that, if approved, allows you to get a drug that is not on the Plan's coverage.

**Generic Drug** – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

**Grievance** - A type of complaint you make about the Plan or one of the Plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

**Late Enrollment Penalty** – If you enroll in another Medicare Part D Prescription Drug Plan and you do not have creditable prescription drug coverage, you will have to pay a late enrollment penalty in addition to your monthly plan premium.

**Medically Necessary** – Services that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical

condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Prescription Drug Coverage** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

**"Medigap" (Medicare supplement insurance) policy** – Many people who have Original Medicare also buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

**Member** (member of this Plan) – A person with Medicare who is eligible to get covered services, who is covered by this Plan, and whose enrollment has been confirmed by CMS.

**Network Pharmacy** – A network pharmacy is a pharmacy where members of the Plan can get their prescription drug benefits.

**Out-of-Network Pharmacy** – A pharmacy that does not have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 2.

**Prior Authorization** – Approval in advance to get certain drugs that may or may not be covered. Some drugs are covered only if your doctor or other plan provider gets "prior authorization" from the Plan.

**Supplemental Security Income (SSI)** – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

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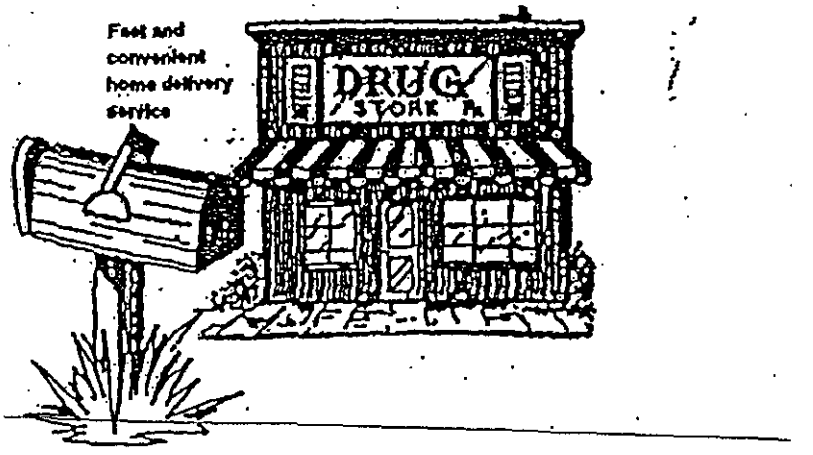



# CFI PHARMACY SERVICE

AN ADDED FEATURE
TO YOUR
PRESCRIPTION DRUG PLAN

## INTRODUCTION

The CFI Pharmacy Service has been created to provide you with the convenience of receiving prescription maintenance medication, in large quantities, right at your home. This service covers any prescription medication your doctor requests to be taken on a long term continual schedule.

## WHO IS COVERED

You and your dependents are covered as long as your eligibility continues in the Program.

## WHAT IS COVERED

Your mail order service covers all medications which require a prescription by either state or federal law and are prescribed by a licensed practitioner. This service may be used to purchase any prescription drug but its primary aim is to offer maintenance drugs used for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc.

## WHAT IS NOT COVERED

Please check the "Exclusions" portion of the Prescription Plan brochures you received with your Employee Benefits Kit.

## WHY USE A MAIL ORDER SERVICE

Participating in the mail order service helps you in several ways. First is the convenience. If you have a chronic condition which requires the taking of medication frequently and for a long period of time, a three or six months supply can be delivered to your house – we absorb all postage. This should be particularly helpful to retiree participants. Secondly, your mail order pharmacy will provide a monitoring service. All you have to do is fill out the allergy information on the mailing envelope enclosed with this brochure.

It asks for general information, but more importantly, requests information, regarding allergies and /or drug sensitivities. When your doctor prescribes a medication, the pharmacist will check to see whether it may conflict with other drugs you are taking.

## GENERIC DRUGS

Under the law, generic equivalent drugs will be dispensed for a brand name drug unless you or your doctor request otherwise. A generic drug is one that is defined by its official pharmaceutical name rather than its advertised brand name. In most cases there is a great difference in price between brand name drugs and generic drugs – but that is the only difference between them.

## HOW TO USE THE SERVICE

- Fill out the information on the envelope. Don't forget to include the allergy information.
- Enclose your doctor's prescription for up to a three or six months supply of medication, depending upon the quantity limitations established by your plan.
- Remember to enclose the copayment for each prescription (if applicable).
- Enter your return address on the envelope including your apt. no. if applicable.

Your order should be delivered by United Parcel Service or U.S. Mail within seven business days from receipt at the pharmacy. You will also receive another mailing envelope with your shipment.

Please remember, reorders should be sent about two weeks before your medication is due to run out.

## WHAT HAPPENS IF THE DRUGS NEVER ARRIVE

If you fail to receive your medication within the time prescribed, contact CFI:

973-560-2700 1-800-628-0717

Give your name, the name of your doctor, the type of prescription mailed to the pharmacy and the date you mailed it. An immediate trace will be made. If it is determined that your prescription or shipment has been lost, a CFI representative will contact your doctor to arrange for a new prescription which will be phoned in directly to the pharmacy.

## WHAT ABOUT GENERAL INQUIRIES

If you have any questions regarding your program, please call your Fund office or CFI.

INSERT THIS PAMPHLET IN YOUR
EMPLOYEE BENEFIT KIT
FOR FUTURE REFERENCE

CFI
P.O. BOX 2000
EAST HANOVER, NJ 07936-2000

973-560-2700 1-800-628-0717

# MEDICARE QUESTIONNAIRE FOR BENEFICIARIES WITH PRESCRIPTION DRUG COVERAGE

| NAME | DATE OF BIRTH | MEDICARE NUMBER |
|---|---|---|
| | | |

## SECTION A - INFORMATION ABOUT YOU

1) Are YOU currently employed? YES ☐ NO ☐ (If NO, go to SECTION B)

2) Do YOU have any group health plan coverage through your current employer?
YES ☐ NO ☐ (If NO, go to SECTION B)

3) How many employees, including yourself, work for your employer?
Don't know ☐ 1-19 ☐ 20-99 ☐ 100 or more ☐

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

DATE INSURANCE COVERAGE BEGAN — — POLICY NUMBER
M M D D Y Y Y Y

4) Does your employer group health plan cover prescription drugs? YES ☐ NO ☐ (If NO, go to SECTION B)
Please use your insurance card to provide the following information if available:

Rx GROUP Rx PCN

MEMBER ID Rx BIN

## SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE/FAMILY MEMBER

1) Is your family member currently employed? YES ☐ NO ☐ N/A ☐ (If NO or N/A, go to SECTION C)

Husband/Wife/Family Member's Name

First

Last

Husband/Wife/Family Member's Social Security Number — —

2) Does your husband/wife/family member have group health insurance coverage through their employer?
YES ☐ NO ☐ (If NO, STOP, go to SECTION C)

3) How many employees including your family member, work for the employer from whom they have health insurance?
Don't know ☐ 1-19 ☐ 20-99 ☐ 100 or more ☐ (if less than 20, STOP, go to SECTION C)

(TURN PAGE OVER)

*PROOF 050713*

## SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE/FAMILY MEMBER, CONTINUED

4) Does your husband/wife/family member's employer group health plan cover prescription drugs?

YES ☐ NO ☐ (If NO, go to SECTION C)

Please use your husband/wife/family member's insurance card to provide the following information if available:

RxGROUP

RxPCN

MEMBER ID

RxBIN

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

DATE INSURANCE COVERAGE BEGAN — — POLICY NUMBER

M M D D Y Y Y Y

*PROOF 050713*

## SECTION C - INFORMATION ABOUT YOUR SUPPLEMENTAL COVERAGE

1) Do you have any supplemental prescription drug coverage under your policy or another family member?

YES ☐ NO ☐ (If NO, go to SECTION D)

If YES, what is your relationship to the policy holder? ☐ Self ☐ Family Member ☐ Both

2) What type of policy is your supplemental drug coverage?

☐ TRICARE ☐ MEDIGAP ☐ State Pharmaceutical Assistance Program (SPAP) ☐ OTHER

*Please print below the name, and address of the insurance company providing your prescription drug coverage:*

NAME

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY NUMBER

DATE COVERAGE BEGAN — —

M M D D Y Y Y Y

*Please use your insurance card to provide the following information if available:*

RxGROUP

RxPCN

MEMBER ID

RxBIN

(CONTINUED ON NEXT PAGE)

## SECTION D - MORE INFORMATION ABOUT YOU

1) Are **YOU** receiving Black Lung Benefits? YES ☐ NO ☐
2) Are **YOU** receiving Workers' Compensation benefits? YES ☐ NO ☐
3) Are **YOU** receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance? YES ☐ NO ☐

If YOU answered YES to any questions in this section, go to SECTION E
If YOU answered NO to all of these questions, sign below and return this form.

*Your Signature*

AREA CODE PHONE NUMBER

## SECTION E - MORE INFORMATION ABOUT YOUR BENEFITS

1) If **YOU** are getting **Black Lung** (Coal Miner's) Medical Benefits, print the date the benefits began.

M M — D D — Y Y Y Y

2) If **YOU** are now receiving any medical services related to an illness or injury which occured on the job, for which **YOU** have or will file a **Workers' Compensation** claim, print the date the illness or injury.

M M — D D — Y Y Y Y

Please provide information about the employer, insurance carrier, and attorney in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

*PROOF 050713*

(TURN PAGE OVER)

## SECTION E - MORE INFORMATION ABOUT YOUR BENEFITS, CONTINUED

3) If YOU are now getting any treatment for an illness or injury for which another party could be held liable, please print the date of illness or injury: ___ — ___ — ____ (M M D D Y Y Y Y)

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

4) If YOU are now getting any treatment for an illness or injury which could be covered under no-fault or automobile insurance, print the date the of illness or injury: ___ — ___ — ____ (M M D D Y Y Y Y)

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

*Your Signature*

AREA CODE — PHONE NUMBER

*PROOF 050713*

November 14, 2008

Dear PATH Employee,

As a result of your union contract settlement, your dental coverage will no longer be administered through the MetLife Reasonable and Customary Dental Plan. Instead, effective January 1, 2009, your dental coverage will be administered through Empire BlueCross BlueShield (Empire). You should receive your identification card in mid-December. You will notice that your identification card contains a generic number issued by Empire to provide for enhanced privacy and security. Your identification card will also contain your group number (No. 374071), followed by a three digit sub-group number which is specific to your union.

To ensure a smooth transition and address any questions you may have regarding your dental benefits, we have prepared the enclosed package of information which includes:

- *Summary of Dental Benefits*
- *Directory of Dental Providers*
- *Frequently Asked Questions*
- *Claim Forms*

The Empire BlueCross Dental Plan gives you the freedom to choose a participating Fee for Service provider or a non-participating provider for your covered dental expenses, for you and your eligible dependents. Please contact your provider to confirm his/her enrollment in the Fee for Service network.

If you have any questions regarding your dental benefit or the contents of this letter, please contact Empire BlueCross Customer Service at (800) 722-8879 after December 8, 2008 or Employee Benefits at any time at (212) 435-2870.

Sincerely,

Randy Cherkis
General Manager, Employee Benefits

Encs.

*225 Park Avenue South, XX Floor*
*New York, NY 10003*

Empire BlueCross BlueShield
www.empireblue.com

# Benefits SUMMARY

**Port Authority Trans-Hudson Corp.** **Group No. 374071**

| Dental Services | Empire Fee For Service | Non-Participating Provider* |
|---|---|---|
| **Diagnostic and Preventive** | **100% of allowed amount** | **100% of allowed amount** |
| **Basic Services** | **100% of allowed amount** | **100% of allowed amount** |
| **Endodontics** | **100% of allowed amount** | **100% of allowed amount** |
| **Periodontics** | **100% of allowed amount** | **100% of allowed amount** |
| **Oral Surgery** | **100% of allowed amount** | **100% of allowed amount** |
| **Major Restorative** | **100% of allowed amount** | **100% of allowed amount** |
| **Prosthetic Repairs and Adjustments** Denture repair/relining, crown, recementing | **100% of allowed amount** | **100% of allowed amount** |
| **Prosthetics** Bridges and Dentures | **100% of allowed amount** | **100% of allowed amount** |
| **Orthodontia** (child only - up to age 19) | **50% of allowed amount** | **50% of allowed amount** |
| **Deductible** | **$25 per person** | |
| **Annual Maximum** | **$2,000 per person** | |
| **Lifetime Ortho Maximum** | **$2,000 per person** | |

**Dependent Children Over Age 19** **Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.**

| | Benefit Description | Timeframes | Comments |
|---|---|---|---|
| ***Diagnostic and Preventive Services*** | *Oral Exams* | *2 times in a calendar year* | |
| | Full Mouth x-rays | 1 series every 3 years | |
| | Bitewing x-rays | 2 series of 4 every 12 months | |
| | Periapical x-rays | Not to exceed allowance for full mouth | |
| | Cleanings | 2 times in a calendar year | |
| | Topical Fluoride Application | 2 times in a calendar year | Coverage available up to age 19 |
| **Basic Services** | Fillings, preformed crowns | | |
| | Emergency treatment for the relief of pain | | |
| | Space maintainers | | For missing posterior primary teeth |
| **Restorations** | Preformed crowns | Once every 6 months | |
| | Composite, Amalgam, Inlays | Once every 12 months | |
| | Onlays | Once every 5 years | |
| **Oral Surgery** | Simple and impacted extractions | | |
| **Endodontics** | Root Canals | | On permanent teeth only |
| **Periodontics** | Gum cleaning and surgery | | |
| | Scaling and root planing | One procedure per quadrant every 12 months | |
| **Major Restorative Services** | Crowns, inlays, or onlays | Replacements available after 5 years | |
| **Prosthetics** | Prosthetics—Removable/Fixed | Replacements available after 5 years | |
| | Prosthetic Repair and Adjustment | Adjustments, relining, or re- basing available after 6 months | |
| **Orthodontics** | Children only | | Coverage available up to age 19 |

**NOTES**

* Non -participating providers will be paid up to the Allowed Amount. The member will be responsible for the balance up to the provider's charge.

The Allowed Amount is the maximum available benefit for each covered service under the contract. In no event will Emire's payment exceed the lesser of the Allowed Amount or the provider's charges.

Participating providers cannot bill the member over and above the allowed amount, except for deductibles or non covered services.

This is a benefit summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract.
Failure to comply with our requirements could result in benefit reductions.

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

# *FREQUENTLY ASKED QUESTIONS*

***Will I receive an identification card and, if so, when can I expect to receive it?***
Yes. You can expect to receive you identification card in mid-December.

***Is there a telephone number for customer service?***
Yes. The toll-free telephone number for Empire BlueCross Dental is 800-722-8879. You can contact BlueCross Dental after December 8, 2008.

***How can I obtain claim forms?***
Enclosed are claim forms for your use. Claim forms can also be copied, obtained via Empire Blue Cross' website at www.empireblue.com or by contacting BlueCross Dental at the above toll-free number.

***How are claims processed?***
If you are using a participating provider, the provider will submit the claim for you. If you are using a non-participating provider, you will need to get an itemized statement and submit it on a claim form or have a claim form filled out by the provider and submitted directly to Empire BlueCross by either you or your provider. The address to submit a claim form is:

Empire BlueCross BlueShield
Dental Benefits Programs
P.O. Box 791
Minneapolis, MN 55440-0791

***What is my group number?***
Your group number is 374071, followed by a three digit sub-group number which is specific to your union, as noted below.

| Sub-Group No. | Union Group |
|---|---|
| 591 | American Train Dispatchers Association |
| 592 | Brotherhood of Railroad Signalmen |
| 593 | International Brotherhood of Electrical Workers-Craft |
| 594 | International Brotherhood of Electrical Workers-Supv. |
| 595 | International Brotherhood of Teamsters |
| 596 | Transportation Workers Union |
| 597 | United Transportation Union - Towers |

***How can I locate a participating dentist? How can I find out if my dentist is in the Fee for Service network?***
Please refer to the enclosed *Directory of Dental Providers*.. You should also contact Empire BlueCross at the toll-free number above ***and check with your dentist*** to confirm provider enrollment in the Fee for Services network.

***Is there an annual maximum? If so, what counts toward it?***
There is a $2,000 annual maximum per person. Everything will count towards your annual maximum, except orthodontia and the annual deductible.

***What is the orthodontia maximum? Is it inclusive or exclusive of the annual maximum benefit?***
There is a $2,000 lifetime orthodontia maximum per eligible person which is exclusive of the annual maximum benefit.

***What happens with orthodontia work already in progress?***
You will need to submit a current treatment plan from the dentist indicating when the treatment began, how many months of treatment were completed and how many to go. Empire will not repay for banding and the initial exam, but will pro rate the remaining treatment up to the unused lifetime orthodontia maximum.

***How will Empire BlueCross handle the lifetime orthodontia maximum?***
Same as above.

***What happens with dental work already in progress (i.e., crowns, bridges, dentures, etc.)?***
For services such as root canal and major restorative services started prior to your effective date under the Empire BlueCross dental plan, payment of the claim is based on the service completion date.

Empire BlueCross BlueShield

# DENTAL CLAIM FORM

1. CHECK ONE (✓)
☐ DENTIST FEE TREATMENT ESTIMATE
☐ DENTIST STATEMENT OF ACTUAL SERVICES

2. PRIOR AUTHORIZATION NO.
PATIENT ID NO.

3. CARRIER NAME AND ADDRESS
EMPIRE BLUECROSS BLUESHIELD
DENTAL BENEFITS PROGRAMS
P.O. BOX 791
MINNEAPOLIS, MN 55440-0791

PATIENT COMPLETES

4. PATIENT NAME

5. RELATIONSHIP TO EMPLOYEE
☐ SELF ☐ DAUGHTER
☐ SPOUSE ☐ SON
☐ OTHER _____

6. SEX
☐ M ☐ F

7. PATIENT BIRTH DATE
MONTH DAY YEAR

8. IF FULL TIME STUDENT
SCHOOL CITY

9. EMPLOYEE/SUBSCRIBER NAME AND ADDRESS

10. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER

11. EMPLOYEE/SUBSCRIBER BIRTH DATE
MONTH DAY YEAR

12. GROUP NUMBER
374071

13. EMPLOYER NAME AND ADDRESS
Port Authority Trans-Hudson Corp

14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO - IF YES, COMPLETE 15-16
IS PATIENT COVERED BY A MEDICAL PLAN?
☐ YES ☐ NO

15-A. NAME AND ADDRESS OF OTHER CARRIER(S)

15-B. GROUP NUMBER(S)

16. OTHER PLAN-EMPLOYER NAME/ADDRESS

17-A. OTHER PLAN - SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT(S))

17-B. OTHER PLAN-SUBSCRIBER IDENTIFICATION NUMBER

17-C. SUBSCRIBER BIRTH DATE
MONTH DAY YEAR

18. RELATIONSHIP TO PATIENT
☐ SELF ☐ DAUGHTER
☐ SPOUSE ☐ SON
☐ OTHER _____

19. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN AND FEES. I AGREE TO BE RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO THIS CLAIM.

PATIENT SIGNATURE DATE

20. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTIST ENTITY.

SIGNATURE (EMPLOYEE/SUBSCRIBER) DATE

BILLING DENTIST COMPLETES

21. NAME OF BILLING DENTIST OR DENTAL ENTITY

30. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES IF YES, ENTER DESCRIPTION AND DATE

22. ADDRESS WHERE PAYMENT SHOULD BE REMITTED

31. IS TREATMENT RESULT OF AUTO ACCIDENT?

23. CITY, STATE, ZIP

32. OTHER ACCIDENT?

24. DENTIST SSN OR TIN

25. DENTIST LICENSE NO.

26. PHONE NUMBER

33. IF PROSTHESIS, IS IT INITIAL PLACEMENT?

IF NO, REASON FOR REPLACEMENT

34. DATE OF PRIOR PLACEMENT

27. 1ST VISIT

28. PLACE OF TX
OFF ☐ HOSPITAL ☐
ECF ☐ OTHER ☐

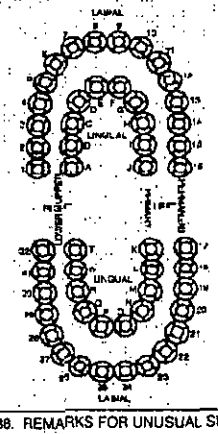
29. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?

35. IS TREATMENT FOR ORTHODONTICS?

DATE APPLIANCES PLACED?

MISC. TREATMENT REMAINING?

36. IDENTIFY MISSING TEETH WITH 'X'




37. EXAMINATION AND TREATMENT PLAN

FOR ADMINISTRATIVE USE ONLY

| TOOTH | SURF | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, ETC.) | DATE OF SERVICE MO | DAY | YEAR | PROCEDURE NUMBER | FEE | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
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| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

38. REMARKS FOR UNUSUAL SERVICES

39. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

SIGNED (TREATING DENTIST) LICENSE NUMBER DATE

40. ADDRESS WHERE TREATMENT WAS PERFORMED

CITY STATE ZIP CODE

| | |
|---|---|
| 41. TOTAL FEE CHARGED | |
| 42. PAYMENT BY OTHER PLAN | |
| MAX ALLOWABLE | |
| DEDUCTIBLE | |
| CARRIER % | |
| PATIENT PAYS | |

Empire BlueCross BlueShield

## PATIENT AND INSURED INSTRUCTION

We need all the information requested on the front of this form to process your claim. Please help us to serve you by filling in all the boxes asking for information about the patient and the subscriber on the upper part of the claim which includes items 1 through 20. Please print or type. **THIS NEW CLAIM FORM SUPPORTS IMAGING TECHNOLOGY WHICH WILL IMPROVE SERVICE TO OUR VALUED CUSTOMER.**

**IMPORTANT** - COPY YOUR IDENTIFICATION NUMBER EXACTLY AS IT APPEARS ON YOUR IDENTIFICATION CARD.

After filling in the upper part of the claim form, please give this form to your dentist who can fill in the lower part of the form which includes items 21 through 42.

## PATIENT'S SIGNATURE

*The patient must sign the claim form, authorizing the release of information as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.*

"I hereby authorize any dentist, physician, health care practitioner, hospital, clinic or other medical or dental related facility to furnish any and all records pertaining to dental or medical history, services rendered, or treatment given to me or my dependent for purposes of review, investigation or evaluation of this claim.

I also authorize Empire BlueCross BlueShield, or its agents, to disclose to a hospital or health care service plan, self-insurer or an insurer, any such dental or medical history information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of this claim or terms of coverage of my insurance policy, including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my heirs, executors or administrators."

## INSTRUCTIONS FOR ORTHODONTIC SERVICES

To facilitate processing of pretreatment estimates for Orthodontic services, the claim form should identify:

- *Dates of service and fees for each procedure*
- Monthly active treatment fee, date active treatment started, total number of months required
- Total fee charged
- *Type of dentition, type of malocclusion, description of malocclusion*
- Whether treatment is full or limited, type of appliance, treatment description

## INSURANCE FRAUD STATEMENT

PURSUANT TO REGULATION 95 OF THE NEW YORK STATE INSURANCE DEPARTMENT, "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED $5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

Empire BlueCross BlueShield

Fee for Service (FFS)

## Directory of

# Dental Providers

Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

## *General Practitioner*

### NEW YORK

### Albany County

#### Albany

**Alvarez, Oscar**
Alvarez Dental
123 Whitehall Rd
(518) 436-9771

**Amr, Ehab M**
Warren S Geisler, DDS, PC
319 S Manning Blvd Ste 102
(518) 438-4401

**Banner, Howard**
Howard Banner
666 Madison Ave
(518) 434-3038

**Barats, Svetlana L**
Warren S Geisler, DDS, PC
319 S Manning Blvd Ste 102
(518) 438-4401

**Barclay, Lee T**
Bresin and Barclay Dentists PC
1021 Western Ave
(518) 482-4948

**Brenner, Robert S**
Robert S Brenner
43 New Scotland Ave
(518) 262-4271

**Bresin, Howard J**
Bresin and Barclay Dentists PC
1021 Western Ave
(518) 482-4948

**Calderon, Vanessa V**
St Peter's Hospital Dental Clinic
1092 Madison Ave
(518) 525-1757

**Chung, Don**
Hudson Dental PC
613 Central Ave
(518) 438-2970

**Cummings, Robert A**
Dr Robert Cummings
4 Executive Prk Dr
(518) 459-4404

**De Siena, Alvin F**
Alvin F Desiena
1016 Watervliet Shaker Rd
(518) 869-3114

**DeSantis, Antony**
St Peter's Hospital Dental Clinic
1092 Madison Ave
(518) 525-1757

**Desanti, Michael M**
Michael M Desanti, DDS, LLC
554 Sand Creek Rd
(518) 869-5397

**Dharia, Jignya K**
Jignya Dharia, DDS, LLC
220 Quail St
(518) 463-2622

**Dillon, William J**
William Joseph Dillon
967 Washington Ave
(518) 438-5416

**Dimeo, Brian**
Rose Dental Associates
5 Pine West Plz
(518) 456-7673

**Duda, Lawrence S**
Midway Family Dental Associates, PLLC
1945 Central Ave
(518) 456-8252

**Duda, Lawrence S**
St Peter's Hospital Dental Clinic
1092 Madison Ave
(518) 525-1757

**Eggert, Raymond L**
Midway Family Dental Associates, PLLC
1945 Central Ave
(518) 456-8252

**El Kordy, Khloud**
Family and Cosmetic Dentistry
756 Madison Ave
(518) 427-2808

**Fischer, Frederick L**
Frederick L Fischer DMD PC
5 Pine W Plaza
Ste 504
(518) 456-5134

**Geisler, Warren S**
Warren S Geisler, DDS, PC
319 S Manning Blvd Ste 102
(518) 438-4401

**Harris, Stephen A**
Stephen A Harris, DMD
1735 Central Ave Ste 105
(518) 869-9453

**Hurlburt, Justin E**
St Peter's Hospital Dental Clinic
1092 Madison Ave
(518) 525-1757

**Hurlburt, Justin E**
Warren S Geisler, DDS, PC
319 S Manning Blvd Ste 102
(518) 438-4401

**Jonnalagadda, Usha**
St Peter's Hospital Dental Clinic
1092 Madison Ave
(518) 525-1757

**Kelman, Kenneth**
Kelman & Bergman
489 Western Ave
(518) 438-8161

**Khan, Abdul H**
Abdul H Khan
25 Dove St
(518) 463-0522

**Krykhtin, Pavel**
St Peter's Hospital Dental Clinic
1092 Madison Ave
(518) 525-1757

**Lakshmi, Champaka**
Rose Dental Associates
5 Pine West Plz
(518) 456-7673

**Levine, Norman J**
Norman Levine DDS & Michael Lipnick, DMD, PC
822 New Scotland Ave
(518) 482-6936

**Levine, Norman J**
Norman Levine DDS & Michael Lipnick, DMD, PC
99 Pine St
(518) 434-3151

**Liang, Victor Y**
Rose Dental Associates
5 Pine West Plz
(518) 456-7673

**Lipnick, Michael J**
Norman Levine DDS & Michael Lipnick, DMD, PC
822 New Scotland Ave
(518) 482-6936

**Lipnick, Michael J**
Norman Levine DDS & Michael Lipnick, DMD, PC
99 Pine St
(518) 434-3151

**Lloyd, Danielle M**
St Peter's Hospital Dental Clinic
1092 Madison Ave
(518) 525-1757

**Malik, Tariq P**
Tariq Malik, DDS
540 Broadway
Ste 100
(518) 465-0808

**Mandava, Amrutha C**
1st Advantage Dental
1662 Central Ave
(518) 452-2121

**Mass, Robert**
Robert Mass, DDS, PC
632 Western Ave
(518) 489-8541

**Mohammed, Feroz S**
Aspen Dental
979 Central Ave
(518) 591-1000

**Nista, Joseph T**
Joseph T Nista DDS PLLC
1035 Washington Ave
(518) 435-0462

**Papa, David J**
David J Papa, DMD
1016 Watervliet Shaker Rd
(518) 869-3114

**Pierce, Ronald M**
Rose Dental Associates
5 Pine West Plz
(518) 456-7673

***Reimann, Ernest F***
Ernest F Reimann
326 Northern Blvd
(518) 462-1471

**Sabai, Mustafa**
Mustafa Sabai, DDS, PC
165 Manning Blvd
(518) 459-2444

**Santoro, Robert Onofri**
Rose Dental Associates
5 Pine West Plz
(518) 456-7673

**Schachter, Neil Robert**
Neil Schachter
4 Executive Dr
(518) 482-7688

**Shah, Mira M**
Mira M Shah
1692 Central Ave
(518) 869-0635



Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

**The participation status of the providers listed above may have changed. Therefore, please contact the individual provider you choose prior to making an appointment to verify their participation status to avoid having claims paid out of network.

*(Albany continued)*

**Shchipkov, Alex**
Rose Dental Associates
5 Pine West Plz
(518) 456-7673

**Thayer, Richard D**
Richard D Thayer, DDS
435 New Karner Rd
(518) 456-1622

**Thomas, Santosh K**
Western Dental Care PC
2021 Western Ave
Ste 101
(518) 456-8040

**Tramontana, Charles M**
Charles M Tramontana DDS PC
Sonia Rai DMD
576 Sand Creek Rd
(518) 869-5348

**Valerio, Dennis J**
United Cerebral Palsy Assoc.
Of The Capital Dist I
314 S Manning Blvd
(518) 437-5731

## Cohoes

***Patregnani, Thomas M***
Thomas M Patregnani DDS
55 Mohawk St
Ste 206
(518) 235-3862

**Sherry, Donna C**
CCC Dentistry
22 White St
Floor 1
(518) 237-2207

**Strumfeld, Charles**
Charles Strumfeld DDS PC
110 Remsen St
(518) 237-8181

## Delmar

**Sagor, Gregg A**
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# Empire Fee for Service Network

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Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

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*(Bronx continued)*

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# Empire Fee for Service Network

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Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

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(718) 817-7920

**Perez, Herminio L**
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**Perez, Herminio L**
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**Perez, Herminio L**
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**Persaud, Gunanand**
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# Empire Fee for Service Network

## *General Practitioner*

*(Bronx continued)*

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**Pichkadze, Inna**
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*(Bronx continued)*

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*(Hopewell Junction continued)*

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### Wappinger Falls

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## Fulton County

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Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

## *General Practitioner*

*(Brooklyn continued)*

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# Empire Fee for Service Network

## *General Practitioner*

*(Brooklyn continued)*

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# Empire Fee for Service Network

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# Empire Fee for Service Network

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# Empire Fee for Service Network

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# Empire Fee for Service Network

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# Empire Fee for Service Network

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*(Kew Gardens continued)*

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# Empire Fee for Service Network

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Empire BLUECROSS BLUESHIELD

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**Chung, Ji Yeon**
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**Schechter, Scott P**
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#### Kew Gardens

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# Empire Fee for Service Network

## *Endodontist*

*(South Richmond Hill continued)*

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## Richmond County (Staten

### Staten Island

**Foran, Denise**
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255 Mason Ave
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**Levine, Brad A**
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Endodontics LLC
165 Westwood Ave
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**Mirman, Brian F**
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## Rockland County

### New City

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## Suffolk County

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Hill & Russo Endodontics PC
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### Farmingville

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Farmingville, LLP
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### Huntington

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### Huntington Station

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### Smithtown

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## Westchester County

### New Rochelle

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**Mastromihalis, Nick**
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Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

## *Oral Surgeon*

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**Singla, Sandeep K**
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### Clinton County

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# Empire Fee for Service Network

## *Oral Surgeon*

### Dutchess County

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#### Plainview

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901 Old Country Rd
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*(Woodmere continued)*

**Woodmere**

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## New York County

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Exceldent of Orange Sullivan
LLP
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**Druce, Richard**
Richard Druce, DDs
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# Empire Fee for Service Network

## *Oral Surgeon*

*(New Windsor continued)*

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## Queens County

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### Floral Park

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### South Richmond Hil

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## Richmond County (Staten

### Staten Island

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# Empire Fee for Service Network

## *Oral Surgeon*

*(Saratoga Springs continued)*

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# Empire Fee for Service Network

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# Empire Fee for Service Network

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*(Brooklyn continued)*

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*(Woodbury continued)*

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### Belle Harbor

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**Nissenbaum, Matthew A**
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### Jackson heights

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## *Orthodontist*

*(Jamaica continued)*

### Jamaica

**Yusupov, Azariy**
Azariy Yusopov
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### Little Neck

**Shpuntoff, Robert L**
Bayside Orthodontic and Dentofacial Orthopedics, PC
5515 Little Neck Pkwy Ste L0
(718) 229-5924

### Maspeth

**Khan, Sabeeh R**
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**Naghavi-Khan, Azita**
Azita Naghavi and Sabeeh R Khan, DDS, PC
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### Rego Park

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9424 63rd Dr
(718) 275-4545

### Richmond Hill

**Feldman, Walter B**
Walter Feldman DDS
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### South Ozone Park

**Chasin, Arthur M**
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(718) 322-9022

### Whitestone

**Friedman, Scott**
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(718) 767-7276

## Richmond County (Staten

### Staten Island

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**Damiano, John A**
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**Reilly, Michael**
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**Saccaro, Kenneth J**
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**Sherwood, Todd F**
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(718) 983-6300

**Tucker, Joseph**
Joseph Tucker
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## Rockland County

### Bardonia

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(845) 623-5551

### Monsey

**Thaler, Martin J**
Martin J Thaler
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### New City

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Melvin B Borg
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### Pomona

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### West Nyack

**Fishman, Donald**
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(845) 358-4600

## Schenectady County

### Scotia

**Kraut, Stuart Marshall**
Stuart M Kraut
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## Suffolk County

### Amityville

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### Center Moriches

**Roche, John J**
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(631) 878-3000

### Commack

**Glaser, Ian A**
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# Empire Fee for Service Network

## *Orthodontist*

*(Commack continued)*

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(631) 499-0040

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### Cutchogue

**Trentalange, James N**
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### East Patchogue

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### Ronkonkoma

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### Stonybrook

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*(Yonkers continued)*

**Yonkers**

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# Empire Fee for Service Network

## *Pediatric Dentist*

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#### Albany

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**Williams, Keith T**
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**Williams, Keith T**
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### Greene County

#### Coxsackie

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### Kings County (Brooklyn)

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**Slepak, Yury**
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**Waltner, Jonathan**
Robert Rosenkranz DDS PC
300 8th Ave
(718) 499-5323

**Waltner, Jonathan**
Williamsburg Pediatric
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390 Berry St
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### Nassau County

#### Great Neck

**Navab, Majid**
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(516) 487-7962

**Neman, Nahid**
Neman Family Dentistry
64 Bayview Ave
(516) 773-4554

#### Hempstead

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Kane Dental PLLC
72 Fulton Ave
(516) 483-2220

### New York County

#### New York

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(212) 757-9653

**Alonso, Robert**
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(212) 374-9500

**Green, Albert**
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**Hemrajani, Sharna**
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271 Madison Ave Ste 801
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**Hovsky, Julia**
Julia Dental PC
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**Jimenez, Libia R**
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*(New York continued)*

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**Mentzelopoulou, Ioanna**
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**Waltner, Jonathan**
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**Waltner, Jonathan**
Next Generation Dental PC
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(212) 362-3360

**Wei, Min-Deh**
Min-Deh Wei
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## Orange County

### Middletown

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Exceldent of Orange Sullivan LLP
127 131 E Main St
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**Hovsky, Julia**
Galleria Mall Dental at Crystal Run PC
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(845) 692-9212

## Putnam County

### Mahopac

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Brighter Smiles Family Dentistry PC
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**Simonis, Anna**
Brighter Smiles Family Dentistry PC
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## Queens County

### Astoria

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Pediatric Dentistry
4209 21st Ave
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### Bayside

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Bell Dental Care, PC
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(718) 352-5582

### Elmhurst

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9015 Queens Blvd
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### Flushing

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### Forest Hills

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(718) 263-1010

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**Kourtsounis, Paraskeva**
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(718) 746-1230

### Woodside

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Kids Dental Village PC
3905 61st St
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Leon A Vasquez
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## Richmond County (Staten

### Staten Island

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## Saratoga County

### Clifton Park

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532 Moe Rd
(518) 373-1181

**McMahon, Eric C**
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532 Moe Rd
(518) 373-1181

**Shavghnessy, Brian F**
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## Suffolk County

### Farmingville

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### Hauppauge

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### Holbrook

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Loan S Mao
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### Holtsville

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### Port Jefferson Sta

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### Riverhead

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# Empire Fee for Service Network

## *Pediatric Dentist*

### Warren County

#### Glens Falls

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88 Broad St
(518) 798-9966

### Westchester County

#### New Rochelle

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Allen M Greenberg
110 Lockwood Ave
(914) 636-3738

#### Scarsdale

**Mohammadi, Vali M**
Scarsdale Pediatric Dentistry
188 Summerfield St
(914) 472-2929

#### White Plains

**Hovsky, Julia**
Galleria Mall Dental, PC
100 Main St
(914) 997-9000



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Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

## *Periodontist*

### Albany County

#### Schodack

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2500 Pond View Dr
Ste 205
(518) 477-6100

### Bronx County

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**Azimi, Mahtab**
Dr Jay Fensterstock DDS PC
55 E Mosholu Pkwy N
(718) 652-7370

**Elashmawy, Iyman M**
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2535 Grand Concourse
(718) 365-4900

**Lewis, Zalman S**
Family Dental Office, PLLC
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(718) 824-4597

**Lindenfeld, Sheldon M**
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(718) 796-2623

**Oken, Steven B**
Steven Oken DDS
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(718) 597-8457

**Sheinberg, Stephen H**
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(718) 817-7920

**Sheinberg, Stephen H**
Bronx Lebanon Hospital Center Dental Department
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Ste 1M
(718) 901-8402

**Sheinberg, Stephen H**
Bronx Lebanon Hospital Ctr Dental
1265 Franklin Ave
(718) 503-7700

**Sheinberg, Stephen H**
Ogden Dental Clinic
1067 Ogden Ave
(718) 466-3222

**Sheinberg, Stephen H**
Westchester Dental
614 Westchester Ave
(718) 742-5255

**Silverbrand, Howard S**
Howard S Silverbrand, DDS, PLLC
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### Dutchess County

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### Kings County (Brooklyn)

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142 Joralemon St Ste 9E
(718) 625-4085

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**Elashmawy, Iyman M**
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**Glazebnik, Sergei**
Refuah Family Dental PC
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**Lewis, Zalman S**
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Lloyd G Soman
9412 4th Ave
(718) 745-3456

**Stevens, Mark C**
A Center for Dental Excellence
8510 Bay 16th St
(718) 232-8289

**Tafreshi, Fahimeh M**
Steven H Backer, DDS, PC
690 Flatbush Ave
(718) 693-8200

**Tahawi, Eman H**
Brilliant Dental and Associates PC
820 Flatbush Ave
(718) 693-9811

**Tahawi, Eman H**
Finest Dental Care
10 Plaza St E
Ste 1F
(718) 622-8020

**Tiger, Jonathan R**
Metropolitan Dental Associates, DDS, PC
447 Fulton St
(718) 875-3200

**Warheit, Ira S**
American Dental Offices, PLLC
434 Albee Sq W
(718) 858-9211



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# Empire Fee for Service Network

## *Periodontist*

### Nassau County

#### Bellmore

**Argento, Joseph**
Bellmore Family Dental PC
2814 A Merrick Rd
(516) 781-7567

#### East Meadow

**Crane, Paul A**
Paul Crane, DMD
1900 Hempstead Tpke
Ste 409
(516) 564-8499

#### Garden City

**Alongi, James A**
James A Alongi DMD PC
226 7th St
Ste 105
(516) 294-6106

#### Hempstead

**Elashmawy, Iyman M**
American Dental Offices, PLLC
760 Fulton Ave
(516) 481-9700

**Gingold, Jack H**
American Dental Offices, PLLC
760 Fulton Ave
(516) 481-9700

**Greenberg, Gerald M**
American Dental Offices, PLLC
760 Fulton Ave
(516) 481-9700

#### Hicksville

**Abitbol, Thierry E**
American Dental Offices, PLLC
35 Broadway
(516) 433-1800

**Elashmawy, Iyman M**
American Dental Offices, PLLC
35 Broadway
(516) 433-1800

**Greenberg, Gerald M**
American Dental Offices, PLLC
35 Broadway
(516) 433-1800

#### Lawrence

**Lewis, Zalman S**
South Nassau Dental PC
290 Central Ave
Ste 208
(516) 239-1879

**Schneider, Paul B**
Paul B Schneider, DMD, PC
360 Central Ave
(516) 569-6686

#### New Hyde Park

**Zatcoff, Adam L**
Beautiful Smiles of Long Island PLLC
700 Hillside Ave
(516) 352-8282

#### Port Washington

**Baron, Michael**
Michael Baron DDS
2 Cow Neck Rd
(516) 883-4477

#### Rockville Centre

**Hasday, Keith H**
Keith H Hasday, DDS, PC
132 N Park Ave
(516) 678-1316

**Kaur, Amandeep**
Periodontology and Dental Implants of Rockville Centre PC
132 N Park Ave
(516) 678-1316

#### Wantagh

**Ross, Sheldon J**
Sheldon J Ross
40 Twisting Ln
(516) 785-4414

### New York County

#### New York

**Ahmadi, Amir**
Citi Dental
271 Madison Ave
Ste 801
(212) 685-2890

**Askari, Ali**
Ali Askari, DDS, PC
317 Madison Ave Rm 906
(212) 973-1126

**Avdic, Mersiha**
Mersiha Avdic, DMD, MMSSC
30 E 60th St
Ste 501
(212) 753-4744

**Azimi, Mahtab**
Concerned Dental Care, PC
30 E 40th St
Ste 207
(212) 696-4979

**Azimi, Mahtab**
Mahtab Azimi, DDS, PC
433 E 56th St Apt 1D
(212) 355-2225

**Berdan, Alan F**
Alan F Berdan Dmd
30 Central Park S Rm 11C
(212) 702-8675

**Beydoun, Fadi I**
NY Dentistry
160 Broadway
Rm 509
(212) 964-3337

**Castillo, Yiselle Z**
Yiselle Z Castillo, DDS PC
160 E 32nd St Ste 103
(212) 683-3328

**Elashmawy, Iyman M**
American Dental Offices, PLLC
241 W 30th St
(917) 351-0200

**Gomez, Cynthia R**
Cynthia R Gomez DDS
133 E 58th St
Ste 410
(212) 207-4020

**Greenberg, Gerald M**
Preferred Dental Care
135 W 27th St
Ste 201
(212) 594-7171

**Hamidi, Babak**
American Dental Offices, PLLC
241 W 30th St
(917) 351-0200

**Hamidi, Babak**
Franklin Dental Health
81-83 Franklin St
(212) 274-8338

**Hamidi, Babak**
Tribeca Dental Associates, PC
80 Warren St
(212) 346-0893

**Hedayati, Ahmad A**
American Dental Offices, PLLC
241 W 30th St
(917) 351-0200

**Kaplan, Daniel A**
Daniel Kaplan
200 Central Park S Apt 209
(212) 489-4867

**Lashgari, Shahram**
Nina Kiani, DDS, PC
14 Penn Plaza
Ste 1314
(212) 279-8770

**Leder, Andrew J**
Charles M Marks, DDS
347 5th Ave
Ste 1310
(212) 279-1232

**Leder, Andrew J**
Howard Berman, DMD, PC & Assoc
30 Central Park S Rm 14C
(212) 755-6818

**Lee, Kelly**
Dental Associates of New York
241 W 23rd St
(212) 691-2112

**Lewis, Zalman S**
Marina Dental PC
3768 Broadway
(212) 234-2244

**Liang, Lixian**
Lixian Liang, DDS
198 Canal St Ste 402
(212) 941-6382

**Lippiner, Daniel**
Daniel Lippiner DDS
77 Park Ave
(212) 683-6505



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*(New York continued)*

**Melnick, Clifford S**
Clifford S Melnick, DMD, PC
800A 5th Ave
Ste 305
(212) 355-1266

**Mohajer, Roya A**
Jeffry Nirenstein Dental PC
461 Park Ave S
Ste 800
(212) 532-7770

**Podolsky, Maxim A**
Maxim A Podolsky
30 E 40th St
Ste 304
(212) 683-2066

**Soman, Lloyd G**
Lloyd G Soman
343 W 58th St
Ste 8
(212) 757-1515

**Stevens, Mark C**
Levingart and Levingart DDS PC
25 Central Park W
Ste 1T
(212) 581-0707

**Stevens, Mark C**
Manhattan Dental Care
127 W 79th St
Ste 2
(212) 580-4790

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(212) 374-9500

**Tiger, Jonathan R**
Dental Specialty Associates
225 Broadway Ste 105
(212) 374-9500

**Wank, Daniel E**
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**Warheit, Ira S**
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(212) 223-1220

**Wozniak, Mariam**
Carl Caravana DDS
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## Orange County

### Highland Mills

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### Middletown

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**Toporoff, Donald M**
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Ste 103
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## Queens County

### Astoria

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### Bayside

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### Elmhurst

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### Flushing

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**Mantzikos, Katherine**
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**Mohajer, Roya A**
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**Varnai, Sheryl R**
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### Forest Hills

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### Fresh Meadows

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Howard J Winter, DDS, PC
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### Jackson Heights

**Katz, Elan D**
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### Maspeth

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Maspeth Dental-HL PC
6662 Grand Ave
(718) 779-9000

### Middle Village

**Froum, Scott**
Middle Village Dental Group LLP
66 26 Metropolitan Ave
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### Queens Village

**Boguslaw, Richard G**
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### Rego Park

**Kaplan, Daniel A**
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**Pavlakos, Constantine**
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93 54 Queens Blvd
(718) 275-6262

**Sheinkman-Goykman, Kar**
Yuriy Nektalov DDS PC
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**Varnai, Sheryl R**
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(718) 275-6262

**Warheit, Ira S**
Yuriy Nektalov DDS PC
9424 63rd Dr
(718) 275-4545

### Ridgewood

**Alongi, James A**
James A Alongi DMD PC
6835 Fresh Pond Road
(718) 417-9313

### South Ozone Park

**Azimi, Mahtab**
Concerned Dental Care, PC
133-40 131st St
(718) 529-3800

**Tahawi, Eman H**
Concerned Dental Care, PC
133-40 131st St
(718) 529-3800

### South Richmond Hil

**Tahawi, Eman H**
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(718) 843-1616



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*(Whitestone continued)*

**Whitestone**

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16032 20th Ave
(718) 423-4500

**Olan, Robert M**
Whitestone Dental Specialty Group
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## Richmond County (Staten

**Staten Island**

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**Chang, Kuang-Min**
American Dental Offices, PLLC
1659 Richmond Ave
(718) 983-6300

**Elashmawy, Iyman M**
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1659 Richmond Ave
(718) 983-6300

**Greenfield, Barry M**
Barry M Greenfield
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**Lewis, Zalman S**
Harry Weisenfeld DDS PC
310 Richmond Hill Rd
(718) 494-0100

**Tiger, Jonathan R**
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1839 N Railroad Ave
(718) 979-2121

**Tsambazis, Peter**
Oakwood Dental Arts LLC
1839 N Railroad Ave
(718) 979-2121

## Rockland County

**New City**

**Vinieris, Eleni**
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**Nyack**

**Lampidis, John J**
Dental Care Of Rockland
372 Route 59
(845) 353-1880

**West Nyack**

**Toporoff, Donald M**
West Nyack Dental, PC
719 W Nyack Rd Ste 26
(845) 358-6888

## Saratoga County

**Clifton Park**

**Azadivatan-Le, Neda**
Precision Periodontics & Dental Implants
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(518) 477-6100

## Suffolk County

**Commack**

**Abitbol, Thierry E**
American Dental Offices, PLLC
6180 Jericho Tpke
(631) 499-0040

**Desantis, Sara**
Exceldent Dental of Commack
77 Veterans Memorial Hwy
Ste 2
(631) 499-5663

**Elashmawy, Iyman M**
American Dental Offices, PLLC
6180 Jericho Tpke
(631) 499-0040

**Greenberg, Gerald M**
American Dental Offices, PLLC
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(631) 499-0040

**Podolsky, Maxim A**
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Ste 2
(631) 499-5663

**E Nesconset**

**Knakal, Mark W**
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Ste 109
(631) 751-6700

**East Northport**

**Lepre, Biagio M**
Biagio M Lepre DDS PC
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(631) 368-8585

**Farmingville**

**Froum, Scott**
Total Dental Care of Farmingville, LLP
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Ste H
(631) 696-0100

**Varnai, Sheryl R**
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(631) 696-0100

**Hauppauge**

**Greenberg, Jonathan**
Jonathan Greenberg, DMD, PC
111 Smithtown Byp Ste 102
(631) 724-7150

**Reisfeld, Stacy**
Iannello Dental Group
335 Terry Rd
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**Islandia**

**Desantis, Sara**
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(631) 348-7777

**Middle Island**

**Zatcoff, Adam L**
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(631) 924-8155

**Nesconset**

**Lepre, Biagio M**
Biagio M Lepre DDS PC
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(631) 382-8585

**North Babylon**

**Froum, Scott**
Ideal Dental Services
1251 Deer Park Ave
(631) 242-7711

**Port Jefferson**

**Froum, Scott**
Modern Dentistry of Long Island
714 Main St
(631) 473-0582

**Port Jefferson Sta**

**Reisfeld, Stacy**
Iannello Dental Group
492 Old Town Rd
(631) 928-1018

**Rocky Point**

**Lashgari, Shahram**
Rocky Point Family Dentistry
745 Rt 25A
Ste E
(631) 744-3770

**Ronkonkoma**

**Reisfeld, Stacy**
Iannello Dental Group
966 Portion Rd
(631) 451-2245

**Selden**

**Desantis, Sara**
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(631) 698-2221

**Lepre, Biagio M**
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(631) 732-8338



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# Empire Fee for Service Network

## *Periodontist*

### Ulster County

#### Kingston

**Azadivatan-Le, Neda**
Precision Periodontics & Dental Implants
130 N Front St
Ste 1
(845) 331-0103

### Westchester County

#### Dobbs Ferry

**Gurell, Gabriel**
Dr G Gurell
381 Broadway
(914) 693-1826

#### Elmsford

**Hedayati, Ahmad A**
Robert Wasserberger DMD PC
160 S Central Ave
(914) 592-4416

#### Peekskill

**Hedayati, Ahmad A**
Bijan Khaknegar Moghadam
1016 Brown St
Ste 301
(914) 737-0703

#### Rye Brook

**Vinieris, Eleni**
Rye Periodontics and Implant Dentistry
10 Rye Ridge Plz
(914) 253-8020

#### Scarsdale

**Chen, Joseph**
Joseph Chen
455 Central Ave
Ste 310
(914) 472-1884

#### White Plains

**Elashmawy, Iyman M**
American Dental Offices, PLLC
200 Hamilton Ave
(914) 949-6800

**Hedayati, Ahmad A**
Norman I Bander
16 Martine Ave
(914) 428-2052

#### Yorktown Heights

**Ahmadi, Amir**
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2649 Strang Blvd
Ste 300
(888) 433-6820

**Toporoff, Donald M**
iDent Dental at Yorktown PC
2649 Strang Blvd
Ste 300
(888) 433-6820



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# Empire Fee for Service Network

## *Prosthodontist*

### Bronx County

**Schwarz, Evan**
Dr Jay Fensterstock DDS PC
55 E Mosholu Pkwy N
(718) 652-7370

### Nassau County

#### Freeport

**Espinoza, Julio**
Atlantic Dental Care
396 Atlantic Ave
(516) 378-1968

#### Long Beach

**Mayo, Edward R**
Edward Ralph Mayo DDS
350 National Blvd
(516) 889-0464

### New York County

#### New York

**Fisher, Robert H**
Robert H Fisher
245 E 50th St
(212) 308-7082

**Holden, Jason**
Concerned Dental Care, PC
30 E 40th St
Ste 207
(212) 696-4979

**Orbach, Gary A**
Gary A Orbach
30 Central Park S Rm 5A
(212) 371-6622

**Rouse, Jeffrey A**
Dental Specialty Associates
225 Broadway Ste 105
(212) 374-9500

**Schulman, Robert M**
Dr Robert Schulman
635 Madison Ave
19th Floor
(212) 752-1662

### Queens County

#### Little Neck

**Glavas, Peter**
Ideal Dental Care PLLC
4522 Little Neck Pkwy
(718) 224-4040

### Suffolk County

#### East Northport

**Zuckerman, Gabriel R**
Gabriel R Zuckerman
1199 5th Ave
(631) 261-1199

#### Middle Island

**Sheth, Sameet**
Total Dental Care Of Middle Island PC
699 Middle Country Rd
(631) 924-8155

### Washington County

#### Granville

**Coco, Harvey S**
Family Dentistry PC
89 North St
(518) 642-2111

### Westchester County

#### White Plains

**Schulman, Robert M**
Robert Schulman, DMD
137 Maple Ave
(914) 948-8898



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# Empire Fee for Service Network

## *General Practitioner*

### CONNECTICUT

#### Fairfield County

##### Bethel

**San Giacomo, Kenneth S**
San Giacmo Perotta
27 Grassy Plain St
(203) 743-5600

##### Danbury

**Shalmi, Gabriel**
Best Dental Care PC
13 Backus Ave
(203) 744-7111

##### Fairfield

**Bartolone, Cynthia A**
Cynthia Bartolone DMD
2150 Black Rock Tpke
(203) 333-2060

##### Greenwich

**Cordero, Judith Lynne**
Greenwich Dental LLC
100 Melrose Ave
Ste 202
(203) 622-3068

##### Norwalk

**Bort, Morton L**
Santorella DDS PC
20 N Main St
(203) 866-6658

##### Stamford

**Krasnov, Ross**
Town Center Dental of
Stamford Connecticut PC
100 Greyrock Pl
(203) 348-0300

#### Litchfield County

##### New Milford

**Mullen, Peter P**
Peter P Mullen
16 Sunny Valley Rd
(860) 354-1400

##### Woodbury

**Desomma, Martin S**
Martin S Desomma DDS
42 Main St S
(203) 263-4201



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# Empire Fee for Service Network

## *Endodontist*

**Fairfield County**

**Westport**

**Simon, Harvey P**
Dr Harvey P Simon
225 Main St
Ste 201
(203) 222-9553



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# Empire Fee for Service Network

## *Orthodontist*

### Fairfield County

#### New Fairfield

**Kenny, Joseph J**
Joseph J Kenny
11 Route 37
(203) 746-9122

### Litchfield County

#### Sharon

**Kenny, Joseph J**
Joseph J Kenny, DMD
2 Hospital Hill Rd
(860) 364-1833



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# Empire Fee for Service Network

## *Pediatric Dentist*

**Fairfield County**

**Stamford**

**Egol, Arthur B**
Family Dental Center
1 Strawberry Hill Ct
(203) 324-7611



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# Empire Fee for Service Network

## *Periodontist*

**Fairfield County**

**Stamford**

**Miller, Allan N**
Allan N Miller, DDS
126 Hoyt St
(203) 357-8822



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# Empire Fee for Service Network

## *General Practitioner*

## NEW JERSEY

### Bergen County

#### Bergenfield

**Leben, Murray J**
Murray J Leben
147 S Washington Ave
(201) 385-5454

#### Carlstadt

**Patel, Manish**
Patel Dental Center
326 Garden St
Ste 6
(201) 729-0900

#### Cliffside PK

**Totera, John J**
John J Totera DMD
547 Anderson Ave
(201) 941-5900

#### Cliffside Park

**Durgam, Chithra**
Aesthetic Dental PC
551 Anderson Ave
(201) 943-3033

**Frangiskou, Mario A**
Mario A Frangiskou, DMD PC
460 Anderson Ave
(201) 943-8066

**Kantrowitz, Mark A**
Mark Kantrowitz, DMD
451 Palisade Ave
(201) 945-0970

**Landau-Kennis, Debra G**
Debra G Landau-Kennis
537 Anderson Ave
(201) 943-3322

**Sedehi, Ahmad**
Cliffside Park Dental Group
527 Anderson Ave
(201) 941-8500

#### Closter

**Shyong, Michael S**
Shyong Dental Group LLC
235 Closter Dock Rd
(201) 768-6101

#### Dumont

**Roshong, Bryon E**
Bryon E Roshong
111 W Madison Ave
(201) 381-1555

#### Edgewater

**Kantor, Barry R**
Kantor & Kantor
1402 River Rd
(201) 886-0888

**Ost, Ellen**
River Road Dental
103 River Rd
Ste 105
(201) 840-0045

#### Elmwood Park

***Dubover, Gregory J***
Gregory Dubover
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**Liu, I-Hsin**
I Hsin Liu, DMD
1 Lincoln Ave
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#### Englewood

**Adams, Rick**
Dr Rick Adams
106 W Palisade Ave
(201) 567-3098

**Factor, Steven H**
Dr Steven H Factor
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Ste C-11
(201) 569-9393

**Sherzoy, Roshana S**
Smile NJ Inc
334 Grand Ave
(201) 541-8111

#### Fair Lawn

**Guelfguat, Marina**
Apple Dentistry, PC
19-21 Fair Lawn Ave
(201) 475-5555

**Renny, Thomas**
Thomas Renny
15 01 Broadway Ste 10F
(201) 791-0130

#### Fort Lee

**Igdalev, Julia Y**
PainlessDDS PC
1625 Anderson Ave
Ste 202
(201) 224-9444

**Levine, Harris J**
Harris J Levine DDS PA
*2500 Lemoine Ave*
(201) 592-1066

**Lin, Huei Ju**
Huei Ju Lin
1231 Inwood Ter
(201) 867-6606

**Miller, Paul S**
Miller & Beals DDS PA
1196 Palisade Ave
(201) 886-1477

**Rosen, David W**
David W Rosen
520 Main St Ste 201
(201) 592-6770

**Zeino, Samer**
Metropolitan Dental
Associates
799 Abbott Blvd
(201) 224-0310

#### Garfield

**Sloan, Bruce W**
Bruce W Sloan
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#### Hackensack

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*(New Milford continued)*

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# Empire Fee for Service Network

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*(Monmouth Junction continued)*

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**Feinstein, Steven**
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**Iavarone, Joseph J**
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(732) 727-3399

**Jones, Derek**
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**Meehan, James**
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**Modi, Dipti A**
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**Niebudek, Nicole**
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### South Plainfield

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Ac Dental of Hadley NJ Inc
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**Shah, Miloni**
Ac Dental of Hadley NJ Inc
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(908) 753-9901

### Spotswood

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Joshua D Verona
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### Woodbridge

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# Empire Fee for Service Network

## *General Practitioner*

### Monmouth County

#### Englishtown

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Amnon Faktor, DDS & Dave Faktor, DDS
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#### Freehold

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4249 Rt 9 N
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Bldg 2
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#### Holmdel

**Elbasty, Mohamed A**
Elbasty Pediatric and Dental Associates
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**Lo Presti, C Anthony**
Holmdel Dental Arts
723 N Beers St
(732) 687-3553

**Shah, Dipika T**
Dipika T Shah DDS FAGD LLC
723 N Beers St Ste 2F
(732) 264-8180

#### Howell

**Bode, Douglas P**
DPB Dental Assoc
56 Ramtown Greenville Rd
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**Feiler, Aaron T**
Eastern Dental of Howell, LLC
2346 Rte 9 S
(732) 683-1130

**Kushner, Kevan**
Kevan Kushner, DDS
5170 Us Highway 9
(732) 367-8600

**Santomenna, Mark A**
Ramtown Dental
137 Newtons Corner Rd
(732) 206-0408

#### Keyport

**Michael, Dahlia T**
Monmouth Dental Group North
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(732) 888-7770

#### Long Branch

**Yusufov, Namik**
Garden State Healthy Smile PC
170 Morris Ave
Ste A
(732) 728-7075

#### Manalapan

**Barenbaum, Polina**
Galleria Dental Group LLC
100 US Hwy 9
Ste 11
(732) 462-5511

**Dibling, John B**
Omni Dental Associates
317 Us Highway 9
(732) 780-6426

**LaFemina, Alfonse**
Georgetown Dental Associates LLC
821 Tennent Rd
(732) 536-2600

**Mamoun, John S**
Sunbeam Dental LLC
100 Craig Rd
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(732) 431-2888

**Trevino, Beatriz**
Hispanic Dental Clinic PC
2 Smallwood Ln
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#### Manasquan

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Dr Mario Frangiskou
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Sage Dental PA
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Dr Mario Frangiskou
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(732) 223-2334

#### Matawan

**Vayntraub, Sofya**
MMC Dental, PC
1032 Rte 34
(732) 290-9000

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Lawrence S Gordon
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#### Morganville

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(732) 972-2300

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#### Neptune

**Eldin, Khaled**
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**Ginsberg, Michael B**
Neptune Dental Care
2200 Hwy 66
Ste B
(732) 775-7800

**Karamzadeh, Nina**
Neptune Dental Care
2200 Hwy 66
Ste B
(732) 775-7800

#### Neptune City

**Patel, Purva R**
Ocean Dental Group, PA
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(732) 774-1744

#### Oakhurst

**Archer, Elizabeth**
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**Barenbaum, Polina**
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1802 Rte 35 S
(732) 660-0500

**Cipriani, Pier**
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1802 Rte 35 S
(732) 660-0500

**Derrickson, William L**
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1802 Rte 35 S
(732) 660-0500

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1802 Rte 35 S
(732) 660-0500

**Feinstein, Steven**
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1802 Rte 35 S
(732) 660-0500

**Iavarone, Joseph J**
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1802 Rte 35 S
(732) 660-0500

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1802 Rte 35 S
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*(Oakhurst continued)*

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**Torregrossa, Ermete J**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

### Ocean

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### Red Bank

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**Morales-Medina, Hector**
The Dental Center
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**Sanell, Rebecca L**
Rebecca L Sanell DDS LLC
50 Wallace St
(732) 747-2221

### Shrewsbury

**Lanfranchi, Alfred J**
Shrewsbury Dental Associates PA
555 Shrewsbury Ave
Ste D
(732) 747-9333

### Spring Lake Height

**Linfante, Jeffrey C**
Dr Jeffrey C Linfante DMD
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## Morris County

### Butler

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Butler Family Dental Associates, LLC
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(973) 838-1477

### Denville

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Mountain Lakes Dental Associates PA
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### Dover

**McElroy, David A**
David A Mcelroy
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### Florham Park

**Estrella, Rafael S**
Helix Dental LLP
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Ste 1
(973) 377-8668

**Liao, Anita**
Helix Dental LLP
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Ste 1
(973) 377-8668

### Landing

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Robertl Daniels
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### Morris Plains

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(973) 292-2550

### Netcong

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Gregory I Dubover, DDS
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### Parsippany

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Raymond L Merkler
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### Randolph

**Orlans, Laurence L**
Laurence L Orlans
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### Riverdale

**Sheehan, Noreen**
Noreen Sheehan DMD LLC
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### Rockaway

**Gross, Richard S**
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(973) 627-7810

### Succasunna

**Jupiter, Ronald M**
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## Passaic County

### Clifton

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Eastern Dental of Passaic Essex, LLC
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**Attili, Khaled**
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**Batarseh, Michael**
Michael Batarseh
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(973) 473-8100

**Brown, Deborah E**
Eastern Dental of Passaic Essex, LLC
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**Bui, Toan K**
Transcendental LLC
1373 Broad St
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(973) 458-9899

**Cipriani, Pier**
Eastern Dental of Passaic Essex, LLC
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(973) 478-9300

**Feiler, Aaron T**
Eastern Dental of Passaic Essex, LLC
251 Clifton Ave
(973) 478-9300

**Grober, Stephen**
Eastern Orthodontic Associates North LLC
251 Clifton Ave
(973) 478-9300

**Iavarone, Joseph J**
Eastern Dental of Passaic Essex, LLC
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(973) 478-9300

**Leary, Paul**
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(973) 478-9300

**Meehan, James**
Eastern Dental of Passaic Essex, LLC
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(973) 478-9300

**Patel, Anand**
Eastern Dental of Passaic Essex, LLC
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(973) 478-9300

**Raja, Abdul H**
Eastern Dental of Passaic Essex, LLC
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(973) 478-9300

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*(Clifton continued)*

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**Siegel, Juliet A**
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Associates, LLC
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(973) 778-2226

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Essex, LLC
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(973) 478-9300

### Hawthorne

**Margherita, Vincent A**
V A Margherita
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### Hewitt

**Hengeveld, Robert A**
Family and Pediatric Laser
Dentistry LLC
1950 Greenwood Lk Tpke
(973) 728-7550

### Passaic

**Castillo, Guillermo R**
Castillo & Mulkay Family
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601 Main Ave
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**Guerrero, Estela**
Passaic Family Dental LLC
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(973) 815-0053

**Mulkay, Zenaida E**
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601 Main Ave
(973) 473-8188

### Paterson

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**Gross, Jerry**
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Union Dental
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**Sherman, Stephen A**
Stephen A Sherman
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### Patterson

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(973) 684-3803

**Pogoda, John M**
West Broadway Dental PA
1 West Broadway
(973) 684-3803

**Saleh, Mahir**
West Broadway Dental PA
1 West Broadway
(973) 684-3803

### Totowa

**Doblin, Michael S**
Michael S Doblin
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**Maher, Ryan C**
Perfect Smiles, LLC
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### Wayne

**Burton, Alan M**
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**Hengeveld, Robert A**
Dr. Robert A Hengeveld DMD
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### West Milford

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## Sussex County

### Vernon

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## Union County

### Clark

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138 Westfield Ave
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### Cranford

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### Elizabeth

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### Kenilworth

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### Linden

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*(North Plainfield continued)*

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**Plainfield**

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(908) 755-3030

**Brown, Deborah E**
Dental Health Associates, PA
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(908) 755-3030

**Eguaibor-Nwajei, Efema**
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200 W 2nd St
(908) 755-3030

**Gedeon, Simon**
Dental Health Associates, PA
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(908) 755-3030

**Litvinov, Alexander**
Dental Health Associates, PA
200 W 2nd St
(908) 755-3030

**Patel, Mihir M**
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**Springfield**

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**Summit**

**Chiu, Evelyn H**
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**Grober, Stephen**
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**Iavarone, Joseph J**
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**Joo, Ilcheon**
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(908) 964-5406

**Meehan, James**
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**Sudziute, Regina**
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**Torregrossa, Ermete J**
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**Yaghoubinejad, Faranak**
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(908) 964-5406

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# Empire Fee for Service Network

## *Endodontist*

### Essex County

#### Irvington

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**Gavrilis, Nikolaos G**
Dental Health Associates
2 Washington Ave
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#### Newark

**Gavrilis, Nikolaos G**
Dental Health Associates PA
9-25 Alling St
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#### South Orange

**Johnson, Kevin D**
Kevin D Johnson
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### Middlesex County

#### Edison

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#### New Brunswick

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Ste 2
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**Kallur, Sathya P**
K K Dental Associates LLC
330 Livingston Ave
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#### North Brunswick

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(732) 418-9800

#### Old Bridge

**Finegan, Sandra**
N J Team Dental Center PA
2515 Hwy 516
(732) 679-3600

### Monmouth County

#### Neptune

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Neptune Dental Care
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Ste 8
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### Union County

#### Elizabeth

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Elizabeth Endodontics PA
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Ste 301
(908) 469-4375

#### Plainfield

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(908) 755-3030



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# Empire Fee for Service Network

## *Oral Surgeon*

### Bergen County

#### Fort Lee

**Carrao, Vincent**
Palisades Oral Surgery LLC
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#### Hackensack

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Barbieri Colameo Berardo
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(201) 342-7353

**Berardo, Nicholas**
Barbieri Colameo Berardo
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**Colameo, Kenneth J**
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#### Mahwah

**Druce, Richard**
Richard Druce, DDS
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#### Ridgefield

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**Berardo, Nicholas**
Barbieri Colameo Berardo
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(201) 941-9494

**Colameo, Kenneth J**
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(201) 941-9494

### Essex County

#### Irvington

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2 Washington Ave
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**Lapeyrolerie, Jacques**
Dental Health Associates
1146 Stuyvesant Ave
(973) 399-4242

#### Newark

**Herbst, Nancy**
Dental Health Associates PA
9-25 Alling St
(973) 297-1550

**Robinson, Lealon A**
Clinton Hill Dental Associates
804 Clinton Ave
(973) 374-5200

### Hudson County

#### Jersey City

**Gold, Ronen**
Jersey Dental Arts PA
846 Bergen Ave
(201) 946-1000

#### North Bergen

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Barbieri Colameo Berardo
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(201) 867-0404

**Berardo, Nicholas**
Barbieri Colameo Berardo
7322 Bergenline Ave
(201) 867-0404

**Colameo, Kenneth J**
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(201) 867-0404

#### Secaucus

**Maron, Andrew**
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### Middlesex County

#### Avenel

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**Bryant Ponquinette, Mi**
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**Chiodo, Thomas**
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**Famiglietti, Ralph B**
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(732) 750-3600

**Hullett, Jason S**
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**Kasahara, Takehiro**
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**Navilio, Anthony R**
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(732) 750-3600

**Petriella, Victor**
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**Ponquinette, Justin**
Eastern Dental of Woodbridge, LLC
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(732) 750-3600

**Santora, Philip J**
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#### Edison

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(732) 738-6555

**Regenye, Glenn R**
Rantan Valley Oral and Maxillofacial Surgery PA
619 Amboy Ave
(732) 738-6555

#### North Brunswick

**Baron, Elliot**
Dental Health Associates, PA
977 Livingston Ave
(732) 418-9800

**Herbst, Nancy**
Dental Health Associates, PA
977 Livingston Ave
(732) 418-9800

#### Old Bridge

**Arora, Eshansh**
N J Team Dental Center PA
2515 Hwy 516
(732) 679-3600

**Hershkin, Adam T**
N J Team Dental Center PA
2515 Hwy 516
(732) 679-3600

**Muduli, Anup**
N J Team Dental Center PA
2515 Hwy 516
(732) 679-3600

**Singla, Sandeep K**
N J Team Dental Center PA
2515 Hwy 516
(732) 679-3600

#### S Plainfield

**Huberman, Bruce A**
Rantan Valley Oral and Maxillofacial Surgery PA
1907 Park Ave
(908) 757-4122

**Regenye, Glenn R**
Rantan Valley Oral and Maxillofacial Surgery PA
1907 Park Ave
(908) 757-4122

#### South Amboy

**Allora, Louis P**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399



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*(South Amboy continued)*

**Bryant Ponquinette, Mi**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399

**Chiodo, Thomas**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399

**Famiglietti, Ralph B**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399

**Hullett, Jason S**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399

**Kasahara, Takehiro**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399

**Navilio, Anthony R**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399

**Ponquinette, Justin**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399

**Santora, Philip J**
Eastern Dental of Old Bridge LLC
960 Route 9 South
(732) 727-3399

### Woodbridge

**Santora, Philip J**
Philip J Santora
676 Amboy Ave
(732) 636-2900

## Monmouth County

### Eatontown

**Maron, Andrew**
Monmouth Dental Group
288 State Route 35 S
(732) 542-7770

### Howell

**Kovall, Michael**
Eastern Dental of Howell, LLC
2346 Rte 9 S
(732) 683-1130

### Keyport

**Gold, Ronen**
Monmouth Dental Group North
1 Highway 35
(732) 888-7770

### Neptune

**Pagonis, Tommy**
Neptune Dental Care
2200 Hwy 66
Ste 8
(732) 775-7800

### Oakhurst

**Allora, Louis P**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Bryant Ponquinette, Mi**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Chiodo, Thomas**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Famiglietti, Ralph B**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Hullett, Jason S**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Kasahara, Takehiro**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Kovall, Michael**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Navilio, Anthony R**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Ponquinette, Justin**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

**Santora, Philip J**
Eastern Dental of Eatontown LLC
1802 Rte 35 S
(732) 660-0500

### Red Bank

**Maron, Andrew**
Perfect Smile Dental Office PA
326 Broad St
(732) 224-9339

## Morris County

### Morris Plains

**Famiglietti, Ralph B**
Eastern Dental of Parsippany, LLC
2936 Rte 10 W
(973) 292-2550

**Hullett, Jason S**
Eastern Dental of Parsippany, LLC
2936 Rte 10 W
(973) 292-2550

**Kovall, Michael**
Eastern Dental of Parsippany, LLC
2936 Rte 10 W
(973) 292-2550

**Navilio, Anthony R**
Eastern Dental of Parsippany, LLC
2936 Rte 10 W
(973) 292-2550

### Parsippany

**Hullett, Jason S**
Lake View Dental Associates Inc
146 Parsippany Rd
(973) 887-5013

### Rockaway

**Del Valle, Antonio L**
Jorge G Cordova Inc JC Dental
272 Rt 46
(973) 627-2121

## Passaic County

### Clifton

**Allora, Louis P**
Eastern Dental of Passaic Essex, LLC
251 Clifton Ave
(973) 478-9300

**Bryant Ponquinette, Mi**
Eastern Dental of Passaic Essex, LLC
251 Clifton Ave
(973) 478-9300

**Chiodo, Thomas**
Eastern Dental of Passaic Essex, LLC
251 Clifton Ave
(973) 478-9300

**Famiglietti, Ralph B**
Eastern Dental of Passaic Essex, LLC
251 Clifton Ave
(973) 478-9300

**Hullett, Jason S**
Eastern Dental of Passaic Essex, LLC
251 Clifton Ave
(973) 478-9300

**Kasahara, Takehiro**
Eastern Dental of Passaic Essex, LLC
251 Clifton Ave
(973) 478-9300

**Kovall, Michael**
Eastern Periodontic Associates LLC
251 Clifton Ave
(732) 478-9300



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*(Clifton continued)*

**Navilio, Anthony R**
Eastern Dental of Passaic
Essex, LLC
251 Clifton Ave
(973) 478-9300

**Ponquinette, Justin**
Eastern Dental of Passaic
Essex, LLC
251 Clifton Ave
(973) 478-9300

**Ponquinette, Justin**
Tri County Oral Surgeons
970 Clifton Ave
2nd Flr
(973) 473-3100

**Santora, Philip J**
Eastern Dental of Passaic
Essex, LLC
251 Clifton Ave
(973) 478-9300

### Paterson

**Bovino, Brian F**
Union Dental
55 Union Ave
(973) 942-2423

## Union County

### Plainfield

**Baron, Elliot**
Dental Health Associates, PA
200 W 2nd St
(908) 755-3030

**Lapeyrolerie, Jacques**
Dental Health Associates, PA
200 W 2nd St
(908) 755-3030

### Union

**Allora, Louis P**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

**Bryant Ponquinette, Mi**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

**Chiodo, Thomas**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

**Famiglietti, Ralph B**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

**Hullett, Jason S**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

**Kasahara, Takehiro**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

**Navilio, Anthony R**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

**Ponquinette, Justin**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

**Santora, Philip J**
Eastern Dental of Union LLC
2115 Route 22 West
(908) 964-5406

### Westfield

**Gold, Ronen**
Oral and Maxillofacial
Surgery of Westfield PA
116 S Euclid Ave
(908) 232-5551



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# Empire Fee for Service Network

## *Orthodontist*

### Bergen County

#### Hackensack

**Drut, Oleg**
Diamond Braces
385 Prospect Ave
(201) 996-0770

#### Old Tappan

**Stern, Alyse**
Alyse Stern DDS, MS
215 Old Tappan Rd
(201) 666-8811

#### Palisades Park

**Chung, Christopher H**
Hasan Chung DDS PA
309 A Broad Ave
(201) 242-9300

#### Ridgefield

**Kim, Jinsang**
3S Orthodontics PA
669 Broad Ave Ste 102
(201) 840-1123

#### River Edge

**Schachter, Allen A**
Allen A Schachter, DDS, PA
130 Kinderkamack Rd
Ste 304
(201) 489-7444

### Essex County

#### Irvington

**Kim, Raymond**
Dental Health Associates
2 Washington Ave
(973) 399-5000

**Kim, Raymond**
Dental Health Associates
1146 Stuyvesant Ave
(973) 399-4242

**Seiger, Jeffrey**
Dental Health Associates
2 Washington Ave
(973) 399-5000

#### Newark

**Gagnon, Genevieve**
Dental Health Associates PA
9-25 Alling St
(973) 297-1550

**Gong, Jean**
Dental Health Associates PA
9-25 Alling St
(973) 297-1550

**Kim, Raymond**
Dental Health Associates PA
9-25 Alling St
(973) 297-1550

**Skolnick, Michael**
ChildSmiles, PA
66 Somme St
2nd Fl
(973) 578-8788

### Hudson County

#### Jersey City

**Drut, Oleg**
Diamond Braces
35 Journal Sq
6th Flr
(201) 420-7116

**Seiger, Jeffrey**
Jeffrey Seiger DMD
3183 John F Kennedy Blvd
(201) 798-2322

**Seiger, Jeffrey**
Jeffrey Seiger DMD
846 Bergen Ave
(201) 946-1000

#### North Bergen

**Freedner, Myron M**
Myron M Freedner
6225 Kennedy Blvd
(201) 869-4873

#### West New York

**Drut, Oleg**
Bergenline Orthodontics, LLC
5918 Bergenline Ave
Ste 201 B
(201) 662-0662

### Middlesex County

#### Avenel

**Kiernan, Brian**
Eastern Orthodontic
Associates North LLC
1030 Saint Georges Ave
(732) 750-3600

**Shah, Paresh**
Eastern Orthodontic
Associates North LLC
1030 Saint Georges Ave
(732) 750-3600

**Stern, Alyse**
Eastern Orthodontic
Associates North LLC
1030 Saint Georges Ave
(732) 750-3600

#### Edison

**Chung, Christopher H**
Smile Solutions
3900 Park Ave
Ste 104
(732) 516-1999

**Kim, Jinsang**
3S Orthodontics PA
1032 New Durham Rd
(732) 287-1223

#### New Brunswick

**Clemente, Peter L**
Peter L Clemente
374 Livingston Ave
(732) 545-0093

#### North Brunswick

**Gong, Jean**
Dental Health Associates, PA
977 Livingston Ave
(732) 418-9800

**Kim, Raymond**
Dental Health Associates, PA
977 Livingston Ave
(732) 418-9800

**Nebblett, Natalie M**
Dental Health Associates, PA
977 Livingston Ave
(732) 418-9800

#### Old Bridge

**Bosin, Sanford D**
Old Bridge Orthodontics LLC
2101 County Road 516
Ste A
(732) 607-2488

#### Piscataway

**Clemente, Peter L**
Peter L Clemente
121 Metlars Ln
(732) 985-1666

#### South Amboy

**Kiernan, Brian**
Eastern Orthodontic
Associates North LLC
960 Route 9 South
(732) 727-3399

**Segall, Robert C**
Eastern Orthodontic
Associates North LLC
960 Route 9 South
(732) 727-3399

**Shah, Paresh**
Eastern Orthodontic
Associates North LLC
960 Route 9 South
(732) 727-3399

**Stern, Alyse**
Eastern Orthodontic
Associates North LLC
960 Route 9 South
(732) 727-3399

#### Woodbridge

**Kessler, Leonard**
Joseph Silverman DMD LLC
123 Green St
(732) 636-3900

### Monmouth County

#### Howell

**Segall, Robert C**
Eastern Orthodontic
Associates, LLC
2346 Rte 9 S
(732) 683-1130



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# Empire Fee for Service Network

## *Orthodontist*

*(Marlboro continued)*

### Marlboro

**Schwitz, Mark J**
Mark J Schwitz
33 N Main St
(732) 577-0075

### Neptune

**Esposito, Salvatore**
Neptune Dental Care
2200 Hwy 66
Ste 8
(732) 775-7800

### Oakhurst

**Kiernan, Brian**
Eastern Orthodontic
Associates North LLC
1802 Rt 35 S
(732) 660-0500

**Kim, Raymond**
Raymond A Kim, DMD, MMSc, LLC
251 Monmouth Rd
(732) 663-0770

**Margulies, Seth D**
Eastern Orthodontic
Associates North LLC
1802 Rt 35 S
(732) 660-0500

**Shah, Paresh**
Eastern Orthodontic
Associates North LLC
1802 Rt 35 S
(732) 660-0500

## Morris County

### Morris Plains

**Segall, Robert C**
Eastern Orthodontic
Associates North LLC
2936 Rte 10 W
(973) 292-2550

### Parsippany

**Caggiano, David J**
Caggiano Orthodontics LLC
316 Parsippany Rd
(973) 887-8780

### Randolph

**Skolnick, Michael**
Seidner Dentistry and
Associates PC
924 Rte 10 W
(973) 598-9555

## Passaic County

### Clifton

**Kiernan, Brian**
Eastern Orthodontic
Associates North LLC
251 Clifton Ave
(973) 478-9300

**Segall, Robert C**
Eastern Orthodontic
Associates North LLC
251 Clifton Ave
(973) 478-9300

**Shah, Paresh**
Eastern Orthodontic
Associates North LLC
251 Clifton Ave
(973) 478-9300

**Stern, Alyse**
Eastern Orthodontic
Associates North LLC
251 Clifton Ave
(973) 478-9300

## Union County

### Linden

**Seiger, Jeffrey**
Jeffrey Seiger DMD
924 N Wood Ave
(908) 925-8110

### Plainfield

**Kim, Raymond**
Dental Health Associates, PA
200 W 2nd St
(908) 755-3030

**Margulies, Seth D**
Dental Health Associates, PA
200 W 2nd St
(908) 755-3030

### Union

**Chung, Christopher H**
Smile Solutions
381 Chestnut St
(908) 687-3221

**Kiernan, Brian**
Eastern Orthodontic
Associates North LLC
2115 Us Highway 22 W
(908) 964-4343

**Segall, Robert C**
Eastern Orthodontic
Associates North LLC
2115 Us Highway 22 W
(908) 964-4343

**Shah, Paresh**
Eastern Orthodontic
Associates North LLC
2115 Us Highway 22 W
(908) 964-4343

**Stern, Alyse**
Eastern Orthodontic
Associates North LLC
2115 Us Highway 22 W
(908) 964-4343



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# Empire Fee for Service Network

## *Pediatric Dentist*

### Bergen County

#### Emerson

**Egol, Arthur B**
Arthur B Egol
466 Old Hook Rd Ste 24B
(201) 261-7755

#### Englewood

**Cohen, Daniel B**
Dental Care 4 Kids
216 Engle St
Ste 204
(201) 569-5437

#### Fairlawn

**Gupta, Preeti**
Sparkle Kids Dentistry
15 01 Broadway
Ste 18
(201) 475-1600

#### Fort Lee

**Jacobson, Barry L**
Laser Dentistry For Children LLC
1530 Palisade Ave
(201) 944-9696

**Nasri-Ghajari, Noushin**
Noushin N Ghajari, DDS
2225 Lemoine Ave
(201) 302-9844

#### New Milford

**Hovsky, Julia**
Steven J Nagy DMD
140 Henley Ave
(201) 261-1311

#### Ridgefield Park

**Stillman, Dmitry**
All Family Dental Center LLC
45 Route 46 East
(201) 440-2100

#### Teaneck

**Jacobson, Barry L**
Laser Dentistry For Children LLC
751 Teaneck Rd
(201) 837-1612

### Essex County

#### Irvington

**Brown, Tamara**
Dental Health Associates
1146 Stuyvesant Ave
(973) 399-4242

**Franklin, Natarica**
Dental Health Associates
2 Washington Ave
(973) 399-5000

**Lisman, Clifford G**
Dental Health Associates
1146 Stuyvesant Ave
(973) 399-4242

**Lisman, Clifford G**
Dental Health Associates
2 Washington Ave
(973) 399-5000

**Piccoli, Leandro**
Dental Health Associates
2 Washington Ave
(973) 399-5000

#### Newark

**Lisman, Clifford G**
Dental Health Associates PA
9-25 Alling St
(973) 297-1550

### Hudson County

#### Bayonne

**Berenbaum, Morton**
Morton Berenbaum, DDS
124 Avenue B
(201) 858-3800

#### Jersey City

**Stillman, Dmitry**
ABA Pediatric LLC
35 Journal Sq 6th Flr
(201) 386-0353

### Middlesex County

#### North Brunswick

**Bamgboye, Patrick O**
Dental Health Associates, PA
977 Livingston Ave
(732) 418-9800

**Lisman, Clifford G**
Dental Health Associates, PA
977 Livingston Ave
(732) 418-9800

#### Woodbridge

**Silverman, Joseph**
Joseph Silverman DMD LLC
123 Green St
(732) 636-3900

### Monmouth County

#### Oakhurst

**Gindi, Richard A**
Richard A Gindi DMD
167 Monmouth Rd
(732) 531-0071

#### Sea Girt

**Lin, Amy**
Amy Lin DDS Pediatric Dentistry
2130 Hwy 35
Ste 116
(732) 974-8801

### Union County

#### Elizabeth

**Matos, Rosalie V**
Dr Matos's Growing Smiles PA
520 Westfield Ave
Ste 301
(908) 469-4375

#### Plainfield

**Hutnick, Gail S**
Dental Health Associates, PA
200 W 2nd St
(908) 755-3030

**Lisman, Clifford G**
Dental Health Associates, PA
200 W 2nd St
(908) 755-3030



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# Empire Fee for Service Network

## *Periodontist*

### Bergen County

#### Paramus

**Gupta, Priya**
Periodontal Specialists
523 Forest Ave
Ste 1
(201) 262-6212

### Essex County

#### Caldwell

**Kaplan, Richard B**
Richard B Kaplan
519 Bloomfield Ave
Ste L 19
(973) 228-8500

#### Irvington

**Mintz, Shalom**
Dental Health Associates
2 Washington Ave
(973) 399-5000

**Mintz, Shalom**
Dental Health Associates
1146 Stuyvesant Ave
(973) 399-4242

#### Newark

**Jodhan, Nikisha N**
Dental Health Associates PA
9-25 Alling St
(973) 297-1550

**Mintz, Shalom**
Dental Health Associates PA
9-25 Alling St
(973) 297-1550

### Hudson County

#### Jersey City

**Chang, Kuang-Min**
Jersey Dental Arts PA
846 Bergen Ave
(201) 946-1000

**Glazebnik, Sergei**
Davis Saltzberg and Wenger
142 Palisade Ave
Ste 200
(201) 798-5551

### Middlesex County

#### Avenel

**Beydoun, Fadi I**
Eastern Periodontic
Associates LLC
1030 Saint Georges Ave
(732) 750-3600

**Dannenbaum, Richard M**
Eastern Periodontic
Associates LLC
1030 Saint Georges Ave
(732) 750-3600

**Lambert, Harold**
Eastern Periodontic
Associates LLC
1030 Saint Georges Ave
(732) 750-3600

**Prestup, Aaron**
Eastern Periodontic
Associates LLC
1030 Saint Georges Ave
(732) 750-3600

**Shah, Neha P**
Eastern Periodontic
Associates LLC
1030 Saint Georges Ave
(732) 750-3600

#### Edison

**Chang, Kuang-Min**
Dental One Specialties
495 Plainfield Ave
(732) 985-1400

#### New Brunswick

**Chang, Kuang-Min**
Dental One Specialties
330 Livingston Ave
Ste 2
(732) 846-8383

#### North Brunswick

**Mintz, Shalom**
Dental Health Associates, PA
977 Livingston Ave
(732) 418-9800

#### Perth Amboy

**Tsambazis, Peter**
Dr Lydia E David
325 State St
(732) 826-0210

#### South Amboy

**Beydoun, Fadi I**
Eastern Periodontic
Associates LLC
960 Route 9 South
(732) 727-3399

**Dannenbaum, Richard M**
Eastern Periodontic
Associates LLC
960 Route 9 South
(732) 727-3399

**Lambert, Harold**
Eastern Periodontic
Associates LLC
960 Route 9 South
(732) 727-3399

**Prestup, Aaron**
Eastern Periodontic
Associates LLC
960 Route 9 South
(732) 727-3399

**Shah, Neha P**
Eastern Periodontic
Associates LLC
960 Route 9 South
(732) 727-3399

#### South Plainfield

**Strassberg, Michael C**
Joseph Aiello DDS
160 Oak Tree Rd
(908) 756-3600

#### Woodbridge

**Tsambazis, Peter**
Dental Arts of Woodbridge,
LLP
871 Saint George Ave
(732) 634-5200

### Monmouth County

#### Howell

**Prestup, Aaron**
Eastern Periodontic
Associates, LLC
2346 Rte 9 S
(732) 683-1130

#### Keyport

**Strassberg, Michael C**
Monmouth Dental Group North
1 Highway 35
(732) 888-7770

#### Manalapan

**Penner, Gary J**
Leslie Ann Furie DDS & Gary
J Penner DDS
193 Us Highway 9
Ste 2C
(732) 409-2900

#### Morganville

**Eisen, Steven F**
Eisen & Zirkin PA
50 US Highway 9 N
Ste 102
(732) 972-5922

**Zirkin, Scott L**
Eisen & Zirkin PA
50 US Highway 9 N
Ste 102
(732) 972-5922

#### Oakhurst

**Beydoun, Fadi I**
Eastern Periodontic
Associates LLC
1802 Rte 35 S
(732) 660-0500

**Dannenbaum, Richard M**
Eastern Periodontic
Associates LLC
1802 Rte 35 S
(732) 660-0500

**Lambert, Harold**
Eastern Periodontic
Associates LLC
1802 Rte 35 S
(732) 660-0500

**Prestup, Aaron**
Eastern Periodontic
Associates LLC
1802 Rte 35 S
(732) 660-0500

#### Sea Girt

**Eisen, Steven F**
Steven F Eisen, DMD, PA
2130 Highway 35
Ste 121
(732) 449-1166



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*(See Girl continued)*

**Zirkin, Scott L**
Steven F Eisen, DMD, PA
2130 Highway 35
Ste 121
(732) 449-1166

### Shrewsbury

**Tsambazis, Peter**
Shrewsbury Dental Associates PA
555 Shrewsbury Ave
Ste D
(732) 747-9333

## Morris County

### Denville

**Tsambazis, Peter**
Advanced Dental LLC
515 E Main St
(973) 586-4444

### Flanders

**Lewis, Zalman S**
Rand Dental Associates PA
191 Route 206
Ste 11
(973) 927-8800

### Morris Plains

**Prestup, Aaron**
Eastern Dental of Parsippany, LLC
2936 Rte 10 W
(973) 292-2550

## Passaic County

### Clifton

**Beydoun, Fadi I**
Eastern Periodontic Associates LLC
251 Clifton Ave
(732) 478-9300

**Dannenbaum, Richard M**
Eastern Periodontic Associates LLC
251 Clifton Ave
(732) 478-9300

**Lambert, Harold**
Eastern Periodontic Associates LLC
251 Clifton Ave
(732) 478-9300

**Shah, Neha P**
Eastern Periodontic Associates LLC
251 Clifton Ave
(732) 478-9300

### Little Falls

**Tsambazis, Peter**
Dental Delivery Systems PA
245 Paterson Ave
(973) 256-3912

## Union County

### Clark

**Kelner, Richard M**
Drs Pecoraro Kelner
1119 Raritan Rd
(732) 382-9090

### Plainfield

**Jodhan, Nikisha N**
Dental Health Associates, PA
200 W 2nd St
(908) 755-3030

### Union

**Beydoun, Fadi I**
Eastern Periodontic Associates LLC
2115 Route 22 W
(908) 964-4506

**Dannenbaum, Richard M**
Eastern Periodontic Associates LLC
2115 Us Highway 22 W
(908) 964-5406

**Lambert, Harold**
Eastern Periodontic Associates LLC
2115 Us Highway 22 W
(908) 964-5406

**Shah, Neha P**
Eastern Periodontic Associates LLC
2115 Us Highway 22 W
(908) 964-5406



Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, *an association of independent Blue Cross and Blue Shield Plans.*

**The participation status of the providers listed above may have changed. Therefore, please contact the individual provider you choose prior to making an appointment to verify their participation status to avoid having claims paid out of network.

Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

## *Prosthodontist*

**Morris County**

**Parsippany**

**Yang, Shuyuan J**
Prosthodent PC
60 Baldwin Rd Ste 104
(973) 263-3006



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Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

*General Practitioner*

## VERMONT

### Bennington County

#### Brandon

**Coleman, Thomas A**
Thomas A Coleman
5 Carver St
Ayshire Prof Bldg
(802) 247-3336



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Empire BLUECROSS BLUESHIELD

# Empire Fee for Service Network

*Oral Surgeon*

**Rutland County**

**Rutland**

**Stofka, Sherilynn**
Green Mountain Oral Surgery LLC
66 N Main St
(802) 775-9700



Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

**The participation status of the providers listed above may have changed. Therefore, please contact the individual provider you choose prior to making an appointment to verify their participation status to avoid having claims paid out of network.

THE PORT AUTHORITY OF NY & NJ



(212) 435-7000
(973) 961-6600

October 18, 1999

Dear Port Authority Employee:

The Port Authority of New York & New Jersey is conducting the annual health and dental benefits Open Enrollment now through November 19, 1999 for all employees. The options you choose in this Open Enrollment are *effective January 1, 2000*. Attached are a brief overview of the health (Attachments I, II) and dental (Attachment III) options available to you, and 'Typical Questions and Answers' (Attachment IV). I am pleased to announce the following benefit plan enhancement:

**United HealthCare PPO Plan**

- Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

Also, please note that the new bi-weekly employee contribution rates for the Prudential/Blue Cross Traditional Indemnity Plan will be $32 for individual and $70 for family coverage.

After reading the attached material:

If you wish to REMAIN in your present coverage, DO NOTHING.

If you are CHANGING health or dental coverage, please COMPLETE THE ATTACHED *BENEFIT SELECTION FORM*.

Please help us to get you enrolled properly by completing the *Benefit Selection Form* and returning it to Employee Benefits, 1WTC-61S no later than November 19, 1999. To avoid confusion and to ensure that the form is received by the due date, you can request that it be signed for upon receipt if sent through the internal PA mail. For outside delivery, you may want to request a return receipt.

If you have questions regarding a specific plan, please call the carrier directly (see Attachment V). Employees with *general* questions can call Employee Benefits at (212) 435-6163. All coverage changes are *effective January 1, 2000* and remain in effect until the next open enrollment unless a change in family status occurs.

Sincerely,

Rosetta A. Jannotto

Rosetta A. Jannotto
Manager, Employee Benefits
Human Resources Department

Attachments

Attachment I

## UNITED HEALTHCARE PLAN (PPO) OVERVIEW

The United HealthCare Preferred Provider Organization Plan (PPO) offers members complete freedom to use either a network provider or an out-of-network provider for medical and hospital care. Members who wish to use a network provider have a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, health care delivery resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reimbursement at reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- Unlimited Lifetime Major Medical Maximum.
- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Full range of medical services including specialist care and outpatient surgery.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United HealthCare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- A $5 co-payment if you use a United HealthCare network physician.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 (in addition to the deductible).

In addition, the United HealthCare PPO includes the following health promotion benefits through its *OPTUM program:*

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors who are able to answer your medical questions;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United HealthCare directly (1-888-441-9815).

## COST OF PLAN

Contributions for this plan are not required at this time.

**United HealthCare**
**Summary of Coverage**
**Port Authority of NY & NJ**

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK * ** |
|---|---|---|
| Deductible – Single | None | $50 |
| Family | None | $100 |
| Coinsurance | None | 20% |
| Maximum Out-of-Pocket per person | Not Applicable | $1,000 (excluding deductible) |
| **PREVENTIVE CARE** | | |
| Physical Examination | $5 copay per visit | No coverage |
| Routine Pediatric Care | 100% coverage | 100% of Reasonable & Customary |
| **OUTPATIENT CARE** | | |
| Physician Office Visits | $5 copay per visit | Subject to Deductible & Coinsurance |
| Surgery | 100% coverage | 100% of Reasonable & Customary |
| Laboratory Services | 100% coverage | 100% of Reasonable & Customary |
| **HOSPITAL CARE** | | |
| Semi-private room & board | 100% coverage | 120 days at 100% balance paid at 80% |
| **EMERGENCY CARE** | | |
| Ambulance Services when medically necessary | No charge | No charge |
| **AT HOSPITAL EMERGENCY ROOM** | | |
| Accident Care, Serious Illness | 100% coverage | 100% coverage |
| **MATERNITY CARE** | | |
| Prenatal & Post-natal care | $5 copay per visit | 100% of Reasonable & Customary |
| Hospital services for mother & child | 100% coverage | 100% - 120 day maximum balance at 80% per stay |
| **SHORT TERM REHABILITATION** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOME HEALTH CARE** | | |
| 60 visits in and out-of- network combined | $5 copay per visit | Subject to Deductible & Coinsurance |
| **SKILLED NURSING FACILITY** | | |
| 60 days per year combined in and out-of-network | 100% coverage | Subject to Deductible & Coinsurance |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| **Inpatient** - 7 days detoxification, 30 days per Year, 2 confinements per lifetime | 100% coverage | 100% coverage |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| **Outpatient** – 60 visits per year, 120 visits Per lifetime combined in and out-of- network | $5 copay per visit | Subject to Deductible & Coinsurance |
| **MENTAL HEALTH CARE** | | |
| Inpatient | 100% coverage | 100% 30 days per year balance paid at 80% |
| Outpatient | $10 copay per visit | Subject to Deductible & Coinsurance |
| **CHIROPRACTIC CARE** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOSPICE CARE** | | |
| 210 days maximum | 100% coverage | 100% coverage |
| **INFERTILITY TREATMENT** | | |
| 3 Attempt Combined Limit | $5 copay per visit | Subject to Deductible & Coinsurance |
| **OTHER COVERAGE** | | |
| Durable Medical Equipment | 100% coverage | Subject to Deductible & Coinsurance |

* All Benefits are subject to Reasonable & Customary.
** All benefits must meet medical necessity.

**This summary is not all inclusive. Please refer to your handbook which you will be receiving after enrollment.**

Attachment II

## PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN OVERVIEW

The Prudential/Blue Cross Traditional Indemnity Plan is designed to provide broad financial protection against hospital, doctor and related medical expenses. This plan offers members complete freedom in choosing their health care providers and facilities. Hospitalization is provided through Empire Blue Cross and Surgical/Major Medical coverage is provided by Prudential Insurance Company of America. Members of this plan are subject to an annual deductible of $50 for individual and $100 for family coverage. Eligible Major Medical expenses are reimbursed through Prudential Insurance Company at 80% of Reasonable and Customary Charges up to a $1,000,000 lifetime maximum per covered individual.

A more detailed explanation of this plan follows. For specific claim information, please contact the insurance carrier directly (see attached telephone directory).

## COST OF PLAN

Employees enrolled in this option will have a biweekly payroll deduction of $32 for individual and $70 for family coverage.

Employees may elect to have these deductions taken on a pre-tax basis by completing the Compensation Reduction Agreement section on the attached *Benefit Selection Form* and returning it to the Employee Benefits Division by November 19, 1999. Deductions on a pre-tax basis result in a lower taxable income so you pay less federal income tax and less state income tax (except in New Jersey). Also, depending on your salary level, you may pay less Social Security (FICA) tax as well.

If you prefer to have these deductions made on a post-tax basis, do not complete the Compensation Reduction Agreement section on the attached *Benefit Selection Form*.

## HOW TO ENROLL

To enroll in the Prudential/Blue Cross Traditional Indemnity Plan, complete the attached *Benefit Selection Form* and return it to the Employee Benefits Division, One WTC-61 South by November 19, 1999.

## PRUDENTIAL/BLUE CROSSTRADITIONAL INDEMNITY PLAN
(Continued)

**Employees who enroll in this plan will have a biweekly payroll deduction of $32 for individual and $70 for family coverage. Deductions will be effective January 1, 2000 and be reflected in your payroll check dated January 22, 2000.**

I. Plan provides basic coverage through Empire Blue Cross of Greater New York for:

A. Hospitalization
- 120 days paid at a semiprivate room rate for each period of confinement in a participating Blue Cross of Greater NY hospital.

B. Emergency Room Treatment (rendered in a participating Blue Cross of Greater N.Y. hospital by a salaried hospital staff member)
- Accidental Injury: within 72 hours of the injury
- Sudden and Serious: within 12 hours of the illness

II. Plan provides surgical/major medical coverage through The Prudential Insurance Company of America:

A. Surgical Procedures
- 100% reimbursement rate based on the reasonable and customary fee.

B. Major Medical Expenses
- 80% reimbursement rate based on the reasonable and customary fee for doctor visits, lab fees, and x-rays.
- The following primary and preventive care services are covered in full for dependents from birth to age 19. That is, they are not subject to coinsurance or annual deductibles.
  - Initial hospital check-up for newborns.
  - Scheduled well-child visits.
  - Certain services at each well-child visit, such as physical examinations, developmental assessment and laboratory tests.
  - Appropriate immunizations including diphtheria, haemophilus, influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, and tetanus.
  - One preventive care visit every two years for children ages six up to their nineteenth birthday.
- Routine exams not covered.
- Vision and eye exams not covered.

## PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
(Continued)

C. Mental and Nervous Coverage

- Inpatient hospital benefits are reimbursed at 100% up to 30 days in any 12-month period in a participating accredited non-governmental hospital. Confinements in excess of 30 days are reimbursed at 80%. Confinements in a non-participating hospital are reimbursed at 80%. All confinements in a non-participating hospital and/or those reimbursed at 80% are subject to the plan maximum as stated above and must be deemed medically necessary.
- Outpatient services will be reimbursed at 50% of reasonable and customary charges to a maximum of $45 per visit, with a fifty (50) visit annual limit.

D. Alcohol and Substance Abuse

| | |
|---|---|
| 1. Inpatient Alcohol: | 7 days detoxification reimbursed at 100%. 30 days inpatient rehabilitation reimbursed at 100%. One course of treatment in a 12-month period, twice per lifetime. |
| 2. Inpatient Substance Abuse: | 7 days detoxification and 30 days inpatient rehabilitation reimbursed at 100%, one course of treatment in 12-month period, twice per lifetime. |
| 3. Outpatient Rehabilitation: | 120 days per lifetime, combination of alcohol and substance abuse. 60-visit maximum per calendar year. Day 1-30 reimbursed at 100%, balance reimbursed at 80%. |

III. Group Health Deductibles/Maximums

A. Annual Deductibles

- Hospitalization - none
- Surgical - none
- Major Medical - $50 Individual/$100 Family

B. Major Medical Maximum - $1,000,000

- Lifetime Maximum (includes mental and nervous lifetime maximum).
- Each eligible dependent has their own major medical maximum.
- $5,000 cap - After the annual major medical deductible has been satisfied, an individual covered under the Major Medical Plan will be reimbursed at 80% of all reasonable and eligible medical expenses through the first of such expenses in a calendar year and, thereafter, for 100% of such expenses in the calendar year (dental claims not included).

Attachment III

# DENTAL OPTIONS

## 1. PRUDENTIAL REASONABLE AND CUSTOMARY DENTAL PLAN

A. Dental Expenses
- 80% reimbursement rate based on reasonable and customary charges.
- Orthodontic expenses reimbursed under a fixed schedule of allowances only (will not be applicable toward your annual deductible as indicated below). One treatment per lifetime per eligible dependent under age 19.

B. Annual Dental Deductibles
- $50/Individual
- $100/Family

---

## 2. PRUDENTIAL SCHEDULE OF ALLOWANCES DENTAL PLAN

A. Expenses are reimbursed under a fixed schedule of allowances (see attached).

B. This plan does not require a deductible.

## 3. DENTCARE DENTAL PLAN

- Generally no out of pocket expenses (call Dentcare for brochure and exceptions).
- Must go to a designated Dentcare dentist.
- Pre-certification needed from the Dentcare Program for all major dental work done by a Dentcare Dentist.
- No deductibles.

If two Port Authority and/or PATH employees are married to each other, and they both choose Dentcare, they can only have one Dentcare plan which must cover both employees and all family members.

Port Authority Group Dental Plan
Schedule of Allowances

## Part I — Basic Services

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Diagnostic and Preventive Services** | |
| 0110 | 1. Clinical oral examination* | $ 10.00 |
| 1110 | 2. Cleaning, scaling and polishing* | 15.00 |
| 1210 | 3. Fluoride treatment (up to age 19)* | 8.00 |
| | 4. X-RAYS — individual total not to exceed the allowance for full-mouth series | |
| 0210 | (a) Full mouth or Panorex (at least 10 times)** | 15.00 |
| 0270 | (b) Bitewing, each | 3.00 |
| 0200 | (c) Periapical, single, each | 2.00 |
| 0240 | (d) Intra-oral occlusal (edentulous jaw), each | 7.00 |
| 0321 | (e) Temporo-mandibular joint film | 15.00 |
| 0340 | (f) Anterior/posterior; head and jaws | 15.00 |
| 0290 | (g) Lateral, head and jaws | 15.00 |
| | *Not more than twice annually | |
| | **Not more than once in three years | |
| | **Palliative Services** | |
| 9110 | Emergency treatment for relief of pain | 7.00 |
| | **Restorative Services** | |
| | 1. FILLINGS | |
| | Silver Fillings | |
| 2140 | (a) One surface | 12.00 |
| 2150 | (b) Two surfaces | 18.00 |
| 2160 | (c) Three or more surfaces | 27.00 |
| | Tooth Color Fillings | |
| 2330 | (d) Per filling | 12.00 |
| | 2. STAINLESS STEEL CROWN | |
| 2830 | each (up to age 19) | 25.00 |
| | **Oral Surgery (including X-rays, anesthesia and post-operative treatment)** | |
| | 1. EXTRACTIONS | |
| 7110 | (a) Routine or simple and surgical | 10.00 |
| 7220 | (b) Soft tissue impaction | 25.00 |
| 7235 | (c) Partial bony impaction | 40.00 |
| 7245 | (d) Complete bony impaction | 55.00 |
| | (e) Complex including bone removal and sutures | 30.00 |
| | 2. FRACTURES | |
| 7620 | (a) Upper jaw, closed reduction | 200.00 |
| 7640 | (b) Lower jaw, closed reduction | 225.00 |
| 7610 | (c) Upper jaw, open reduction | 300.00 |
| 7630 | (d) Lower jaw, open reduction | 300.00 |
| | 3. OTHER ORAL SURGICAL PROCEDURES | |
| 7430 | (a) Removal of cysts, including necessary extractions | 35.00 |
| 7340 | (b) Alveolectomy, maximum per arch | 30.00 |
| 3410 | (c) Apicoectomy | 35.00 |
| 7285 | (d) Biopsy, including report | 25.00 |
| 7960 | (e) Removal of labial frenum | 40.00 |
| 7260 | (f) Closure of oral antral fistula | 90.00 |
| | **Root Canal Treatment (including X-rays and follow-up care)** | |
| 3315 | 1. Filling one canal | 75.00 |
| 3325 | 2. Filling two canals | 100.00 |
| 3335 | 3. Filling three canals | 130.00 |
| | **Space Maintainers, simple (up to age 19)** | |
| 1510 | Any type | 50.00 |
| | **Periodontic Services (treatment of gums and associated tissues)** | |
| | 1. Periodontal root scaling and planing, including medications | |
| 4341 | (a) Fewer than 12 teeth per sitting | 15.00 |
| 4340 | (b) Per arch | 22.00 |
| | 2. Gum or bone surgery, including post-operative visits, (per quadrant) | |
| 4210 | | 90.00 |
| 4220 | 3. Subgingival curettage | 10.00 |

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Repair of Dentures and Bridges** | |
| | 1. Broken full or partial denture | |
| 5610 | (a) No tooth damage | $ 20.00 |
| 5620 | (b) Replace one tooth | 30.00 |
| 5630 | (c) Each additional tooth | 7.00 |
| | 2. Replace broken teeth only | |
| 5630 | (a) First tooth | 20.00 |
| 5640 | (b) Each additional | 7.00 |
| 5670 | 3. Reattaching undamaged clasp | 20.00 |
| 5680 | 4. Replacing broken clasp with new clasp | 45.00 |
| 5650 | 5. Adding tooth to partial denture to replace natural extracted tooth, each tooth | 35.00 |
| 5725 | 6. Rebasing upper or lower full or partial denture | 50.00 |
| 2920 | 7. Recement crowns and inlays | 6.00 |
| 6640 | 8. Repair broken facing | 15.00 |

## Part II — Major Services

| | | |
|---|---|---|
| | **Inlays, Gold** | |
| 2510 | 1. One surface | 50.00 |
| 2520 | 2. Two surfaces | 80.00 |
| 2530 | 3. Three or more surfaces, maximum per tooth | 90.00 |
| | **Dentures, Full (including supplying, inserting, fitting and adjustments)** | |
| 5110 | 1. Upper, once in five years | 175.00 |
| 5120 | 2. Lower, once in five years | 175.00 |
| | **Dentures, Partial** | |
| 5220 | 1. Bilateral acrylic or comparable base, either jaw, two or more full clasps and rests, each | 170.00 |
| 5250 | 2. Upper bilateral, chrome cobalt alloy or gold base, two or more clasps and rests, acrylic attachments, each | 200.00 |
| 5230 | 3. Lower, bilateral chrome cobalt alloy or gold base, two or more cast clasps and tests, acrylic attachments, each | 200.00 |
| | **Crowns and Bridgework** | |
| | 1. Bridgework, Removable (one piece casing with clasps and rests) | |
| 5280 | (a) One tooth replaced | 100.00 |
| 5280 | (b) Two teeth replaced | 110.00 |
| | 2. Bridgework, Fixed (single abutments only) | |
| 6780 | (a) 3/4 crown | 85.00 |
| 6790 | (b) Full cast crown | 110.00 |
| 6720 | (c) Full cast with veneer | 140.00 |
| | 3. Pontics | |
| 6230 | (a) Tru-pontic (porcelain or acrylic facing with cast backing) | 95.00 |
| 6210 | (b) Pontic of other type | 85.00 |
| | 4. Crowns | |
| 2740 | (a) Porcelain jacket | 150.00 |
| 2710 | (b) Acrylic jacket | 115.00 |

## Part III — Orthodontic Services

8410 Initial appliance, X-rays, diagnosis, study models, etc. Maximum — $150.

Active treatment $35 per month. Not to exceed $840.00

Passive treatment, per 6 month period — $15. Maximum of 3 periods, Total — $45.

Total benefits available ..... $1035 per course of treatment

Note: If a charge is incurred for a service not included in the Schedule, in connection with the dental care of a specific condition, and if the Schedule [illegible] more services which, according to customary dental prac- charge for the least expensive of the suitable services included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.

Attachment IV

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW DO I CHANGE MY COVERAGE?

If you wish to change your current coverage, please complete the attached *Benefit Selection Form* and return it to Employee Benefits, One WTC-61 South by **Friday, November 19, 1999**. To allow enough time to process your change with the carrier, forms must be received by November 19, 1999.

### 2. WHEN WILL MY NEW COVERAGE BEGIN?

Your new coverage will begin on **January 1, 2000**. All changes in health/dental coverage will be considered final and will remain in effect until the next open enrollment period.

### 3. WHAT IF I DON'T WANT TO CHANGE MY CURRENT COVERAGE?

You will automatically be continued in your present plans if no *Benefit Selection Form* is received.

### 4. HOW CAN I FIND OUT WHAT MY CURRENT COVERAGE IS?

*If you are not sure which plan you are enrolled in, call Employee Benefits at (212) 435-6163.*

### 5. IF I AM CURRENTLY ENROLLED IN AN HMO, CAN I REMAIN IN THAT HMO?

Yes. However, you should note that if you change coverage during this open enrollment, you will not have the option to enroll in any HMO in the future. Please refer to the *Benefit Selection Form* in this package, which lists the health care options available to you.

### 6. DID THE TAKEOVER OF PRUDENTIAL HEALTHCARE BY AETNA RESULT IN ANY CHANGES?

While it may not result in changes to the level of benefits currently offered by Prudential, it may affect the level of service.

### 7. WHAT IS A PPO?

A PPO (Preferred Provider Organization) offers the best features of both a traditional indemnity plan and managed care by giving members the freedom to use any provider, either in-network or out-of-network, for medical and hospital care without requiring a referral from a primary care physician to use a specialist.

### 8. WHAT IS A NETWORK PROVIDER?

A network provider is one who participates in a network and has agreed to charge preferred rates for members who seek care. The network includes a broad range of providers including Family Practitioners, Internists, Pediatricians, Neurologists, Oncologists and OB/GYNs. Additionally, the network includes labs, X-ray facilities and mental health providers. Again, you are not restricted to only use network providers.

## 9. WHAT IS THE DIFFERENCE BETWEEN PPO AND HMO PLANS?

The difference is that the PPO is not a managed care plan. You are not required to choose a Primary Care Physician and you will be reimbursed if you use an out-of-network physician under a PPO plan. This allows you and your family direct access to all specialists.

## 10. HOW DO I FIND OUT IF MY DOCTOR IS A MEMBER OF THE UNITED HEALTHCARE PPO NETWORK?

- Check the Provider Directory available directly from United HealthCare;
- Call United HealthCare Member Services at 1-888-441-9815 (select the option to speak with a customer services representative) or call your doctor and ask;
- Check the Internet (www.unitedhealthcare.com). This will also give you directions and an easy to read color map showing the provider's location;

## 11. WHAT IF MY DOCTOR IS NOT A MEMBER OF THE UNITED HEALTHCARE NETWORK?

If you wish to encourage your doctor to join the United HealthCare network, simply have your doctor call United HealthCare Network/Provider Services at 1-800-638-8075 to obtain an application. Due to the thorough credentialing process, in which United checks or verifies board certification, training and education, hospital affiliation and malpractice status, the process can take up to 180 days. However, you can still go to your doctor as an out-of-network provider and be reimbursed at 80% of reasonable and customary charges.

## 12. HOW DO I GET UNITED HEALTHCARE OUT-OF-NETWORK CLAIM FORMS?

Your department can obtain claim forms through Corporate Express or you can call United HealthCare. Claim forms are also included with United's reimbursement materials.

## 13. WILL I BE REQUIRED TO CONTRIBUTE FOR MY HEALTH AND/OR DENTAL COVERAGE?

There are no employee contributions necessary for coverage through United HealthCare, any of the HMO's or any of the dental options at this time. Employees who choose or remain in the Prudential/Blue Cross Traditional Indemnity Plan, and are currently contributing to their health coverage, can refer to the Prudential/Blue Cross Traditional Indemnity Plan Overview section of this package for biweekly pre-tax or post-tax contribution rates.

## 14. HOW DOES PRE- AND POST-TAX WORK?

Employees required to contribute to the cost of their health coverage can elect to have these contributions taken out on pre-tax basis by completing the Compensation Reduction Agreement section on the attached *Benefit Selection Form*. Contributions on a pre-tax basis result in a lower taxable income so you pay less Federal Income Tax and less NY State Income Tax. (NJ taxable income is not affected.) If you are currently having deductions taken out on a pre-tax basis and wish to continue doing so, you do not need to complete a new *Benefit Selection Form*.

## 15. HOW DOES PRE- AND POST-TAX AFFECT RETIREMENT?

Your full gross salary is reported to the New York State & Local Employees Retirement System regardless of whether you select pre- or post-tax contributions.

## 16. IF I SWITCH OUT OF THE PRUDENTIAL TRADITIONAL INDEMNITY PLAN, WHEN WILL MY EMPLOYEE CONTRIBUTION STOP?

The last deduction from your paycheck will be on January 22, 2000 (which, due to the retrospective payroll, covers the December 26, 1999 to January 8th period).

## 17. HOW WILL MY PRESCRIPTIONS BE FILLED?

National Prescription Administrators, Inc. (NPA) provides your prescription benefit regardless of the health plan selected. The cost of each prescription is either $2 for generic brand drugs or $5 for name brand. For specific information or questions, please contact NPA directly at 1-800-467-2006.

**Important Note:** CWA 1032 employees who choose or remain in the United HealthCare PPO plan will have the NPA prescription plan. However, if you chose the Prudential Traditional Indemnity Plan or any of the HMO's, your prescription benefit will be provided by that specific carrier.

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## 18. WILL MY DENTAL INSURANCE PLAN CHANGE IF I SWITCH HEALTH PLANS?

No. Your dental plan will remain the same unless you choose one of the other dental options available to you on the *Benefits Selection Form*.

## 19. ARE PRE-EXISTING CONDITIONS COVERED?

Yes. There is no pre-existing condition limitation under any of the current healthcare coverage plans.

## 20. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED HEALTHCARE'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

## 21. WHO IS AN ELIGIBLE DEPENDENT?

For this purpose, eligible dependents are defined as an employee's spouse or dependent children. Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage can extend through the end of the calendar year in which the child turns age 26 provided the child is unmarried, in full-time attendance at an accredited educational institution, and dependent on the employee for support. However, your health carriers will require you to provide verification of your child's full-time student status. Domestic partners, parents and grandchildren are not considered eligible for this purpose.

## 22. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing the enclosed *Benefit Selection Form* and returning it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable documentation (i.e. state marriage certificate, divorce decree, birth certificate for children, etc.) in order for the change to be made. Failure to notify Employee Benefits within the required time frame will result in having your request denied by the insurance carrier, and you will not be permitted to add your dependents(s) to your plan coverage until the next open enrollment period.

## 23. WHAT IS A CHANGE IN FAMILY STATUS?

For this purpose, a change in status includes the marriage or divorce of the employee, death of the employee's spouse or dependent children, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, switching from part-time to full-time employment status (or vice versa) by the employee or the employee's spouse, taking of an unpaid leave of absence by the employee or the employee's spouse, or a significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment.

## 24. HOW DO I CHANGE MY DENTCARE DENTIST, HIP CENTER, PRIMARY CARE PHYSICIAN OR PHARMACY?

Please contact your health and/or dental carriers directly for instructions.

## 25. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a Provider Directory by contacting the specific carrier directly. A list of telephone numbers is attached to this package.

## 26. CAN I WAIVE MY RIGHT TO GROUP HEALTH AND/OR DENTAL BENEFITS?

Yes, provided you are covered by other insurance, such as a spouse's plan. Should you choose to waive your right to coverage, you must complete the Benefits Waiver Section on the attached *Benefit Selection Form* and provide proof of coverage by another carrier. However, you should note that if you waive your health benefits you must also waive your dental benefits and vice versa.

## 27. IF I WAIVE COVERAGE NOW, WILL I BE ABLE TO OBTAIN COVERAGE LATER ?

Yes, provided that a change in family status has occurred within the past thirty (30) days. Otherwise, you will not be permitted to enroll until the next open enrollment period.

## 28. WHO DO I CALL WITH GENERAL QUESTIONS?

You can call Employee Benefits at 212-435-6163.

M/C pre&post

Attachment V

# TELEPHONE DIRECTORY

## Health Coverage

| | | |
|---|---|---|
| United HealthCare | 1-888-441-9815 | |
| Prudential Indemnity Plan | 1-800-772-4683 | |
| Empire Blue Cross Blue Shield | 1-800-662-5193 | |
| HIP New York | 1-800-447-8632 | |
| HMO Blue<br>~~*Horizon Blue Cross Blue Shield of NJ*~~ | 1-800-722-2583 | |
| Prudential Healthcare HMO | 1-800-422-7399 | |
| Aetna/U.S. Healthcare | 1-800-323-9930<br>1-888-277-8742 | Information<br>Enrollment<br>Packages |
| | **PIN Number in NJ:** | **111** |
| | **PIN Number in NY & other states:** | **112** |

## Dental Coverage

| | |
|---|---|
| Prudential Dental | 1-800-772-4683 |
| Dentcare | 1-800-468-0600 |

**THE PORT AUTHORITY** OF NY & NJ

ONE WORLD TRADE CENTER
NEW YORK, NY 10048

(212) 435-7000
(973) 961-6600

October 18, 1999

Dear Port Authority Employee:

The Port Authority of New York & New Jersey is conducting the annual health and dental benefits Open Enrollment now through November 19, 1999 for all employees. The options you choose in this Open Enrollment are *effective January 1, 2000*. Attached are a brief overview of the health (Attachments I, II, III) and dental (Attachment IV) plans available to you, and 'Typical Questions and Answers' (Attachment V). I am pleased to announce the following benefit plan enhancement:

**United HealthCare PPO Plan**

- Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

After reading the attached material:

If you wish to REMAIN in your present coverage, DO NOTHING.

---

If you are CHANGING health or dental coverage, please COMPLETE THE ATTACHED *BENEFIT SELECTION FORM*.

Please help us to get you enrolled properly by completing the *Benefit Selection Form* and returning it to Employee Benefits, 1WTC-61S no later than November 19, 1999. To avoid confusion and to ensure that the form is received by the due date, you can request that it be signed for upon receipt if sent through the internal PA mail. For outside delivery, you may want to request a return receipt.

If you have questions regarding a specific plan, please call the carrier directly (see Attachment VI). Employees with *general* questions can call Employee Benefits at (212) 435-6163. All coverage changes are *effective January 1, 2000* and remain in effect until the next open enrollment unless a change in family status occurs.

Sincerely,

Rosetta A. Jannotto

Rosetta A. Jannotto
Manager, Employee Benefits
Human Resources Department

Attachments (represented employees)

# UNITED HEALTHCARE PLAN (PPO) OVERVIEW

The United HealthCare Preferred Provider Organization Plan (PPO) offers members complete freedom to use either a network provider or an out-of-network provider for medical and hospital care. Members who wish to use a network provider have a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, health care delivery resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reimbursement at reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- Unlimited Lifetime Major Medical Maximum.
- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Full range of medical services including specialist care and outpatient surgery.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United HealthCare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- A $5 co-payment if you use a United HealthCare network physician.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 (in addition to the deductible).

In addition, the United HealthCare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors who are able to answer your medical questions;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United HealthCare directly (1-888-441-9815).

## COST OF PLAN

Contributions for this plan are not required at this time.

**United HealthCare**
**Summary of Coverage**
**Port Authority of NY & NJ**

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK * ** |
|---|---|---|
| Deductible – Single | None | $50 |
| Family | None | $100 |
| Coinsurance | None | 20% |
| Maximum Out-of-Pocket per person | Not Applicable | $1,000 (excluding deductible) |
| **PREVENTIVE CARE** | | |
| Physical Examination | $5 copay per visit | No coverage |
| Routine Pediatric Care | 100% coverage | 100% of Reasonable & Customary |
| **OUTPATIENT CARE** | | |
| Physician Office Visits | $5 copay per visit | Subject to Deductible & Coinsurance |
| Surgery | 100% coverage | 100% of Reasonable & Customary |
| Laboratory Services | 100% coverage | 100% of Reasonable & Customary |
| **HOSPITAL CARE** | | |
| Semi-private room & board | 100% coverage | 120 days at 100% balance paid at 80% |
| **EMERGENCY CARE** | | |
| Ambulance Services when medically necessary | No charge | No charge |
| **AT HOSPITAL EMERGENCY ROOM** | | |
| Accident Care, Serious Illness | 100% coverage | 100% coverage |
| **MATERNITY CARE** | | |
| Prenatal & Post-natal care | $5 copay per visit | 100% of Reasonable & Customary |
| Hospital services for mother & child | 100% coverage | 100% - 120 day maximum balance at 80% per stay |
| **SHORT TERM REHABILITATION** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOME HEALTH CARE** | | |
| 60 visits in and out-of- network combined | $5 copay per visit | Subject to Deductible & Coinsurance |
| **SKILLED NURSING FACILITY** | | |
| 60 days per year combined in and out-of-network | 100% coverage | Subject to Deductible & Coinsurance |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Inpatient - 7 days detoxification, 30 days per Year, 2 confinements per lifetime | 100% coverage | 100% coverage |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Outpatient – 60 visits per year, 120 visits Per lifetime combined in and out-of- network | $5 copay per visit | Subject to Deductible & Coinsurance |
| **MENTAL HEALTH CARE** | | |
| Inpatient | 100% coverage | 100% 30 days per year balance paid at 80% |
| Outpatient | $10 copay per visit | Subject to Deductible & Coinsurance |
| **CHIROPRACTIC CARE** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOSPICE CARE** | | |
| 210 days maximum | 100% coverage | 100% coverage |
| **INFERTILITY TREATMENT** | | |
| 3 Attempt Combined Limit | $5 copay per visit | Subject to Deductible & Coinsurance |
| **OTHER COVERAGE** | | |
| Durable Medical Equipment | 100% coverage | Subject to Deductible & Coinsurance |

* All Benefits are subject to Reasonable & Customary.
** *All benefits must meet medical necessity.*

**This summary is not all inclusive. Please refer to your handbook which you will be receiving after enrollment.**

# UOAT
# PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
# OVERVIEW

**THIS OPTION IS NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER JANUARY 1, 1999.**

The Prudential/Blue Cross Traditional Indemnity Plan is designed to provide broad financial protection against hospital, doctor and related medical expenses. This plan offers members complete freedom in choosing their health care providers and facilities. Hospitalization is provided through Empire Blue Cross and Surgical/Major Medical coverage is provided by Prudential Insurance Company of America. Members of this plan are subject to an annual deductible of $50 for individual and $100 for family coverage. Eligible Major Medical expenses are reimbursed through Prudential Insurance Company at 80% of Reasonable and Customary Charges up to a $1,000,000 lifetime maximum per covered individual.

A more detailed explanation of this plan follows. For specific claim information, please contact the insurance carrier directly (see attached telephone directory).

---

## COST OF PLAN

Contributions for this plan are not required at this time.

## HOW TO ENROLL

To enroll in the Prudential/Blue Cross Traditional Indemnity Plan, complete the attached *Benefit Selection Form* and return it to the Employee Benefits Division, One WTC, 61 South, by November 19, 1999.

## PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
(Continued)

I. Plan provides basic coverage through Empire Blue Cross of Greater New York for:

A. Hospitalization
- 120 days paid at a semiprivate room rate for each period of confinement in a participating Blue Cross of Greater NY hospital.

B. Emergency Room Treatment (rendered in a participating Blue Cross of Greater N.Y. hospital by a salaried hospital staff member).
- Accidental Injury: within 72 hours of the injury
- Sudden and Serious: within 12 hours of the illness

II. Plan provides surgical/major medical coverage through The Prudential Insurance Company of America:

A. Surgical Procedures
- 100% reimbursement rate based on the reasonable and customary fee.

B. Major Medical Expenses
- 80% reimbursement rate based on the reasonable and customary fee for doctor visits, lab fees, and x-rays.
- The following primary and preventive care services are covered in full, for dependents from birth to age 19. That is, they are not subject to coinsurance or annual deductibles.
  - Initial hospital check-up for newborns.
  - Scheduled well-child visits.
  - Certain services at each well-child visit, such as physical examinations, developmental assessment and laboratory tests.
  - Appropriate immunizations including diphtheria, haemophilus, influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, and tetanus.
  - One preventive care visit every two years for children ages six up to their nineteenth birthday.
- Routine physical exams not covered.
- Vision and eye exams not covered.

C. Mental and Nervous Coverage

- Inpatient hospital benefits are reimbursed at 100% up to 30 days in any 12-month period in a participating accredited non-governmental hospital. Confinements in excess of 30 days are reimbursed at 80%. Confinements in a non-participating hospital are reimbursed at 80%. All confinements in a non-participating hospital and/or those reimbursed at 80% are subject to the plan maximum as stated above and must be deemed medically necessary.
- Outpatient services will be reimbursed at 80% of reasonable and customary charges.

D. Alcohol and Substance Abuse

| | |
|---|---|
| 1. Inpatient Alcohol: | 7 days detoxification reimbursed at 100%. 30 days inpatient rehabilitation reimbursed at 100%. One course of treatment in a 12-month period, twice per lifetime. |
| 2. Inpatient Substance Abuse: | 7 days detoxification and 30 days inpatient rehabilitation reimbursed at 100%, one course of treatment in 12-month period, twice per lifetime. |
| 3. Outpatient Rehabilitation: | 120 days per lifetime, combination of alcohol and substance abuse. 60-visit maximum per calendar year. Day 1-30 reimbursed at 100%, balance reimbursed at 80%. |

III. Group Health Deductibles/Maximums

A. Annual Deductibles

- Hospitalization - none
- Surgical - none
- Major Medical - $50 Individual/$100 Family

B. Major Medical Maximum - $1,000,000

- Lifetime Maximum (includes mental and nervous lifetime maximum).
- Each eligible dependent has their own major medical maximum.
- $5,000 cap - After the annual major medical deductible has been satisfied, an individual covered under the Major Medical Plan will be reimbursed at 80% of all reasonable and eligible medical expenses through the first of such expenses in a calendar year and, thereafter, for 100% of such expenses in the calendar year (dental claims not included).

Attachment III

# HEALTH MAINTENANCE ORGANIZATIONS (HMO) OVERVIEW

A Health Maintenance Organization (HMO) is a system of health care that provides managed, pre-paid hospital and medical services to its members. As an HMO member, all your care will be coordinated through a Primary Care Physician (PCP), who manages your health care needs. You can choose a physician from the HMO's provider directory that lists a network of doctors in your area. HMO members can receive health care at little or no out-of-pocket cost, provided they use network providers and facilities. There are no deductibles to meet or claim forms to file. In most HMOs, if a physician outside of the health plan is used without authorization from the HMO, the patient is responsible for all bills incurred.

The Port Authority offers the following HMOs:

- Health Insurance Plan of Greater New York (available to NY residents only);
- HMO Blue *Horizon Blue Cross Blue Shield of NJ* (available to NJ residents only);
- Prudential HealthCare HMO (available in CT, NJ, NY, and PA); and,
- Aetna US Healthcare (available in CT, NJ, NY, and PA).

A summary plan description is attached. For additional information please refer to the literature you may request by calling the specific carrier directly (see attached telephone directory).

## COST OF PLAN

Contributions for these plans are not required at this time.

## HOW TO ENROLL

To enroll in an HMO, complete the attached *Benefit Selection Form* and return it to the Employee Benefits Division, One WTC-61 South by November 19, 1999.

**Please Note:** An HMO will only allow you to enroll if they provide service to residents of your zip code. Please contact the carrier directly if you have any questions concerning service area (see attached telephone directory).

## HEALTH MAINTENANCE ORGANIZATION (HMO)
(Continued)

Plan provides basic/major medical coverage through the HMO of your choice. The available HMOs to choose from are:

- HIP New York
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*
- Prudential HealthCare HMO of New York, New Jersey, Pennsylvania and Connecticut
- Aetna US Healthcare of New York, New Jersey, Pennsylvania and Connecticut

Please note that if two Port Authority or PATH employees are married to each other, and they both choose the same HMO, they can only have one HMO contract which must cover both employees and all family members.

A. Hospitalization

Covered in full for unlimited number of days when approved by the HMO.

B. Emergency Room Treatment in the Hospital

Covered in full when service is approved and/or rendered by the HMO, subject to applicable co-payments as follows:

- HMO Blue *Horizon Blue Cross Blue Shield of NJ* has a $35 co-payment.
- Prudential HealthCare HMO has a $25 co-payment in New York and Connecticut and a $50 co-payment in New Jersey and Pennsylvania.
- Aetna US Healthcare has a $35 co-payment.

C. Surgical Procedures

Covered in full when approved by the HMO, including obstetrical care.

D. Major Medical Expenses

**Primary and Preventive Care:** covered in full subject to a $5 co-payment if you choose HMO Blue *Horizon Blue Cross Blue Shield of NJ*, Prudential HealthCare HMO or Aetna US Healthcare (except New Jersey*). HIP New York does not require a co-payment. Covers services such as routine illness and injury, physical exams, routine child care and well baby visits, immunizations (except those required for travel or work), gynecological exams and pap smears, x-rays, lab tests, routine mammograms.

***Note:** Under Aetna US Healthcare of New Jersey, primary care physician visits are covered in full subject to a $10 co-payment, specialty care office visits are covered in full subject to a $15 co-payment and preventive eye and gynecological exams are covered in full subject to a $15 co-payment.

## HEALTH MAINTENANCE ORGANIZATION (HMO)
(Continued)

**Hearing Exams:** Covered in full subject to the applicable co-payments as follows:

- HIP New York: no co-payment.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*: $5 co-payment.
- Prudential HealthCare HMO: $5 co-payment, but only available if the person is under age 18.
- Aetna US Healthcare: $5 co-payment.

**Vision Care:** Eye Exams covered in full subject to the applicable co-payment as follows:

- HIP New York: No co-payment.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*, Prudential HealthCare HMO and Aetna US Healthcare (except New Jersey): $5 co-payment.
- Aetna US Healthcare - New Jersey: $15 co-payment.

---

**Eye Glasses and Contact Lenses:** Covered as follows:

- HIP New York: Not available.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*: $50 reimbursement per 24 month period.
- Prudential HealthCare HMO: New Jersey only - available at discount rates in plan affiliated optical shops.
- Aetna US Healthcare: $35 reimbursement per 24 month period.

**Preventive Dental:** Covered as follows:

- HIP New York: Preventive and diagnostic services provided by a HIP New York participating dentist. There is a $5 co-payment for services. Each family member receives two exams (including 2 bitewing x-rays) every 6 months, and one application of fluoride per year for all children up to and including age 15 free of cost. There is a $5 co-payment for one cleaning per calendar year.
- Prudential HealthCare HMO: Not available.
- Aetna US Healthcare: Children through age 12 can visit a participating dentist for 2 routine exams per year. This includes an exam and cleaning, polishing and fluoride treatment. There is a $5 co-payment per visit.

## HMO HEALTH PLAN OPTIONS
(Continued)

E. Mental and Nervous Benefit Comparison

| | Inpatient | Outpatient |
|---|---|---|
| HIP of New York | Up to 30 days per year (combined with alcohol and drug services) paid in full. | Short term outpatient therapy. Paid in full |
| HMO Blue* (New Jersey) | 30 days per year paid in full. | 100% after a $25 copayment per visit with a limit of 20 days per year. |
| Prudential HMO (New York) | Up to 30 days per year paid in full. | Reimburses 70% with a 20 visit limit per year. |
| Prudential HMO (New Jersey) | Up to 30 days per year paid in full. | 100% after a $5 copayment per visit with a limit of 20 visits per year. |
| Prudential HMO (Connecticut) | Up to 60 days per year paid in full. | 100% after a $5 copayment per visit with a limit of 20 visits per year. |
| Aetna/ US Healthcare (New York) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |
| Aetna/ US Healthcare (New Jersey) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |
| Aetna/ US Healthcare (Connecticut) | 60 days per year covered in full. | 40 visits per year with $25 copayment per visit. |
| Aetna/ US Healthcare (Pennsylvania) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |

* Combined with Mental and Nervous benefit.

## HMO HEALTH PLAN OPTIONS
(Continued)

F. Alcohol and Substance Abuse Benefit Comparison

| | Inpatient Benefits | Outpatient Benefits |
|---|---|---|
| HIP/NY | Detoxification – Up to 30 days per year, covered In full. (Combined with inpatient mental and Nervous coverage)<br>Rehabilitation – Up to 30 days for alcoholism And/or drug abuse, covered in full. | Up to 60 visits per year for alcohol and drug rehabilitation. Covered in full. |
| HMO Blue *<br>(New Jersey) | Detoxification – Covered in full<br>Rehabilitation – Covered in full (combined 30 day limit) | After a $25 copayment, covered in full with a limit of 20 visits per year. |
| Prudential HMO<br>(New York) | Detoxification – Covered in full<br>Rehabilitation – Covered in full if medically Necessary. | After $5 copayment, covered in full up to 90 days per year for rehabilitative services. 20 family member out patient visits per year. |
| Prudential HMO<br>(New Jersey) | Detoxification – Covered in full<br>Rehabilitation – Covered in full up to 90 days per year if medically necessary. The 90-day limit is combined for in and out patient services. | After $5 copayment, covered in full if medically necessary. 90 day limit for rehabilitative services if medically necessary. The 90-day limit is combined for in and out patient services. |

* Combined with Mental and Nervous benefit.

## HMO HEALTH PLAN OPTIONS
(Continued)

F. Alcohol and Substance Abuse Benefit Comparison

| | Inpatient Benefits | Outpatient Benefits |
|---|---|---|
| Prudential HMO (Connecticut) | Detoxification – Covered in full<br>Rehabilitation – Covered in full if medically Necessary. | After $5 copayment per visit, covered in full up to 90 day for rehabilitative services if medically necessary. 20 family member visits per year. |
| Aetna/US Healthcare (New York) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – Not covered. | 60 visits per year with $5 copayment per visit. |
| Aetna/US Healthcare (New Jersey) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – Not covered. | Not Covered. |
| Aetna/US Healthcare (Connecticut) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – 45 days per year. | Not Covered. |
| Aetna/US Healthcare (Pennsylvania) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – 30 days per year, lifetime maximum 90 days. | 30 visits with $5 copayment and an additional 30 visits which may be exchanged for up to 15 inpatient days per year, lifetime maximum 120 visits. A 50% copayment of the costs of services applies to second and subsequent courses of treatment for residential care. |

Attachment IV

# DENTAL OPTIONS

## 1. PRUDENTIAL REASONABLE AND CUSTOMARY DENTAL PLAN

A. Dental Expenses
- 80% reimbursement rate based on reasonable and customary charges.
- Orthodontic expenses reimbursed under a fixed schedule of allowances only (will not be applicable toward your annual deductible as indicated below). One treatment per lifetime per eligible dependent under age 19.

B. Annual Dental Deductibles
- $50/Individual
- $100/Family

---

## 2. PRUDENTIAL SCHEDULE OF ALLOWANCES DENTAL PLAN

A. Expenses are reimbursed under a fixed schedule of allowances (see attached).

B. This plan does not require a deductible.

## 3. DENTCARE DENTAL PLAN

- Generally no out of pocket expenses (call Dentcare for brochure and exceptions).
- Must go to a designated Dentcare dentist.
- Pre-certification needed from the Dentcare Program for all major dental work done by a Dentcare Dentist.
- No deductibles.

If two Port Authority and/or PATH employees are married to each other, and they both choose Dentcare, they can only have one Dentcare plan which must cover both employees and all family members.

*Port Authority Group Dental Plan*
Schedule of Allowances

## Part I — Basic Services

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Diagnostic and Preventive Services** | |
| 0110 | 1. Clinical oral examination* | $ 10.00 |
| 1110 | 2. Cleaning, scaling and polishing* | 15.00 |
| 1210 | 3. Fluoride treatment (up to age 19)* | 8.00 |
| | 4. X-RAYS — individual total not to exceed the allowance for full-mouth series | |
| 0210 | (a) Full mouth or Panorex (at least 10 times)** | 15.00 |
| 0270 | (b) Bitewing, each | 3.00 |
| 0200 | (c) Periapical, single, each | 2.00 |
| 0240 | (d) Intra-oral occlusal (edentulous jaw), each | 7.00 |
| 0321 | (e) Temporo-mandibular joint film | 15.00 |
| 0340 | (f) Anterior/posterior; head and jaws | 15.00 |
| 0290 | (g) Lateral, head and jaws | 15.00 |
| | *Not more than twice annually | |
| | **Not more than once in three years | |
| | **Palliative Services** | |
| 9110 | Emergency treatment for relief of pain | 7.00 |
| | **Restorative Services** | |
| | 1. FILLINGS | |
| | Silver Fillings | |
| 2140 | (a) One surface | 12.00 |
| 2150 | (b) Two surfaces | 18.00 |
| 2160 | (c) Three or more surfaces | 27.00 |
| | Tooth Color Fillings | |
| 2330 | (d) Per filling | 12.00 |
| | 2. STAINLESS STEEL CROWN | |
| 2830 | each (up to age 19) | 25.00 |
| | **Oral Surgery (including X-rays, anesthesia and post-operative treatment)** | |
| | 1. EXTRACTIONS | |
| 7110 | (a) Routine or simple and surgical | 10.00 |
| 7220 | (b) Soft tissue impaction | 25.00 |
| 7235 | (c) Partial bony impaction | 40.00 |
| 7245 | (d) Complete bony impaction | 55.00 |
| | (e) Complex including bone removal and sutures | 30.00 |
| | 2. FRACTURES | |
| 7620 | (a) Upper jaw, closed reduction | 200.00 |
| 7640 | (b) Lower jaw, closed reduction | 225.00 |
| 7610 | (c) Upper jaw, open reduction | 300.00 |
| 7630 | (d) Lower jaw, open reduction | 300.00 |
| | 3. OTHER ORAL SURGICAL PROCEDURES | |
| 7430 | (a) Removal of cysts, including necessary extractions | 35.00 |
| 7340 | (b) Alveolectomy, maximum per arch | 30.00 |
| 3410 | (c) Apicoectomy | 35.00 |
| 7285 | (d) Biopsy, including report | 25.00 |
| 7960 | (e) Removal of labial frenum | 40.00 |
| 7260 | (f) Closure of oral antral fistula | 90.00 |
| | **Root Canal Treatment (including X-rays and follow-up care)** | |
| 3315 | 1. Filling one canal | 75.00 |
| 3325 | 2. Filling two canals | 100.00 |
| 3335 | 3. Filling three canals | 130.00 |
| | **Space Maintainers, simple (up to age 19)** | |
| 1510 | Any type | 50.00 |
| | **Periodontic Services (treatment of gums and associated tissues)** | |
| | 1. Periodontal root scaling and planing, including medications | |
| 4341 | (a) Fewer than 12 teeth per sitting | 15.00 |
| 4340 | (b) Per arch | 22.00 |
| 4210 | 2. Gum or bone surgery, including post-operative visits, (per quadrant) | 90.00 |
| 4220 | 3. Subgingival curettage | 10.00 |

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Repair of Dentures and Bridges** | |
| | 1. Broken full or partial denture | |
| 5610 | (a) No tooth damage | $ 20.00 |
| 5620 | (b) Replace one tooth | 30.00 |
| 5630 | (c) Each additional tooth | 7.00 |
| | 2. Replace broken teeth only | |
| 5630 | (a) First tooth | 20.00 |
| 5640 | (b) Each additional | 7.00 |
| 5670 | 3. Reattaching undamaged clasp | 20.00 |
| 5680 | 4. Replacing broken clasp with new clasp | 45.00 |
| 5650 | 5. Adding tooth to partial denture to replace natural extracted tooth, each tooth | 35.00 |
| 5725 | 6. Rebasing upper or lower full or partial denture | 50.00 |
| 2920 | 7. Recement crowns and inlays | 6.00 |
| 6640 | 8. Repair broken facing | 15.00 |

## Part II — Major Services

| | | |
|---|---|---|
| | **Inlays, Gold** | |
| 2510 | 1. One surface | 50.00 |
| 2520 | 2. Two surfaces | 80.00 |
| 2530 | 3. Three or more surfaces, maximum per tooth | 90.00 |
| | **Dentures, Full (including supplying, inserting, fitting and adjustments)** | |
| 5110 | 1. Upper, once in five years | 175.00 |
| 5120 | 2. Lower, once in five years | 175.00 |
| | **Dentures, Partial** | |
| 5220 | 1. Bilateral acrylic or comparable base, either jaw, two or more full clasps and rests, each | 170.00 |
| 5250 | 2. Upper bilateral, chrome cobalt alloy or gold base, two or more clasps and rests, acrylic attachments, each | 200.00 |
| 5230 | 3. Lower, bilateral chrome cobalt alloy or gold base, two or more cast clasps and tests, acrylic attachments, each | 200.00 |
| | **Crowns and Bridgework** | |
| | 1. Bridgework, Removable (one piece casing with clasps and rests) | |
| 5280 | (a) One tooth replaced | 100.00 |
| 5280 | (b) Two teeth replaced | 110.00 |
| | 2. Bridgework, Fixed (single abutments only) | |
| 6780 | (a) 3/4 crown | 85.00 |
| 6790 | (b) Full cast crown | 110.00 |
| 6720 | (c) Full cast with veneer | 140.00 |
| | 3. Pontics | |
| 6230 | (a) Tru-pontic (porcelain or acrylic facing with cast backing) | 95.00 |
| 6210 | (b) Pontic of other type | 85.00 |
| | 4. Crowns | |
| 2740 | (a) Porcelain jacket | 150.00 |
| 2710 | (b) Acrylic jacket | 115.00 |

## Part III — Orthodontic Services

8410 *Initial appliance, X-rays, diagnosis, study models, etc.* Maximum — $150

Active treatment $35 per month. Not to exceed $840.00

Passive treatment, per 6 month period — $15. Maximum of 3 periods, Total — $45.

Total benefits available ..... $1035 per course of treatment

Note: If a charge is incurred for a service not included in the Schedule, in connection with the dental care of a specific condition, and if the Schedule contains one or more services which, according to customary dental practices, are separately suitable for the dental care of that condition, then a charge for the least expensive of the suitable services included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.

Attachment V

# TYPICAL QUESTIONS AND ANSWERS

## 1. HOW DO I CHANGE MY COVERAGE?

If you wish to change your current coverage, please complete the attached *Benefit Selection Form* and return it to Employee Benefits, One WTC-61 South by **Friday, November 19, 1999**. To allow enough time to process your change with the carrier, forms must be received by November 19, 1999.

## 2. WHEN WILL MY NEW COVERAGE BEGIN?

Your new coverage will begin on **January 1, 2000**. All changes in health/dental coverage will be considered final and will remain in effect until the next open enrollment period.

## 3. WHAT IF I DON'T WANT TO CHANGE MY CURRENT COVERAGE?

You will automatically be continued in your present plans if no *Benefit Selection Form* is received.

## 4. HOW CAN I FIND OUT WHAT MY CURRENT COVERAGE IS?

~~If you are not sure which plan you are enrolled in, call Employee Benefits at (212) 435-6163.~~

## 5. DID THE TAKEOVER OF PRUDENTIAL HEALTHCARE BY AETNA RESULT IN ANY CHANGES?

While it may not result in changes to the level of benefits currently offered by Prudential, it may affect the level of service.

## 6. WHAT IS A PPO?

A PPO (Preferred Provider Organization) offers the best features of both a traditional indemnity plan and managed care by giving members the freedom to use any provider, either in-network or out-of-network, for medical and hospital care without requiring a referral from a primary care physician to use a specialist.

## 7. WHAT IS A NETWORK PROVIDER?

A network provider is one who participates in a network and has agreed to charge preferred rates for members who seek care. The network includes a broad range of providers including Family Practitioners, Internists, Pediatricians, Neurologists, Oncologists and OB/GYNs. Additionally, the network includes labs, X-ray facilities and mental health providers. Again, you are not restricted to only use network providers.

## 8. WHAT IS THE DIFFERENCE BETWEEN PPO AND HMO PLANS?

The difference is that the PPO is <u>not</u> a managed care plan. You are not required to choose a Primary Care Physician and you will be reimbursed if you use an out-of-network physician under a PPO plan. This allows you and your family direct access to all specialists.

## 9. HOW DO I FIND OUT IF MY DOCTOR IS A MEMBER OF THE UNITED HEALTHCARE PPO NETWORK?

- Check the Provider Directory available directly from United HealthCare;
- Call United HealthCare Member Services at 1-888-441-9815 (select the option to speak with a customer services representative) or call your doctor and ask;
- Check the Internet (www.unitedhealthcare.com). This will also give you directions and an easy to read color map showing the provider's location;

## 10. WHAT IF MY DOCTOR IS NOT A MEMBER OF THE UNITED HEALTHCARE NETWORK?

If you wish to encourage your doctor to join the United HealthCare network, simply have your doctor call United HealthCare Network/Provider Services at 1-800-638-8075 to obtain an application. Due to the thorough credentialing process, in which United checks or verifies board certification, training and education, hospital affiliation and malpractice status, the process can take up to 180 days. However, you can still go to your doctor as an out-of-network provider and be reimbursed at 80% of reasonable and customary charges.

## 11. HOW DO I GET UNITED HEALTHCARE OUT-OF-NETWORK CLAIM FORMS?

Your department can obtain claim forms through Corporate Express or you can call United HealthCare. Claim forms are also included with United's reimbursement materials.

## 12. WILL I BE REQUIRED TO CONTRIBUTE FOR MY HEALTH AND/OR DENTAL COVERAGE?

There are no employee contributions necessary for coverage through United HealthCare, any of the HMO's or any of the dental options at this time. Employees who choose or remain in the Prudential/Blue Cross Traditional Indemnity Plan, and are currently contributing to their health coverage, can refer to the Prudential/Blue Cross Traditional Indemnity Plan Overview section of this package for biweekly pre-tax or post-tax contribution rates.

## 13. HOW DOES PRE- AND POST-TAX WORK?

Employees required to contribute to the cost of their health coverage can elect to have these contributions taken out on pre-tax basis by completing the Compensation Reduction Agreement section on the attached *Benefit Selection Form*. Contributions on a pre-tax basis result in a lower taxable income so you pay less Federal Income Tax and less NY State Income Tax. (NJ taxable income is not affected.) If you are currently having deductions taken out on a pre-tax basis and wish to continue doing so, you do not need to complete a new *Benefit Selection Form*.

## 14. HOW DOES PRE- AND POST-TAX AFFECT RETIREMENT?

Your full gross salary is reported to the New York State & Local Employees Retirement System regardless of whether you select pre- or post-tax contributions.

## 15. IF I SWITCH OUT OF THE PRUDENTIAL TRADITIONAL INDEMNITY PLAN, WHEN WILL MY EMPLOYEE CONTRIBUTION STOP?

The last deduction from your paycheck will be on January 22, 2000 (which, due to the retrospective payroll, covers the December 26, 1999 to January 8th period).

## 16. HOW WILL MY PRESCRIPTIONS BE FILLED?

National Prescription Administrators, Inc. (NPA) provides your prescription benefit regardless of the health plan selected. The cost of each prescription is either $2 for generic brand drugs or $5 for name brand. For specific information or questions, please contact NPA directly at 1-800-467-2006.

**Important Note:** CWA 1032 employees who choose or remain in the United HealthCare PPO plan will have the NPA prescription plan. However, if you chose the Prudential Traditional Indemnity Plan or any of the HMO's, your prescription benefit will be provided by that specific carrier.

## 17. WILL MY DENTAL INSURANCE PLAN CHANGE IF I SWITCH HEALTH PLANS?

No. Your dental plan will remain the same unless you choose one of the other dental options available to you on the *Benefits Selection Form*.

## 18. ARE PRE-EXISTING CONDITIONS COVERED?

Yes. There is no pre-existing condition limitation under any of the current healthcare coverage plans.

## 19. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED HEALTHCARE'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

## 20. WHO IS AN ELIGIBLE DEPENDENT?

For this purpose, eligible dependents are defined as an employee's spouse or dependent children. Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage can extend through the end of the calendar year in which the child turns age 26 provided the child is unmarried, in full-time attendance at an accredited educational institution, and dependent on the employee for support. However, your health carriers will require you to provide verification of your child's full-time student status. Domestic partners, parents and grandchildren are not considered eligible for this purpose.

## 21. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing the enclosed *Benefit Selection Form* and returning it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable documentation (i.e. state marriage certificate, divorce decree, birth certificate for children, etc.) in order for the change to be made. Failure to notify Employee Benefits within the required time frame will result in having your request denied by the insurance carrier, and you will not be permitted to add your dependents(s) to your plan coverage until the next open enrollment period.

## 22. WHAT IS A CHANGE IN FAMILY STATUS?

For this purpose, a change in status includes the marriage or divorce of the employee, death of the employee's spouse or dependent children, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, switching from part-time to full-time employment status (or vice versa) by the employee or the employee's spouse, taking of an unpaid leave

of absence by the employee or the employee's spouse, or a significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment.

## 23. HOW DO I CHANGE MY DENTCARE DENTIST, HIP CENTER, PRIMARY CARE PHYSICIAN OR PHARMACY?

Please contact your health and/or dental carriers directly for instructions.

## 24. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a Provider Directory by contacting the specific carrier directly. A list of telephone numbers is attached to this package.

## 25. CAN I WAIVE MY RIGHT TO GROUP HEALTH AND/OR DENTAL BENEFITS?

Yes, provided you are covered by other insurance, such as a spouse's plan. Should you choose to waive your right to coverage, you must complete the Benefits Waiver Section on the attached *Benefit Selection Form* and provide proof of coverage by another carrier. However, you should note that if you waive your health benefits you must also waive your dental benefits and vice versa.

## 26. IF I WAIVE COVERAGE NOW, WILL I BE ABLE TO OBTAIN COVERAGE LATER ?

Yes, provided that a change in family status has occurred within the past thirty (30) days. Otherwise, you will not be permitted to enroll until the next open enrollment period.

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## 27. WHO DO I CALL WITH GENERAL QUESTIONS?

You can call Employee Benefits at 212-435-6163.

Attachment VI

# TELEPHONE DIRECTORY

## Health Coverage

| | | |
|---|---|---|
| United HealthCare | 1-888-441-9815 | |
| Prudential Indemnity Plan | 1-800-772-4683 | |
| Empire Blue Cross Blue Shield | 1-800-662-5193 | |
| HIP New York | 1-800-447-8632 | |
| HMO Blue<br>*Horizon Blue Cross Blue Shield of NJ* | 1-800-722-2583 | |
| Prudential Healthcare HMO | 1-800-422-7399 | |
| Aetna/U.S. Healthcare | 1-800-323-9930<br>1-888-277-8742 | Information<br>Enrollment<br>Packages |
| | **PIN Number in NJ:**<br>**PIN Number in NY & other states:** | **111**<br>**112** |

## Dental Coverage

| | |
|---|---|
| Prudential Dental | 1-800-772-4683 |
| Dentcare | 1-800-468-0600 |

**THE PORT AUTHORITY OF NY & NJ**

ONE WORLD TRADE CENTER
NEW YORK, NY 10048

(212) 435-7000
(973) 961-6600

October 18, 1999

Dear Port Authority Employee:

The Port Authority of New York & New Jersey is conducting the annual health and dental benefits Open Enrollment now through November 19, 1999 for all employees. The options you choose in this Open Enrollment are *effective January 1, 2000*. Attached are a brief overview of the health (Attachments I, II, III) and dental (Attachment IV) plans available to you, and 'Typical Questions and Answers' (Attachment V). I am pleased to announce the following benefit plan enhancement:

**United HealthCare PPO Plan**

- Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

After reading the attached material:

If you wish to REMAIN in your present coverage, DO NOTHING.

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If you are CHANGING health or dental coverage, please COMPLETE THE ATTACHED *BENEFIT SELECTION FORM*.

Please help us to get you enrolled properly by completing the *Benefit Selection Form* and returning it to Employee Benefits, 1WTC-61S no later than November 19, 1999. To avoid confusion and to ensure that the form is received by the due date, you can request that it be signed for upon receipt if sent through the internal PA mail. For outside delivery, you may want to request a return receipt.

If you have questions regarding a specific plan, please call the carrier directly (see Attachment VI). Employees with *general* questions can call Employee Benefits at (212) 435-6163. All coverage changes are *effective January 1, 2000* and remain in effect until the next open enrollment unless a change in family status occurs.

Sincerely,

Rosetta A. Jannotto
Manager, Employee Benefits
Human Resources Department

Attachments (represented employees)

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United HealthCare Preferred Provider Organization Plan (PPO) offers members complete freedom to use either a network provider or an out-of-network provider for medical and hospital care. Members who wish to use a network provider have a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, health care delivery resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reimbursement at reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- Unlimited Lifetime Major Medical Maximum.
- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Full range of medical services including specialist care and outpatient surgery.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United HealthCare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- A $5 co-payment if you use a United HealthCare network physician.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 (in addition to the deductible).

In addition, the United HealthCare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors who are able to answer your medical questions;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United HealthCare directly (1-888-441-9815).

## COST OF PLAN

Contributions for this plan are not required at this time.

**United HealthCare**
**Summary of Coverage**
**Port Authority of NY & NJ**

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK * ** |
|---|---|---|
| Deductible – Single | None | $50 |
| Family | None | $100 |
| Coinsurance | None | 20% |
| Maximum Out-of-Pocket per person | Not Applicable | $1,000 (excluding deductible) |
| **PREVENTIVE CARE** | | |
| Physical Examination | $5 copay per visit | No coverage |
| Routine Pediatric Care | 100% coverage | 100% of Reasonable & Customary |
| **OUTPATIENT CARE** | | |
| Physician Office Visits | $5 copay per visit | *Subject to Deductible & Coinsurance* |
| Surgery | 100% coverage | 100% of Reasonable & Customary |
| Laboratory Services | 100% coverage | 100% of Reasonable & Customary |
| **HOSPITAL CARE** | | |
| Semi-private room & board | 100% coverage | 120 days at 100% balance paid at 80% |
| **EMERGENCY CARE** | | |
| Ambulance Services when medically necessary | No charge | No charge |
| **AT HOSPITAL EMERGENCY ROOM** | | |
| Accident Care, Serious Illness | 100% coverage | 100% coverage |
| **MATERNITY CARE** | | |
| Prenatal & Post-natal care | $5 copay per visit | 100% of Reasonable & Customary |
| Hospital services for mother & child | 100% coverage | 100% - 120 day maximum balance at 80% per stay |
| **SHORT TERM REHABILITATION** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOME HEALTH CARE** | | |
| 60 visits in and out-of- network combined | $5 copay per visit | Subject to Deductible & Coinsurance |
| **SKILLED NURSING FACILITY** | | |
| 60 days per year combined in and out-of-network | 100% coverage | Subject to Deductible & Coinsurance |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Inpatient - 7 days detoxification, 30 days per Year, 2 confinements per lifetime | 100% coverage | 100% coverage |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Outpatient - 60 visits per year, 120 visits Per lifetime combined in and out-of- network | $5 copay per visit | Subject to Deductible & Coinsurance |
| **MENTAL HEALTH CARE** | | |
| Inpatient | 100% coverage | 100% 30 days per year balance paid at 80% |
| Outpatient | $10 copay per visit | Subject to Deductible & Coinsurance |
| **CHIROPRACTIC CARE** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOSPICE CARE** | | |
| 210 days maximum | 100% coverage | 100% coverage |
| **INFERTILITY TREATMENT** | | |
| 3 Attempt Combined Limit | $5 copay per visit | Subject to Deductible & Coinsurance |
| **OTHER COVERAGE** | | |
| Durable Medical Equipment | 100% coverage | Subject to Deductible & Coinsurance |

* All Benefits are subject to Reasonable & Customary.
** All benefits must meet medical necessity.

**This summary is not all inclusive. Please refer to your handbook which you will be receiving after enrollment.**

# TWU
# PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
# OVERVIEW

**THIS OPTION IS NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER MAY 1, 1999.**

The Prudential/Blue Cross Traditional Indemnity Plan is designed to provide broad financial protection against hospital, doctor and related medical expenses. This plan offers members complete freedom in choosing their health care providers and facilities. Hospitalization is provided through Empire Blue Cross and Surgical/Major Medical coverage is provided by Prudential Insurance Company of America. Members of this plan are subject to an annual deductible of $50 for individual and $100 for family coverage. Eligible Major Medical expenses are reimbursed through Prudential Insurance Company at 80% of Reasonable and Customary Charges up to a $1,000,000 lifetime maximum per covered individual.

A more detailed explanation of this plan follows. For specific claim information, please contact the insurance carrier directly (see attached telephone directory).

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## COST OF PLAN

Contributions for this plan are not required at this time.

## HOW TO ENROLL

To enroll in the Prudential/Blue Cross Traditional Indemnity Plan, complete the attached *Benefit Selection Form* and return it to the Employee Benefits Division, One WTC, 61 South, by November 19, 1999.

## PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
(Continued)

I. Plan provides basic coverage through Empire Blue Cross of Greater New York for:

A. Hospitalization
- 120 days paid at a semiprivate room rate for each period of confinement in a participating Blue Cross of Greater NY hospital.

B. Emergency Room Treatment (rendered in a participating Blue Cross of Greater N.Y. hospital by a salaried hospital staff member).
- Accidental Injury: within 72 hours of the injury
- Sudden and Serious: within 12 hours of the illness

II. Plan provides surgical/major medical coverage through The Prudential Insurance Company of America:

A. Surgical Procedures
- 100% reimbursement rate based on the reasonable and customary fee.

---

B. Major Medical Expenses
- 80% reimbursement rate based on the reasonable and customary fee for doctor visits, lab fees, and x-rays.
- The following primary and preventive care services are covered in full, for dependents from birth to age 19. That is, they are not subject to coinsurance or annual deductibles.
  - Initial hospital check-up for newborns.
  - Scheduled well-child visits.
  - Certain services at each well-child visit, such as physical examinations, developmental assessment and laboratory tests.
  - Appropriate immunizations including diphtheria, haemophilus, influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, and tetanus.
  - One preventive care visit every two years for children ages six up to their nineteenth birthday.
- Routine physical exams not covered.
- Vision and eye exams not covered.

C. Mental and Nervous Coverage

- Inpatient hospital benefits are reimbursed at 100% up to 30 days in any 12-month period in a participating accredited non-governmental hospital. Confinements in excess of 30 days are reimbursed at 80%. Confinements in a non-participating hospital are reimbursed at 80%. All confinements in a non-participating hospital and/or those reimbursed at 80% are subject to the plan maximum as stated above and must be deemed medically necessary.
- Outpatient services will be reimbursed at 80% of reasonable and customary charges.

D. Alcohol and Substance Abuse

| | |
|---|---|
| 1. Inpatient Alcohol: | 7 days detoxification reimbursed at 100%. 30 days inpatient rehabilitation reimbursed at 100%. One course of treatment in a 12-month period, twice per lifetime. |
| 2. Inpatient Substance Abuse: | 7 days detoxification and 30 days inpatient rehabilitation reimbursed at 100%, one course of treatment in 12-month period, twice per lifetime. |
| 3. Outpatient Rehabilitation: | 120 days per lifetime, combination of alcohol and substance abuse. 60-visit maximum per calendar year. Day 1-30 reimbursed at 100%, balance reimbursed at 80%. |

III. Group Health Deductibles/Maximums

A. Annual Deductibles
- Hospitalization - none
- Surgical - none
- Major Medical - $50 Individual/$100 Family

B. Major Medical Maximum - $1,000,000
- Lifetime Maximum (includes mental and nervous lifetime maximum).
- Each eligible dependent has their own major medical maximum.
- $5,000 cap - After the annual major medical deductible has been satisfied, an individual covered under the Major Medical Plan will be reimbursed at 80% of all reasonable and eligible medical expenses through the first of such expenses in a calendar year and, thereafter, for 100% of such expenses in the calendar year (dental claims not included).

Attachment III

# HEALTH MAINTENANCE ORGANIZATIONS (HMO) OVERVIEW

A Health Maintenance Organization (HMO) is a system of health care that provides managed, pre-paid hospital and medical services to its members. As an HMO member, all your care will be coordinated through a Primary Care Physician (PCP), who manages your health care needs. You can choose a physician from the HMO's provider directory that lists a network of doctors in your area. HMO members can receive health care at little or no out-of-pocket cost, provided they use network providers and facilities. There are no deductibles to meet or claim forms to file. In most HMOs, if a physician outside of the health plan is used without authorization from the HMO, the patient is responsible for all bills incurred.

The Port Authority offers the following HMOs:

- Health Insurance Plan of Greater New York (available to NY residents only);
- HMO Blue *Horizon Blue Cross Blue Shield of NJ* (available to NJ residents only);
- Prudential HealthCare HMO (available in CT, NJ, NY, and PA); and,
- Aetna US Healthcare (available in CT, NJ, NY, and PA).

A summary plan description is attached. For additional information please refer to the literature you may request by calling the specific carrier directly (see attached telephone directory).

## COST OF PLAN

Contributions for these plans are not required at this time.

## HOW TO ENROLL

To enroll in an HMO, complete the attached *Benefit Selection Form* and return it to the Employee Benefits Division, One WTC-61 South by November 19, 1999.

**Please Note:** An HMO will only allow you to enroll if they provide service to residents of your zip code. Please contact the carrier directly if you have any questions concerning service area (see attached telephone directory).

## HEALTH MAINTENANCE ORGANIZATION (HMO)
(Continued)

Plan provides basic/major medical coverage through the HMO of your choice. The available HMOs to choose from are:

- HIP New York
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*
- Prudential HealthCare HMO of New York, New Jersey, Pennsylvania and Connecticut
- Aetna US Healthcare of New York, New Jersey, Pennsylvania and Connecticut

Please note that if two Port Authority or PATH employees are married to each other, and they both choose the same HMO, they can only have one HMO contract which must cover both employees and all family members.

A. Hospitalization

Covered in full for unlimited number of days when approved by the HMO.

B. Emergency Room Treatment in the Hospital

Covered in full when service is approved and/or rendered by the HMO, subject to applicable co-payments as follows:

- HMO Blue *Horizon Blue Cross Blue Shield of NJ* has a $35 co-payment.
- Prudential HealthCare HMO has a $25 co-payment in New York and Connecticut and a $50 co-payment in New Jersey and Pennsylvania.
- Aetna US Healthcare has a $35 co-payment.

C. Surgical Procedures

Covered in full when approved by the HMO, including obstetrical care.

D. Major Medical Expenses

**Primary and Preventive Care:** covered in full subject to a $5 co-payment if you choose HMO Blue *Horizon Blue Cross Blue Shield of NJ*, Prudential HealthCare HMO or Aetna US Healthcare (except New Jersey*). HIP New York does not require a co-payment. Covers services such as routine illness and injury, physical exams, routine child care and well baby visits, immunizations (except those required for travel or work), gynecological exams and pap smears, x-rays, lab tests, routine mammograms.

***Note:** Under Aetna US Healthcare of New Jersey, primary care physician visits are covered in full subject to a $10 co-payment, specialty care office visits are covered in full subject to a $15 co-payment and preventive eye and gynecological exams are covered in full subject to a $15 co-payment.

## HEALTH MAINTENANCE ORGANIZATION (HMO)
(Continued)

**Hearing Exams:** Covered in full subject to the applicable co-payments as follows:

- HIP New York: no co-payment.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*: $5 co-payment.
- Prudential HealthCare HMO: $5 co-payment, but only available if the person is under age 18.
- Aetna US Healthcare: $5 co-payment.

**Vision Care:** Eye Exams covered in full subject to the applicable co-payment as follows:

- HIP New York: No co-payment.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*, Prudential HealthCare HMO and Aetna US Healthcare (except New Jersey): $5 co-payment.
- Aetna US Healthcare - New Jersey: $15 co-payment.

---

**Eye Glasses and Contact Lenses:** Covered as follows:

- HIP New York: Not available.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*: $50 reimbursement per 24 month period.
- Prudential HealthCare HMO: New Jersey only - available at discount rates in plan affiliated optical shops.
- Aetna US Healthcare: $35 reimbursement per 24 month period.

**Preventive Dental:** Covered as follows:

- HIP New York: Preventive and diagnostic services provided by a HIP New York participating dentist. There is a $5 co-payment for services. Each family member receives two exams (including 2 bitewing x-rays) every 6 months, and one application of fluoride per year for all children up to and including age 15 free of cost. There is a $5 co-payment for one cleaning per calendar year.
- Prudential HealthCare HMO: Not available.
- Aetna US Healthcare: Children through age 12 can visit a participating dentist for 2 routine exams per year. This includes an exam and cleaning, polishing and fluoride treatment. There is a $5 co-payment per visit.

## HMO HEALTH PLAN OPTIONS
(Continued)

E. Mental and Nervous Benefit Comparison

| | Inpatient | Outpatient |
|---|---|---|
| HIP of New York | Up to 30 days per year (combined with alcohol and drug services) paid in full. | Short term outpatient therapy. Paid in full |
| HMO Blue* (New Jersey) | 30 days per year paid in full. | 100% after a $25 copayment per visit with a limit of 20 days per year. |
| Prudential HMO (New York) | Up to 30 days per year paid in full. | Reimburses 70% with a 20 visit limit per year. |
| Prudential HMO (New Jersey) | Up to 30 days per year paid in full. | 100% after a $5 copayment per visit with a limit of 20 visits per year. |
| Prudential HMO (Connecticut) | Up to 60 days per year paid in full. | 100% after a $5 copayment per visit with a limit of 20 visits per year. |
| Aetna/ US Healthcare (New York) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |
| Aetna/ US Healthcare (New Jersey) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |
| Aetna/ US Healthcare (Connecticut) | 60 days per year covered in full. | 40 visits per year with $25 copayment per visit. |
| Aetna/ US Healthcare (Pennsylvania) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |

* Combined with Mental and Nervous benefit.

## HMO HEALTH PLAN OPTIONS
(Continued)

F. Alcohol and Substance Abuse Benefit Comparison

| | Inpatient Benefits | Outpatient Benefits |
|---|---|---|
| HIP/NY | Detoxification – Up to 30 days per year, covered In full. (Combined with inpatient mental and Nervous coverage)<br>Rehabilitation – Up to 30 days for alcoholism And/or drug abuse, covered in full. | Up to 60 visits per year for alcohol and drug rehabilitation. Covered in full. |
| HMO Blue *<br>(New Jersey) | Detoxification – Covered in full<br>Rehabilitation – Covered in full (combined 30 day limit) | After a $25 copayment, covered in full with a limit of 20 visits per year. |
| Prudential HMO<br>(New York) | Detoxification – Covered in full<br>Rehabilitation – Covered in full if medically Necessary. | After $5 copayment, covered in full up to 90 days per year for rehabilitative services. 20 family member out patient visits per year. |
| Prudential HMO<br>(New Jersey) | Detoxification – Covered in full<br>Rehabilitation – Covered in full up to 90 days per year if medically necessary. The 90-day limit is combined for in and out patient services. | After $5 copayment, covered in full if medically necessary. 90 day limit for rehabilitative services if medically necessary. The 90-day limit is combined for in and out patient services. |

* Combined with Mental and Nervous benefit.

## HMO HEALTH PLAN OPTIONS
(Continued)

F. Alcohol and Substance Abuse Benefit Comparison

| | Inpatient Benefits | Outpatient Benefits |
|---|---|---|
| Prudential HMO (Connecticut) | Detoxification – Covered in full<br>Rehabilitation – Covered in full if medically Necessary. | After $5 copayment per visit, covered in full up to 90 day for rehabilitative services if medically necessary. 20 family member visits per year. |
| Aetna/US Healthcare (New York) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – Not covered. | 60 visits per year with $5 copayment per visit. |
| Aetna/US Healthcare (New Jersey) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – Not covered. | Not Covered. |
| Aetna/US Healthcare (Connecticut) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – 45 days per year. | Not Covered. |
| Aetna/US Healthcare (Pennsylvania) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – 30 days per year, lifetime maximum 90 days. | 30 visits with $5 copayment and an additional 30 visits which may be exchanged for up to 15 inpatient days per year, lifetime maximum 120 visits. A 50% copayment of the costs of services applies to second and subsequent courses of treatment for residential care. |

Attachment IV

# DENTAL OPTIONS

## 1. PRUDENTIAL REASONABLE AND CUSTOMARY DENTAL PLAN

A. Dental Expenses
- 80% reimbursement rate based on reasonable and customary charges.
- Orthodontic expenses reimbursed under a fixed schedule of allowances only (will not be applicable toward your annual deductible as indicated below). One treatment per lifetime per eligible dependent under age 19.

B. Annual Dental Deductibles
- $50/Individual
- $100/Family

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## 2. PRUDENTIAL SCHEDULE OF ALLOWANCES DENTAL PLAN

A. Expenses are reimbursed under a fixed schedule of allowances (see attached).

B. This plan does not require a deductible.

## 3. DENTCARE DENTAL PLAN

- Generally no out of pocket expenses (call Dentcare for brochure and exceptions).
- Must go to a designated Dentcare dentist.
- Pre-certification needed from the Dentcare Program for all major dental work done by a Dentcare Dentist.
- No deductibles.

If two Port Authority and/or PATH employees are married to each other, and they both choose Dentcare, they can only have one Dentcare plan which must cover both employees and all family members.

Port Authority Group Dental Plan
Schedule of Allowances

## Part I — Basic Services

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Diagnostic and Preventive Services** | |
| 0110 | 1. Clinical oral examination* | $ 10.00 |
| 1110 | 2. Cleaning, scaling and polishing* | 15.00 |
| 1210 | 3. Fluoride treatment (up to age 19)* | 8.00 |
| | 4. X-RAYS — individual total not to exceed the allowance for full-mouth series | |
| 0210 | (a) Full mouth or Panorex (at least 10 times)** | 15.00 |
| 0270 | (b) Bitewing, each | 3.00 |
| 0200 | (c) Periapical, single, each | 2.00 |
| 0240 | (d) Intra-oral occlusal (edentulous jaw), each | 7.00 |
| 0321 | (e) Temporo-mandibular joint film | 15.00 |
| 0340 | (f) Anterior/posterior; head and jaws | 15.00 |
| 0290 | (g) Lateral, head and jaws | 15.00 |
| | *Not more than twice annually | |
| | **Not more than once in three years | |
| | **Palliative Services** | |
| 9110 | Emergency treatment for relief of pain | 7.00 |
| | **Restorative Services** | |
| | 1. FILLINGS | |
| | Silver Fillings | |
| 2140 | (a) One surface | 12.00 |
| 2150 | (b) Two surfaces | 18.00 |
| 2160 | (c) Three or more surfaces | 27.00 |
| | Tooth Color Fillings | |
| 2330 | (d) Per filling | 12.00 |
| | 2. STAINLESS STEEL CROWN | |
| 2830 | each (up to age 19) | 25.00 |
| | **Oral Surgery (including X-rays, anesthesia and post-operative treatment)** | |
| | 1. EXTRACTIONS | |
| 7110 | (a) Routine or simple and surgical | 10.00 |
| 7220 | (b) Soft tissue impaction | 25.00 |
| 7235 | (c) Partial bony impaction | 40.00 |
| 7245 | (d) Complete bony impaction | 55.00 |
| | (e) Complex including bone removal and sutures | 30.00 |
| | 2. FRACTURES | |
| 7620 | (a) Upper jaw, closed reduction | 200.00 |
| 7640 | (b) Lower jaw, closed reduction | 225.00 |
| 7610 | (c) Upper jaw, open reduction | 300.00 |
| 7630 | (d) Lower jaw, open reduction | 300.00 |
| | 3. OTHER ORAL SURGICAL PROCEDURES | |
| 7430 | (a) Removal of cysts, including necessary extractions | 35.00 |
| 7340 | (b) Alveolectomy, maximum per arch | 30.00 |
| 3410 | (c) Apicoectomy | 35.00 |
| 7285 | (d) Biopsy, including report | 25.00 |
| 7960 | (e) Removal of labial frenum | 40.00 |
| 7260 | (f) Closure of oral antral fistula | 90.00 |
| | **Root Canal Treatment (including X-rays and follow-up care)** | |
| 3315 | 1. Filling one canal | 75.00 |
| 3325 | 2. Filling two canals | 100.00 |
| 3335 | 3. Filling three canals | 130.00 |
| | **Space Maintainers, simple (up to age 19)** | |
| 1510 | Any type | 50.00 |
| | **Periodontic Services (treatment of gums and associated tissues)** | |
| | 1. Periodontal root scaling and planing, including medications | |
| 4341 | (a) Fewer than 12 teeth per sitting | 15.00 |
| 4340 | (b) Per arch | 22.00 |
| 4210 | 2. Gum or bone surgery, including post-operative visits, (per quadrant) | 90.00 |
| 4220 | 3. Subgingival curettage | 10.00 |

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Repair of Dentures and Bridges** | |
| | 1. Broken full or partial denture | |
| 5610 | (a) No tooth damage | $ 20.00 |
| 5620 | (b) Replace one tooth | 30.00 |
| 5630 | (c) Each additional tooth | 7.00 |
| | 2. Replace broken teeth only | |
| 5630 | (a) First tooth | 20.00 |
| 5640 | (b) Each additional | 7.00 |
| 5670 | 3. Reattaching undamaged clasp | 20.00 |
| 5680 | 4. Replacing broken clasp with new clasp | 45.00 |
| 5650 | 5. Adding tooth to partial denture to replace natural extracted tooth, each tooth | 35.00 |
| 5725 | 6. Rebasing upper or lower full or partial denture | 50.00 |
| 2920 | 7. Recement crowns and inlays | 6.00 |
| 6640 | 8. Repair broken facing | 15.00 |

## Part II — Major Services

| | | |
|---|---|---|
| | **Inlays, Gold** | |
| 2510 | 1. One surface | 50.00 |
| 2520 | 2. Two surfaces | 80.00 |
| 2530 | 3. Three or more surfaces, maximum per tooth | 90.00 |
| | **Dentures, Full (including supplying, inserting, fitting and adjustments)** | |
| 5110 | 1. Upper, once in five years | 175.00 |
| 5120 | 2. Lower, once in five years | 175.00 |
| | **Dentures, Partial** | |
| 5220 | 1. Bilateral acrylic or comparable base, either jaw, two or more full clasps and rests, each | 170.00 |
| 5250 | 2. Upper bilateral, chrome cobalt alloy or gold base, two or more clasps and rests, acrylic attachments, each | 200.00 |
| 5230 | 3. Lower, bilateral chrome cobalt alloy or gold base, two or more cast clasps and tests, acrylic attachments, each | 200.00 |
| | **Crowns and Bridgework** | |
| | 1. Bridgework, Removable (one piece casing with clasps and rests) | |
| 5280 | (a) One tooth replaced | 100.00 |
| 5280 | (b) Two teeth replaced | 110.00 |
| | 2. Bridgework, Fixed (single abutments only) | |
| 6780 | (a) 3/4 crown | 85.00 |
| 6790 | (b) Full cast crown | 110.00 |
| 6720 | (c) Full cast with veneer | 140.00 |
| | 3. Pontics | |
| 6230 | (a) Tru-pontic (porcelain or acrylic facing with cast backing) | 95.00 |
| 6210 | (b) Pontic of other type | 85.00 |
| | 4. Crowns | |
| 2740 | (a) Porcelain jacket | 150.00 |
| 2710 | (b) Acrylic jacket | 115.00 |

## Part III — Orthodontic Services

8410 Initial appliance, X-rays, diagnosis, study models, etc. Maximum — $150

Active treatment $35 per month. Not to exceed $840.00

Passive treatment, per 6 month period — $15. Maximum of 3 periods, Total — $45.

Total benefits available ..... $1035 per course of treatment

*Note: If a charge is incurred for a service not included in the Schedule, in connection with the dental care of a specific condition, and if the Schedule contains one or more services which, according to customary dental practices, are separately suitable for the dental care of that condition, then a charge for the least expensive of the suitable services included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.*

Attachment V

# TYPICAL QUESTIONS AND ANSWERS

## 1. HOW DO I CHANGE MY COVERAGE?

If you wish to change your current coverage, please complete the attached *Benefit Selection Form* and return it to Employee Benefits, One WTC-61 South by **Friday, November 19, 1999**. To allow enough time to process your change with the carrier, forms must be received by November 19, 1999.

## 2. WHEN WILL MY NEW COVERAGE BEGIN?

Your new coverage will begin on **January 1, 2000**. All changes in health/dental coverage will be considered final and will remain in effect until the next open enrollment period.

## 3. WHAT IF I DON'T WANT TO CHANGE MY CURRENT COVERAGE?

You will automatically be continued in your present plans if no *Benefit Selection Form* is received.

## 4. HOW CAN I FIND OUT WHAT MY CURRENT COVERAGE IS?

If you are not sure which plan you are enrolled in, call Employee Benefits at (212) 435-6163.

## 5. DID THE TAKEOVER OF PRUDENTIAL HEALTHCARE BY AETNA RESULT IN ANY CHANGES?

While it may not result in changes to the level of benefits currently offered by Prudential, it may affect the level of service.

## 6. WHAT IS A PPO?

A PPO (Preferred Provider Organization) offers the best features of both a traditional indemnity plan and managed care by giving members the freedom to use any provider, either in-network or out-of-network, for medical and hospital care without requiring a referral from a primary care physician to use a specialist.

## 7. WHAT IS A NETWORK PROVIDER?

A network provider is one who participates in a network and has agreed to charge preferred rates for members who seek care. The network includes a broad range of providers including Family Practitioners, Internists, Pediatricians, Neurologists, Oncologists and OB/GYNs. Additionally, the network includes labs, X-ray facilities and mental health providers. Again, you are not restricted to only use network providers.

## 8. WHAT IS THE DIFFERENCE BETWEEN PPO AND HMO PLANS?

The difference is that the PPO is <u>not</u> a managed care plan. You are not required to choose a Primary Care Physician and you will be reimbursed if you use an out-of-network physician under a PPO plan. This allows you and your family direct access to all specialists.

## 9. HOW DO I FIND OUT IF MY DOCTOR IS A MEMBER OF THE UNITED HEALTHCARE PPO NETWORK?

- Check the Provider Directory available directly from United HealthCare;
- Call United HealthCare Member Services at 1-888-441-9815 (select the option to speak with a customer services representative) or call your doctor and ask;
- Check the Internet (www.unitedhealthcare.com). This will also give you directions and an easy to read color map showing the provider's location;

## 10. WHAT IF MY DOCTOR IS NOT A MEMBER OF THE UNITED HEALTHCARE NETWORK?

If you wish to encourage your doctor to join the United HealthCare network, simply have your doctor call United HealthCare Network/Provider Services at 1-800-638-8075 to obtain an application. Due to the thorough credentialing process, in which United checks or verifies board certification, training and education, hospital affiliation and malpractice status, the process can take up to 180 days. However, you can still go to your doctor as an out-of-network provider and be reimbursed at 80% of reasonable and customary charges.

## 11. HOW DO I GET UNITED HEALTHCARE OUT-OF-NETWORK CLAIM FORMS?

Your department can obtain claim forms through Corporate Express or you can call United HealthCare. Claim forms are also included with United's reimbursement materials.

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## 12. WILL I BE REQUIRED TO CONTRIBUTE FOR MY HEALTH AND/OR DENTAL COVERAGE?

There are no employee contributions necessary for coverage through United HealthCare, any of the HMO's or any of the dental options at this time. Employees who choose or remain in the Prudential/Blue Cross Traditional Indemnity Plan, and are currently contributing to their health coverage, can refer to the Prudential/Blue Cross Traditional Indemnity Plan Overview section of this package for biweekly pre-tax or post-tax contribution rates.

## 13. HOW DOES PRE- AND POST-TAX WORK?

Employees required to contribute to the cost of their health coverage can elect to have these contributions taken out on pre-tax basis by completing the Compensation Reduction Agreement section on the attached *Benefit Selection Form*. Contributions on a pre-tax basis result in a lower taxable income so you pay less Federal Income Tax and less NY State Income Tax. (NJ taxable income is not affected.) If you are currently having deductions taken out on a pre-tax basis and wish to continue doing so, you do not need to complete a new *Benefit Selection Form*.

## 14. HOW DOES PRE- AND POST-TAX AFFECT RETIREMENT?

Your full gross salary is reported to the New York State & Local Employees Retirement System regardless of whether you select pre- or post-tax contributions.

## 15. IF I SWITCH OUT OF THE PRUDENTIAL TRADITIONAL INDEMNITY PLAN, WHEN WILL MY EMPLOYEE CONTRIBUTION STOP?

The last deduction from your paycheck will be on January 22, 2000 (which, due to the retrospective payroll, covers the December 26, 1999 to January 8th period).

## 16. HOW WILL MY PRESCRIPTIONS BE FILLED?

National Prescription Administrators, Inc. (NPA) provides your prescription benefit regardless of the health plan selected. The cost of each prescription is either $2 for generic brand drugs or $5 for name brand. For specific information or questions, please contact NPA directly at 1-800-467-2006.

**Important Note:** CWA 1032 employees who choose or remain in the United HealthCare PPO plan will have the NPA prescription plan. However, if you chose the Prudential Traditional Indemnity Plan or any of the HMO's, your prescription benefit will be provided by that specific carrier.

## 17. WILL MY DENTAL INSURANCE PLAN CHANGE IF I SWITCH HEALTH PLANS?

No. Your dental plan will remain the same unless you choose one of the other dental options available to you on the *Benefits Selection Form*.

## 18. ARE PRE-EXISTING CONDITIONS COVERED?

Yes. There is no pre-existing condition limitation under any of the current healthcare coverage plans.

## 19. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED HEALTHCARE'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

## 20. WHO IS AN ELIGIBLE DEPENDENT?

For this purpose, eligible dependents are defined as an employee's spouse or dependent children. Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage can extend through the end of the calendar year in which the child turns age 26 provided the child is unmarried, in full-time attendance at an accredited educational institution, and dependent on the employee for support. However, your health carriers will require you to provide verification of your child's full-time student status. Domestic partners, parents and grandchildren are not considered eligible for this purpose.

## 21. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing the enclosed *Benefit Selection Form* and returning it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable documentation (i.e. state marriage certificate, divorce decree, birth certificate for children, etc.) in order for the change to be made. Failure to notify Employee Benefits within the required time frame will result in having your request denied by the insurance carrier, and you will not be permitted to add your dependents(s) to your plan coverage until the next open enrollment period.

## 22. WHAT IS A CHANGE IN FAMILY STATUS?

For this purpose, a change in status includes the marriage or divorce of the employee, death of the employee's spouse or dependent children, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, switching from part-time to full-time employment status (or vice versa) by the employee or the employee's spouse, taking of an unpaid leave

of absence by the employee or the employee's spouse, or a significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment.

## 23. HOW DO I CHANGE MY DENTCARE DENTIST, HIP CENTER, PRIMARY CARE PHYSICIAN OR PHARMACY?

Please contact your health and/or dental carriers directly for instructions.

## 24. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a Provider Directory by contacting the specific carrier directly. A list of telephone numbers is attached to this package.

## 25. CAN I WAIVE MY RIGHT TO GROUP HEALTH AND/OR DENTAL BENEFITS?

Yes, provided you are covered by other insurance, such as a spouse's plan. Should you choose to waive your right to coverage, you must complete the Benefits Waiver Section on the attached *Benefit Selection Form* and provide proof of coverage by another carrier. However, you should note that if you waive your health benefits you must also waive your dental benefits and vice versa.

## 26. IF I WAIVE COVERAGE NOW, WILL I BE ABLE TO OBTAIN COVERAGE LATER ?

Yes, provided that a change in family status has occurred within the past thirty (30) days. Otherwise, you will not be permitted to enroll until the next open enrollment period.

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## 27. WHO DO I CALL WITH GENERAL QUESTIONS?

You can call Employee Benefits at 212-435-6163.

Attachment VI

# TELEPHONE DIRECTORY

## Health Coverage

| | | |
|---|---|---|
| United HealthCare | 1-888-441-9815 | |
| Prudential Indemnity Plan | 1-800-772-4683 | |
| Empire Blue Cross Blue Shield | 1-800-662-5193 | |
| HIP New York | 1-800-447-8632 | |
| HMO Blue | 1-800-722-2583 | |
| *Horizon Blue Cross Blue Shield of NJ* | | |
| Prudential Healthcare HMO | 1-800-422-7399 | |
| Aetna/U.S. Healthcare | 1-800-323-9930<br>1-888-277-8742 | Information<br>Enrollment<br>Packages |
| | **PIN Number in NJ:** | **111** |
| | **PIN Number in NY & other states:** | **112** |

## Dental Coverage

| | |
|---|---|
| Prudential Dental | 1-800-772-4683 |
| Dentcare | 1-800-468-0600 |

Cherkis, Randy

From: HR Broadcast
Sent: Friday, June 12, 2009 3:25 PM
Subject: Cost Containment

**THE PORT AUTHORITY OF NEW YORK AND NEW JERSEY**
**PORT AUTHORITY NEWS BULLETIN**

**Chief Administrative Office**
**Bulletin #09-02**

June 12, 2009

Dear Colleague:

Hardly a day goes by without news on the economic crisis, rising health care costs, the aging population, a decreasing Medicare Trust Fund, or the need to provide health care coverage to 45 million uninsured Americans.

The Congressional Budget Office estimates that health care spending this year alone will reach $2.6 trillion and account for 18 percent of the nation's economy.

As President Obama and Congress address these challenges we face as a nation, it is important for us within the Port Authority to carefully consider what each of us can do individually to ensure our benefit programs' continued value and preservation.

It is the responsibility of every person who participates in these programs to do their part in helping to oversee the cost of our benefits. In this regard, there are several things you may be able to do to partner with us in this effort. You can:

- Make certain all of your personal information within the Port Authority is updated and accurate. For example, notify us immediately if one of your dependents becomes ineligible for Port Authority benefits, for example, through divorce or graduation.

- Consider using a generic substitution instead of a brand-name prescription drug if your provider believes it is therapeutically equivalent. Alternatively, for drugs you need to take on an on-going basis, you may be able to have up to a 3-month supply of your prescription drug delivered right to your home by using the mail order program.

- Stay healthy. The advantages and lower health care costs associated with individuals who quit smoking, eat right, exercise regularly and maintain a healthy weight are well documented. Healthy individuals also experience less stress and have fewer sick days.

- Listen to your doctor. Take charge of your health. Make sure to ask questions and fully understand and be comfortable with services being provided to you.

- Carefully review your doctor/hospital bills and your explanation of benefits (EOBs) from our health and dental carriers to make sure they are an accurate accounting of the services you received and paid

for where appropriate.

Health care is a complex industry and administrative errors do occur from time to time. So to borrow a phrase: If you see something…say something!

Thank you for your efforts.

//Original Signed By//

Louis J. LaCapra
Chief Administrative Officer

THE PORT AUTHORITY OF NY & NJ

December 9, 2009

Dear Colleague:

In June 2009, the Chief Administrative Officer wrote to all employees and retirees regarding the need for everyone to do their part in overseeing the cost of their benefits. As we face unprecedented economic challenges, we continue to stress the need for your partnership to make certain all your personal information affecting payment of benefits is current. More specifically, be sure there is an accurate record of those family members eligible for coverage as the Port Authority cannot provide benefits for ineligible persons.

If you experience a family status change, such as a change in marital status or a child that is no longer eligible for our benefits (as described in the enclosed dependent eligibility rules), it is your responsibility to notify Employee Benefits immediately, so that we can discontinue health and dental benefit coverage for all ineligible dependents based upon the specific date they are no longer eligible to participate in our plans.

Two attachments are enclosed for your review and reference. They include explanations on employee and dependent eligibility for benefits, and an Employee Status Change Form - PA 2298 (also available on the eNet) that you need to complete and forward to the Employee Benefits Division if you have experienced a change, or there is a change in the future. If no changes are being made, no action is required at this time.

Beginning January 1, 2010, notifications to Employee Benefits of ineligible dependent coverage that are not received on a timely basis may result in the employee being financially and legally responsible for all claims incurred by those ineligible dependents. Therefore, it is of the utmost importance for you to carefully review all of your personal information, and make any necessary changes before the end of 2009.

Shortly after January 1, 2010, we will also be initiating a Dependent Eligibility Audit. This process is designed to verify the eligibility status of each and every dependent. This is a common practice undertaken by private/public employers and state agencies that provide health benefit plans. This process is the most reliable way for us to ensure the information we have on file is accurate.

The audit will also serve to compile information we require to comply with federal requirements outlined in Section 111 - Medicare Secondary Payer Mandatory Reporting Act. This Act requires health plan sponsors to report Social Security number information on dependents to the federal government.

We will be sending out additional and detailed information regarding this audit over the next several months. Please make certain to review these details, as your participation in this process is required in order to ensure the continued coverage of the dependents you have enrolled under your medical and dental plans.

THE PORT AUTHORITY OF NY & NJ

# EMPLOYEE PERSONAL STATUS CHANGE

PA 2298 (8/06)

**INSTRUCTIONS:** Use this form (PA 2298) for name changes, marital status change and dependent additions/deletions. For home address and telephone changes, submit form PA 3614 to your department administrator.

Name change, marital status and addition/deletion of dependents require a copy of any applicable documentation (i.e. state marriage certificate, divorce decree, birth certificate, etc.). Such documentation must be attached to this form for the requested change to be considered. Forms submitted without proper documentation will be returned unprocessed. Any questions, please call (212) 435-2870.

Return this form to: The Port Authority of NY & NJ, Employee Benefits, 225 Park Ave. South, 10th Floor, New York, NY 10003 or fax it to (212) 435-2871

This Form must be signed and dated before it can be processed.

**You will receive an approved copy of this Form (PA 2298) when changes have been completed.**

| Last Name (as currently on file) | First Name | M.I. | Employee No. |
|---|---|---|---|
| CHECK ONE: ☐ Active Employee ☐ Retired Employee | Social Security No. | Home Telephone No. | Work Telephone No. |
| Department | Title | Work Location/Zip | |

CHECK APPROPRIATE BOX

My spouse is a ☐ PA or ☐ PATH employee (Furnish Name & Employee No. below) ☐ My spouse is not a PA or PATH employee

Name: Employee No.:

*COMPLETE ONLY THOSE SECTIONS IN WHICH A CHANGE IS TO BE DONE*

| Name Change From *Last Name, Fist Name, M.I.* | Name Change To *Last Name, First Name, M.I.* |
|---|---|
| Reason for Name Change (e.g.: married, divorced, etc.) | Date of Event |

**Marital Status Change** ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated Date of Event

**GROUP HEALTH AND DENTAL COVERAGE:** I wish to Add/Delete the following from my Group Health/Dental Coverage. Please indicate below for each dependent whether you are ADDING or DELETING.

| FULL NAME | Relationship | Date of Birth | Add or Delete | Reason | Date of Event | Benefits Use Only |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

*(Attach sheet to list additional dependents if necessary)*

Employee Signature Date

**BENEFICIARY CHANGES** - To change life insurance or retirement beneficiaries contact:

**Prudential Insurance Company** (800) 778-3827 or visit the HRD/Employee Benefits Enet website for life insurance beneficiary change form.

**New York State and Local Retirement System** (866) 805-0990 or visit www.osc.state.ny.us for beneficiary change form.

**Railroad Retirement** (973) 645-3990 or visit www.rrb.gov for beneficiary change form.

**(FOR BENEFITS UNIT USE ONLY)**

☐ Your PA 2298 has been processed.

☐ Your PA 2298 is incomplete. The following information and/or documentation (submit copies only) is required.

☐ Birth Certificate or Baptismal papers for (showing employee as parent)

☐ Custody or Adoption papers for ☐ Divorce Decree for

☐ I.R.S. 1040 for calendar year (which shows financial responsibility for step-children) ☐ Other

☐ Marriage Certificate for ☐ For

Processed by Telephone Date

THE PORT AUTHORITY OF NY & NJ

March 19, 2010

Dear Colleague:

In December, we wrote to all employees and retirees advising them of our plans to conduct a dependent eligibility audit in 2010.

In preparation of this audit, we asked for you to ensure that there is an accurate record of those family members eligible for Port Authority benefits coverage, as we cannot provide benefits for ineligible persons.

The purpose of this letter is to advise you that we will begin conducting this audit within the next 3-4 weeks, and wanted to provide you with ample time and information so that you will be well prepared to provide all documentation required in a timely manner.

**What to expect**

To assist the Port Authority with this effort, we have retained Aon Consulting, a benefits consulting firm with strong technical expertise and experience in the area of dependent eligibility audits, and most importantly a successful track record in the safe and secure handling of confidential personal information. In fact, Aon is conducting the State of New Jersey's dependent eligibility audit.

Aon will be sending you a package of materials that you must read and respond to by a specified date. The company will request that you sign, date and return an affidavit, confirming a pre-populated listing of family members you currently have on file as covered dependents as well as provide supporting documentation. This means you must provide copies of documents such as marriage certificates, birth certificates, specified pages from recent federal tax returns, verification of attendance/enrollment or documentation of full-time student status, as well as Social Security numbers. Social Security numbers are requested because of new federal legislation requiring all dependents with benefit coverage to have Social Security numbers on file. You will be asked to provide documentation for every covered dependent, regardless of your hire or retirement date. A dependent's status is always subject to change, therefore we require all employees (even the recently hired) to respond to the audit.

You will have the option of submitting this supporting documentation through the US Postal Service (Aon will provide a postage paid envelope) or by uploading electronic file copies of your documents via a dedicated and secure website. Attached for your review and reference is a list that defines eligible dependents and a description of the documentation required for each type of dependent, as well as questions and answers about the audit.

**Support services**

Aon will provide you with access to a dedicated customer service telephone number that will be staffed Monday through Friday between 8:00A.M. – 6:00P.M. with trained professionals to assist you with all of your questions and information submission needs.

In addition, Aon can also assist you in submitting documentation through its secure website and completing the entire process online.

**How to best prepare for this audit**

Review the attached eligibility definitions and the corresponding documentation requirements. Make sure you have the requested documentation available. **Do not submit original documents.** You should submit copies only.

If you do not have the required documents, we are providing you with sufficient time to locate the documents necessary to verify your dependents' eligibility. We have also included suggested websites where you may obtain copies of documents that you need. You should allow several weeks for the receipt of these documents.

Please be advised that if you fail to respond to Aon's request for documentation in the timeframe noted, your dependents' benefits could be disrupted. It is therefore important you begin to collect necessary documents in advance.

As mentioned in previous communications, the Port Authority requires each of us to do our part in overseeing the cost of our benefits. If you have any questions before the audit begins, you are welcome to contact Employee Benefits at (212) 435-2870.

Thank you for your support in this important effort.

Randy Cherkis
Manager, Employee Benefits

# Frequently Asked Questions

**Q: Why are you asking me to verify my dependents?**

A: We need to confirm that there is an accurate record of those family members eligible for coverage, as the Port Authority cannot provide benefits for ineligible persons. We realize that, in the majority of situations, the ineligible dependent remains covered due to an oversight. For example, you may not have updated your benefit information following a divorce, or you may have a child who was previously eligible as a college student and has now graduated. Regardless of the circumstances, we are conducting a Dependent Eligibility Verification Audit to bring our dependent information up to date and monitor it going forward.

**Q: Why are you specifically asking me for social security numbers of my dependent children?**

A: We are required by Law: Section 111 – Medicare Secondary Payer Mandatory Reporting Act, to have a Social Security Number (SSN) on file for all dependents who are covered under the plan (including children). In order to comply with this legislation, we will be collecting this information during the audit.

**Q: Which dependent types must be verified?**

A: The eligibility of all covered dependents must be verified in order for their coverage to continue.

**Q: Who is Aon?**

A: Aon is a benefits consulting firm with strong expertise in the area of dependent eligibility verification audits. Aon employees working on the audit are well trained and have a successful track record in the safe and secure handling of confidential personal information. Aon is conducting the dependent eligibility verification audit for the State of New Jersey.

**Q: What type of resources will be made available to assist employees with questions?**

A: Aon will mail you a package of information instructing you how to complete and submit your materials and personal information via United States Postal Service, or how to upload your documents electronically to a secure website. The package of materials will contain a toll free telephone number you may call Monday through Friday, between 8:00A.M. – 6:00P.M. Trained service professionals will be available to assist you with all of your questions and information submission needs.

**Q: How do I obtain the required documentation if I do not have materials or have lost them?**

A: If you do not currently have a copy of your 2008 or 2009 tax return, you may go to http://www.irs.gov/taxtopics/tc156.html and follow the instructions on how to request a copy from the Internal Revenue Service. You may also contact the IRS at 1-800-829-1040.

To obtain a copy of a birth or marriage certificate, you may contact the local courthouse in the county in which the event took place to request a copy. You may also be able to request copies of these documents by going to www.vitalchek.com or www.vitalrec.com or www.cdc.gov/nchs/w2w.htm.

For full-time student verification, you will need to contact your child's school to obtain the child's Verification of Attendance/Enrollment. You may also be able to retain these records by going to www.degreeverify.org or www.studentclearinghouse.org.

**Q: What information must be provided on birth or marriage certificates in order for them to be considered acceptable?**

A: Marriage certificates should include both bride and groom's names as well as the date of marriage. The copy must include a valid signature of authenticity or seal proving that the marriage has been recorded. Official birth certificates should include the child's full name and date of birth as well as the name of the employee or employee's spouse listed as the parent.

**Q: Do I still need to participate in the Dependent Eligibility Verification Audit if I was recently hired and/or just provided all of the same supporting documentation?**

A: Yes. All employees and retirees with dependents (and surviving dependent spouses along with their dependent children) must participate in the audit, regardless of when you were hired/retired, or when you may have recently updated your personal records.

**Q: What happens if I fail to respond to the Dependent Eligibility Verification Audit?**

A: Failure to respond to this audit in the requested timeframe could disrupt coverage for dependents.

**Q: What happens to my documents once I forward them for verification? What measures are in place to ensure the security of the documents?**

A: After hard copies of the documents are converted to an electronic format for storage and conversion is verified by Aon, the hard copies are destroyed. Accordingly, please do not submit original documents and keep copies of everything you send to Aon. Please be assured that only select personnel will have access to Aon's system and will be able to view your information.

**THE PORT AUTHORITY** OF NY & NJ

July 22, 2010

Dear Colleagues,

We have received numerous questions and concerns from Port Authority / PATH employees and retirees regarding how healthcare reform will affect Port Authority benefits.

As many of you are aware, earlier this year, President Obama signed into law the Patient Protection and Affordable Care Act ("PPAC Act") and related legislation. The new law is intended to make healthcare affordable for many Americans who currently lack coverage and will also affect healthcare access for individuals and families who lack employer-based health benefit coverage. As Port Authority and PATH employees/retirees, you and your eligible dependents have very comprehensive health benefits programs, which, in large part, already meet or exceed the requirements of the PPAC Act. While we believe that it is unlikely that the provisions of the PPAC Act will require significant changes to the current levels of benefits, as the specific regulations are written and phased in, you may see changes in emphasis to certain health benefits.

Applicable provisions of the law will become effective at various times during calendar years 2011 through 2018. In order to ensure that the Port Authority fully understands the complexities of the PPAC Act, I have assembled a steering committee made up of professional staff from Human Resources, Law, Labor, Finance and other relevant areas throughout the agency to assess how our health benefits plans will remain compliant with applicable federal laws.

In addition, the Human Resources Department will be conducting targeted focus groups to ensure that we address specific concerns and questions employees/retirees may have about our implementation of and compliance with the PPAC Act. It is important to us that we effectively communicate with you, our health plan participants, through all phases of the implementation.

Finally, the Port Authority maintains that its self-insured health benefits plan is a "grandfathered plan" within the meaning of the PPAC Act. The attached notice, which will be included in many of the benefits communications, which you will receive, provides required basic information concerning "grandfathered plans."

These are indeed times of great change for the healthcare industry as a whole. I believe that the Port Authority and PATH health benefit plans stand in good stead in relation to the goals of healthcare reform. Please be assured that the Human Resources Department will make every effort to communicate with you clearly and concisely as the Port Authority continues to comply with all requirements of applicable federal laws concerning your healthcare benefits.

Thank you in advance for your cooperation.

Sincerely,

Mary Lee Hannell

Mary Lee Hannell
Director, Human Resources Department

## GRANDFATHER STATUS DISCLOSURE UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Port Authority of New York and New Jersey and Port Authority Trans-Hudson Corporation believe each of their plans covered by the Patient Protection and Affordable Care Act (the "Affordable Care Act") is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and which might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

Employee Benefits Division
The Port Authority of New York and New Jersey
225 Park Avenue South, 10th Floor
New York, NY 10003
(212) 435-2870

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

**Note**: Certain consumer protections may not be applicable to retiree only plans or plans providing only dental or vision coverage.

July 2010

# Health Care Reform Communication Survey

As you may recall from recent communications, the Human Resources department is conducting a brief survey to assess your interests and preferences for receiving future communications on how changes in Health Care Reform will impact your benefits at the Port Authority / PATH.

Going forward, as the new Health Reform Law requires changes that may impact your Port Authority /PATH health benefits over the next several years, our goal is to provide you with information that is clear, meaningful and easily attainable. Within this regard, we ask that you participate in this short survey to help Human Resources gauge:

**1. Communication Methods - How you would prefer to receive communications on Health Care Reform?**

**2. Communication Topics - What Health Care Reform topic(s) - as it relates to Port Authority Benefits - would you like to learn more about in future communications?**

Please take a few minutes to respond to the questions as they will help to guide what and how we communicate to you in the future about Health Care Reform.

Responses will be studied in aggregate ONLY. Survey responses will not be integrated, analyzed, or reported in any way in which the confidentiality of the survey responses is compromised.

# Health Care Reform Communication Survey

## Communication Methods

**Please use the scale below to rate the USEFULNESS of following methods of communicating information on Health Care Reform.**

| | Not Useful at All | Slightly Useful | Somewhat Useful | Useful | Very Useful |
|---|---|---|---|---|---|
| E-mails sent to your work e-mail address | ○ | ○ | ○ | ○ | ○ |
| E-NET website | ○ | ○ | ○ | ○ | ○ |
| Hardcopy document attached to pay stub | ○ | ○ | ○ | ○ | ○ |
| Posting on bulletin boards at facilities | ○ | ○ | ○ | ○ | ○ |
| Port Authority News (weekly news letter) | ○ | ○ | ○ | ○ | ○ |
| PATH Notes | ○ | ○ | ○ | ○ | ○ |
| Letters mailed to your home address | ○ | ○ | ○ | ○ | ○ |
| Human Resources Department Facility Visits | ○ | ○ | ○ | ○ | ○ |

**How would you like to receive future communications on Health Care Reform?**
***(Please rank order the choices below with 1 being your top choice)***

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| E-mails sent to your work e-mail address | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| E-NET website | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Hardcopy document attached to pay stub | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Posting on bulletin boards at facilities | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Port Authority News (weekly news letter) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| PATH Notes | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Letters mailed to your home address | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Human Resources Department Facility Visits | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

Please use the space below to suggest any ADDITIONAL WAYS OF COMMUNICATING information about Health Care Reform in the future.

# Health Care Reform Communication Survey

## Communication Topics

Within the next month, you will be receiving additional comunications from Human Resources about how Health Care Reform will further impact your benefits. Information on preventative health care, for example, and other topics will be covered in these communications.

In addition to the topic presented above, what Health Care Reform topic(s) - as it relates to Port Authority Benefits - would you like to learn more about in future communications?

# Health Care Reform Communication Survey

## Demographics

Please take a moment to answer questions about yourself.

**Please select the option below that best describes your current employment status with the Port Authority / PATH.**

- ◯ Active Employee
- ◯ Retired Employee

**Please select the the option below that best describes the part of the organization that you currently work in. *(If retired please select the option based on the last position you held.)***

- ◯ Port Authority (including PAPD)
- ◯ Port Authority Trans Hudson (PATH)

**What is your age?**

- ◯ 25 and Under
- ◯ 26 - 30
- ◯ 31 - 35
- ◯ 36 - 40
- ◯ 41 - 45
- ◯ 46 - 50
- ◯ 51 - 55
- ◯ 56 - 60
- ◯ Over 60

Announcement of Adult Children Open Enrollment

**THE PORT AUTHORITY** OF NY & NJ

*Mary Lee Hannell*
*Director, Human Resources Department*

Dear Colleagues,

As I had mentioned in a July communication, the Human Resources Department considers it a priority to provide the Port Authority/PATH community with clear and concise information regarding the recent health care reform law, and how it may affect your Port Authority benefits.

One key change is that, effective January 1, 2011, dependent children can now be covered under your Port Authority benefits through the age of 26 regardless of whether they are a full-time student, married, or eligible for other employer coverage. Specific eligibility rules and documentation requirements will apply.

**We are conducting an open enrollment from November 8 through December 17, 2010.** During this period, you can apply to have non-covered dependent children who meet the above requirements enrolled in your Port Authority benefit plans. You will receive more details on the enrollment process shortly.

**Please note:** this is the first of several communications you will receive with the UNDERSTANDING HEALTHCARE REFORM FOR THE PORT AUTHORITY emblem (above). Communications bearing this emblem convey information related specifically to the impact health care reform has on your health care benefits.

In the coming days, we will also distribute a brief survey to assess your interests and preferences for receiving future communications from us regarding this matter. I thank you in advance for taking the time to complete the survey; in the past, such measures have proven effective to serve the Port Authority/PATH community.

In the meantime, if it applies to you, I urge you to take advantage of this new opportunity. **Again, the open enrollment period to extend benefits coverage to your dependents will run November 8 through December 17, 2010.** Expect to receive information related to additional changes in your health care benefits before the end of the year.

Sincerely,

Mary Lee Hannell
Director, Human Resources Department

*225 Park Avenue South, 10th Floor*
*New York, NY 10003*

**THE PORT AUTHORITY** OF NY & NJ

*Randy Cherkis*
*Manager, Employee Benefits*

November 3, 2010

Dear Employee/Retiree:

In response to the Patient Protection and Affordable Care Act ("PPAC") that was signed into law on March 23, 2010, and related legislation and regulations, the Port Authority/PATH will extend group health benefits* to your child(ren) between ages 19 and 26 who may have previously been ineligible for the coverage.

Under the new law effective January 1, 2011, we are required to provide benefits coverage for employees' children through age 26, regardless of whether a child is a full-time student, married, financially dependent upon parent(s), or eligible for other employer-provided coverage.

To comply with the law's new requirements, the Port Authority is conducting an open enrollment to allow employees/retirees to enroll their eligible child(ren) in the Port Authority/PATH benefit plans. If you enroll your eligible child(ren) during the open enrollment period, **November 8, 2010 to December 17, 2010,** their benefits coverage will be effective January 1, 2011.

Enclosed with this letter is a benefit election form and a chart that defines eligible children and the documentation required for their enrollment. Please see the table below, which will help you determine the action you need to take to ensure the prompt enrollment of your eligible child(ren) under our plans effective January 1, 2011:

| Scenario | Action Required |
|---|---|
| If your child age 19-26 was part of the Dependent Eligibility Verification Audit (DEVA) and you received a confirmation letter stating that your audit was successfully completed. | No action is required. |
| If your child age 19-26 was part of DEVA and deemed ineligible, but now qualifies for coverage effective January 1, 2011 per the new eligibility rules.<br><br>Or<br><br>If you have a child age 19-26 that has never been considered eligible, but now qualifies for coverage effective January 1, 2011 per the new eligibility rules. | Please submit a completed benefit election form and supporting documentation per the attached chart that defines eligible children and the documentation required for their enrollment. |

**THE PORT AUTHORITY** OF NY & NJ

The Employee Benefits Division must receive a completed benefit election form and supporting documentation by **December 17, 2010** *in order for coverage of your child(ren) to be effective January 1, 2011.*

Complete and mail the benefit election form along with the required supporting documentation in the enclosed envelope to:

The Port Authority of NY & NJ
Attention: Employee Benefits
225 Park Avenue South, 10th Floor
New York, NY 10003

Please note that the open enrollment period to enroll your eligible child(ren) age 19-26 applies to all employees/retirees of the Port Authority/PATH regardless of the Health Benefit Plans you may be enrolled in currently.

If you have any questions, you are welcome to contact Employee Benefits at (212) 435-2870.

Thank you.

Randy Cherkis
Manager, Employee Benefits

** Group Health Benefits include medical, prescription, vision, and dental with the exception of the Railroad Employees National Dental Plan (Aetna Dental plan).*

THE PORT AUTHORITY OF NEW YORK AND NEW JERSEY
EMPLOYEE BENEFITS DIVISION
GROUP HEALTH/DENTAL BENEFIT ELECTION FORM – CHILDREN 19 - 26 YRS OLD

*EMPLOYEE/SURVIVING DEPENDENT INFORMATION (PRINT OR TYPE)*

| Last Name, First Name, MI | Date of Birth | Telephone – Home | Telephone – Work |
|---|---|---|---|
| Home Address | Apt. No. | Employee Badge Number | Check One: ☐ Active Employee ☐ Retired Employee |
| City State | Zip Code | Marital status ( ) Single ( ) Married ( ) Divorced ( ) Legally Separated | |

By completing this election form, including the certification/authorization, I hereby request that The Port Authority of New York and New Jersey ("Port Authority") or Port Authority Trans-Hudson Corporation ("PATH") arrange for enrollment of the child(ren) between the ages of 19-26 listed below in the Port Authority or PATH group health/dental benefit plan in which I am enrolled because they are not currently enrolled under such plan. Please note that child(ren) who have access to other employer-sponsored health care coverage are not eligible for dental coverage alone through the Port Authority. If space is not sufficient, please attach a separate sheet.

| Last Name, First Name, MI | Relationship | Sex | Date of Birth | Social Security Number |
|---|---|---|---|---|
| | | ( ) M ( ) F | / / | |
| | | ( ) M ( ) F | / / | |
| | | ( ) M ( ) F | / / | |
| | | ( ) M ( ) F | / / | |
| | | ( ) M ( ) F | / / | |
| | | ( ) M ( ) F | / / | |

*BENEFIT ELECTION CERTIFICATION/AUTHORIZATION*

I hereby certify that the information and representations above are correct and I authorize the Port Authority to act on this election.

_____ Employee Signature _____/_____/_____ Date

**Please remember to submit the required supporting documentation per the attached chart that establishes your child's eligibility for enrollment in the Port Authority/PATH benefit plans.**

# Definitions and Required Documentation

| *Dependents | *Definitions | Documentation Required |
|---|---|---|
| **Children**<br>(Up to age 26) | An eligible employee's child from birth through the last day of the calendar year in which the child turns age 26, including: | |
| | • Biological Child(ren). | **Biological Child(ren)**<br>⇨ Photocopy of birth certificate showing employee's name.<br>**OR**<br>⇨ A copy of the top half of front page of the employee's 2009 federal tax return **indicating the employee/child relationship** (black out all financial information) and a copy of a government issued identification card showing the child's date of birth.<br>**OR**<br>⇨ The state affidavit of parentage or paternity (or like form) that acknowledge paternity of the child. The form must have some indication that it was filed with the state or with the court. A copy of a government issued identification card showing the child's date of birth must be included if the state affidavit does not provide the information. |
| | • Step Child(ren). | **Step Child(ren)**<br>⇨ Photocopy of birth certificate showing name of employee's spouse.<br>**AND**<br>⇨ Photocopy of marriage certificate identifying the employee and parent's name.<br>**AND**<br>⇨ Divorce decree if applicable.<br>**AND**<br>⇨ A copy of the top half of the front page of the employee's 2009 federal tax return **indicating the employee/child relationship** (black out all financial information). |

*Definitions may vary from the definitions contained in the Summary Plan Descriptions due to the PPAC Act.

# Definitions and Required Documentation

| | | |
|---|---|---|
| | • A legally adopted child, to include legal guardianship. | **Legally Adopted Child/Legal Guardianship**<br>⇨ Photocopy of birth certificate showing employee's name.<br>**OR**<br>⇨ A copy of the Final Court Order with presiding judge's signature and seal and a copy of a government issued identification card showing the child's date of birth.<br>**OR**<br>⇨ A copy of the Adoption Final Decree with presiding judge's signature and seal and a copy of a government issued identification card showing the child's date of birth. |
| | • The child of your domestic partner. | **Child of Your Domestic Partner**<br>⇨ Photocopy of birth certificate showing name of employee's partner.<br>**AND**<br>⇨ A copy of the top half of the front page of the employee's 2009 federal tax return **indicating the employee/child relationship** (black out all financial information). |

**NOTE**: Children between ages 19 and 26 who have access to other employer-sponsored health care coverage are not eligible for the Port Authority or PATH dental coverage alone.

*Definitions may vary from the definitions contained in the Summary Plan Descriptions due to the PPAC Act.

FROM_____

_____

_____

**THE PORT AUTHORITY** OF NY & NJ
ATTENTION: EMPLOYEE BENEFITS
225 PARK AVENUE SOUTH, 10TH FLOOR
NEW YORK, NY 10003

PLACE
STAMP
HERE

**THE PORT AUTHORITY** OF NY & NJ

November 24, 2010

Dear PATH Employee:

The Port Authority of New York & New Jersey is conducting a Biennial Dental Open Enrollment that, per your bargaining agreement, provides you with an opportunity to enroll in an alternative dental benefit program. The option you choose in the Open Enrollment will become effective **January 1, 2011**. During this open enrollment, you are eligible to switch from Empire Blue Cross Blue Shield Dental to Railroad Employees National Dental Plan (Aetna Dental). To assist you with your decision-making, we have enclosed the following:

- Empire Blue Cross Blue Shield Dental Overview
- Aetna Railroad Dental Booklet

If you elect to change your dental coverage, please complete and return the attached Benefit Election Form no later than **Wednesday, December 22, 2010** to:

The Port Authority of NY & NJ
225 Park Avenue South, 10th Floor
New York, NY 10003
Attention: Employee Benefits – DENTAL OPEN ENROLLMENT

If you want to continue with your current dental coverage, NO ACTION IS REQUIRED.

Please *do not* send in a Benefit Election Form to confirm your coverage. Your dental coverage will automatically continue in your present dental plan if we do not receive a Benefit Election Form by December 22, 2010.

If you are adding or dropping dependents during the year, an Employee Personal Status Change Form (PA 2298) is the correct form to use. *Please note that our insurance contracts require that employees who wish to add dependent(s) to their plan coverage must notify Employee Benefits within 30 days of the qualifying event (i.e. birth, marriage).* If you have not made these changes during the year and wish to add eligible dependent(s) to your group health/dental benefit plan effective January 1, 2011, please complete and return the attached Employee Personal Status Change Form (PA 2298) along with the required supporting documentation.

Any dental coverage changes you elect are effective **January 1, 2011** and remain in effect until the next Biennial Dental Open Enrollment. Please feel free to call Employee Benefits at (212) 435-2870 with questions.

Sincerely,

Randy Cherkis
Employee Benefits Manager

Attachments

# Definitions and Required Documentation

| *Dependents | *Definitions | Documentation Required |
|---|---|---|
| **Spouse** | The spouse of an employee, excluding:<br>• A spouse who is also covered as a PA/PATH employee with health benefits. | ⇨ A copy of the top half of the front page of the employee's 2009 federal tax return that **indicates current marital status** (black out all financial information).<br>**OR**<br>⇨ Photocopy of marriage certificate and proof of recent (within 90 days of this letter) joint ownership.<br>Joint ownership documentation can include:<br>• Mortgage statement<br>• Property tax document<br>• Rental/lease agreement<br>• Homeowners/renters insurance policy<br>• Credit card statement<br>• Loan obligation<br>• Bank account statement<br>**OR**<br>⇨ Print out of online marriage record (available in some states or counties) showing the names of the employee and spouse and their date of marriage and proof of recent (within 90 days of this letter) joint ownership.<br>**AND**<br>⇨ Photocopy of spouse's birth certificate or a copy of a government issued identification card showing the spouse's date of birth. |
| **Domestic Partner** | Domestic partners are defined, for this purpose, as two people of the same sex, both of whom are 18 years of age or older, neither of whom is related by blood, who have a close and committed personal relationship, who live together and have been living together on a continuous basis. | ⇨ Proof of recent (within 90 days of this letter) joint ownership that includes both partners' names received at the same address.<br>Joint ownership documentation can include:<br>• Mortgage statement<br>• Property tax document<br>• Rental/lease agreement<br>• Homeowners/renters insurance policy<br>• Credit card statement<br>• Loan obligation<br>• Bank account statement<br>**AND**<br>⇨ A photocopy of the Domestic Partner Certificate or a valid certification from another jurisdiction that recognizes same- |

*Definitions may vary from the definitions contained in the Summary Plan Descriptions due to the PPAC Act.

# Definitions and Required Documentation

| | | |
|---|---|---|
| | | sex civil unions.<br><br>**AND**<br><br>Photocopy of partner's birth certificate or a copy of a government issued identification card showing the partner's date of birth. |
| **Children**<br>(Up to age 26) | An eligible employee's child from birth through the last day of the calendar year in which the child turns age 26, including:<br><br>• Biological Child(ren). | **Biological Child(ren)**<br><br>⇨ Photocopy of birth certificate showing employee's name.<br><br>**OR**<br><br>⇨ A copy of the top half of front page of the employee's 2009 federal tax return **indicating the employee/child relationship** (black out all financial information) and a copy of a government issued identification card showing the child's date of birth.<br><br>**OR**<br><br>⇨ The state affidavit of parentage or paternity (or like form) that acknowledge paternity of the child. The form must have some indication that it was filed with the state or with the court. A copy of a government issued identification card showing the child's date of birth must be included if the state affidavit does not provide the information. |
| | • Step Child(ren). | **Step Child(ren)**<br><br>⇨ Photocopy of birth certificate showing name of employee's spouse.<br><br>**AND**<br><br>⇨ Photocopy of marriage certificate identifying the employee and parent's name.<br><br>**AND**<br><br>⇨ Divorce decree if applicable.<br><br>**AND**<br><br>⇨ A copy of the top half of the front page of the employee's 2009 federal tax return |

*Definitions may vary from the definitions contained in the Summary Plan Descriptions due to the PPAC Act.

# Definitions and Required Documentation

| | | |
|---|---|---|
| | | **indicating the employee/child relationship** (black out all financial information). |
| | • A legally adopted child, to include legal guardianship. | **Legally Adopted Child/Legal Guardianship**<br>⇨ Photocopy of birth certificate showing employee's name.<br>**OR**<br>⇨ A copy of the Final Court Order with presiding judge's signature and seal and a copy of a government issued identification card showing the child's date of birth.<br>**OR**<br>⇨ A copy of the Adoption Final Decree with presiding judge's signature and seal and a copy of a government issued identification card showing the child's date of birth. |
| | • The child of your domestic partner. | **Child of Your Domestic Partner**<br>⇨ Photocopy of birth certificate showing name of employee's partner.<br>**AND**<br>⇨ A copy of the top half of the front page of the employee's 2009 federal tax return **indicating the employee/child relationship** (black out all financial information). |
| **Dependent Children with Disabilities** (No age restriction) | Children with certain disabilities are included as eligible dependents regardless of age. Prior to becoming incapacitated the child must have been covered under the employee's health insurance while meeting the following conditions:<br>• The child is mentally or physically incapacitated, and<br>• The child is not capable of self-support, and<br>• The child depends on the qualified employee for support. | ⇨ Documentation for Children listed above.<br>**AND**<br>⇨ Legal documentation (e.g. court order) demonstrating employee's continued financial responsibility for the child or a copy of the top half of the employee's 2009 federal tax return that includes this child (black out all financial information) to demonstrate continued dependence beyond age 19.<br>**Please note that your health carrier determines the disability status of the child.** |

*Definitions may vary from the definitions contained in the Summary Plan Descriptions due to the PPAC Act.

**THE PORT AUTHORITY** OF NY & NJ

*Randy Cherkis*
*Manager, Employee Benefits*

December 15, 2010

Dear Port Authority/PATH Colleague:

We informed you last month that in compliance with the Patient Protection and Affordable Care Act (PPAC Act), effective January 1, 2011, the Port Authority/PATH is extending group health benefits to your child(ren) between the ages of 19 and 26 who may have previously been ineligible for the coverage.

Consistent with the requirements of the PPAC Act, other changes will be implemented effective January 1, 2011. While the following changes will not affect everyone, we feel that it is appropriate to notify you of all changes resulting from PPAC Act:

**Preventive Health Services**
While the Port Authority/PATH plan already provides coverage for eligible preventive services on an **in-network basis**, those services will no longer have a required co-payment. Please check with your provider when receiving preventive care services to ensure accuracy of coverage and out of pocket expenses. Please be advised that this change does not apply to those individuals enrolled in Medicare and participate in the Retired Employee Coverage.

**Claims Review Procedures**
Extensive claim review procedures already exist to ensure accuracy and consistency. In addition, the new health reform law requires United Healthcare to have formal review procedures conducted by independent non-affiliated external review entities after a final claim appeal determination has been made.

**Lifetime Maximums**
If you are currently enrolled in a medical plan that has an overall lifetime dollar maximum, that maximum benefit limitation will be removed.

**Medicare Part D - Coverage Gap Discount Program for Brand Name Drugs**
This program provides retirees who are Medicare Part D participants with a 50% reduction in the cost of certain brand name drugs at a retail or mail order pharmacy after total costs exceed a maximum threshold of $2,840 in annual drug expenses. The PPAC Act requires the drug manufacturer to bear the added expense of this program. Express Scripts will automatically apply the discount when your pharmacy charges you for your prescription. It is important to note that **not all** drugs will be eligible for this discount, so while there may be a reduction in your co-payment on some drugs, there may not be a reduction in all your co-payments.

**Early Retiree Reinsurance Program (ERRP)**
This program—under the PPAC Act—allows the Port Authority/PATH to seek temporary financial assistance for health care benefits (specifically for United Healthcare and Express Scripts coverage) provided for early retirees between age 55 and age 64, who do not qualify for Medicare. Attached is the required notification to plan participants.

The changes noted above apply only to the Port Authority's employer sponsored plans through United Healthcare and Express Scripts. If you are currently enrolled in any other plan(s), the plan(s) will provide you directly with information regarding any PPAC Act related changes.

In addition, the plan changes referenced above replace portions of the current Summary Plan Description documents (SPDs), which will be updated and distributed at a later date.

If you have any further questions, please contact Employee Benefits at 212-435-2870.

Thank you

Randy Cherkis
Manager, Employee Benefits

*This Notice is for Port Authority/PATH Retirees (or their dependents) between the ages of 55 and 64 who are not covered by Medicare.*

## Notice about the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

*December 2010*

# Retiree Benefits Informational Sheets

**Applicable to: Communications Workers of America – CWA Local 1032 (Over 25 years)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
*(Information About Your Prescription Drug Card Benefit Plan)*

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

1. **HOW WILL MY PRESCRIPTIONS BE FILLED?**

   Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

   The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

2. **HOW CAN I OBTAIN A PROVIDER DIRECTORY?**

   You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

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3. **DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?**

   No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

4. **WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?**

   In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

   Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

5. ***HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?***

   If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

   If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

# UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
# &
# MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

10/2010

CWA (Over 25 Years)

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. Employees hired on or after April 14, 1994 are generally insured for one times their base annual salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of $20,000, the amount of the ICP will continue (at no cost) until your death.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31ST of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informational Sheets

Applicable to: Management, Professional, Technical & Supervisory
Under 25 years, but hired before 7/1/88
Pay Plans A, B, E, F and D (6-10)

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers members complete freedom to use either a network provider or an out-of-network provider for medical and hospital care. Members who wish to use a network provider have a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, health care delivery resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reimbursement at reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- Unlimited Lifetime Major Medical Maximum.
- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Full range of medical services including specialist care and outpatient surgery.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- A $5 co-payment if you use a United Healthcare network physician.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 (in addition to the deductible).

In addition, the United Healthcare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors who are able to answer your medical questions;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly (1-877-259-1391).

## TYPICAL QUESTIONS AND ANSWERS

### 1. *HOW WILL MY PRESCRIPTIONS BE FILLED?*

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRCETORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an *Indemnity Plan*. If you are not yet eligible for Medicare, your ID card is for a *PPO Plan*. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an *Indemnity Plan* and one card for a *PPO Plan*.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

### 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. *WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?*

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried, in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (PA 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

**EXPRESS SCRIPTS**

**SUMMARY PLAN DESCRIPTION**
**(Information About Your Prescription Drug Card Benefit Plan)**

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
HUMAN RESOURCES DEPARTMENT
2000 BENEFIT PROGRSM CHANGE

*(Employees not represented for collective negotiations)*

The Executive Director has authorized an improvement in health benefits effective July 1, 2000. Specifically, non-represented Port Authority and PATH employees retiring on or after July 1, 2000 will be entitled to the reimbursement of Medicare Part B premiums annually for themselves and their eligible spouses, when the retiree reaches age 65. This benefit will be administered by Ceridian Benefits Services, Inc., P.O. Box 2023, Princeton, NJ 08543-2023. Retirees receiving reimbursement for Medicare Part B premiums through other non-Port Authority sources are not eligible for this benefit.

Retirees and their spouses become eligible for Medicare at age 65 and are required to enroll in Medicare Part A and Part B. Medicare Part A covers in-patient hospital services at no cost to the retiree, while Medicare Part B covers medical expenses such as doctor's charges, out-patient hospital care and other health services. Medicare Part B premiums change annually.

Retirees receiving a Social Security check have Medicare Part B premiums automatically deducted from their check. To receive reimbursement of Medicare Part B premium payments, please follow the guidelines that will be sent to you on an *annual* basis by Ceridian. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested. This will be the first and only request**. If documentation from the social Security Administration (SSA) has not been received, the retiree/spouse must contact SSA directly (1-800-772-1213) to request a *Benefit Verification Notice* form *or other record of Medicare Part B premium payments.* All Medicare Part B reimbursements will be made for the current year only.

Retirees not receiving a Social Security check are billed for Medicare Part B premiums on a quarterly basis. Copies of bills and cancelled checks should be sent directly to Ceridian, when requested. As above, all Medicare Part B reimbursements will be made on an annual basis for the current year only. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested.**

Please notify the Port Authority immediately of all address changes. Ceridian will mail Medicare Part B reimbursement checks to the address currently on file with the Port Authority. Retirees should send address changes to: The Port authority of NY & NJ, Employee Benefits, Attn: Retiree Address Change, 225 Park Avenue South – 10th Floor, New York, NY 10003

Management (under 25 years)

PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. The current monthly cost per $1,000 of coverage is ***$0.318*** and is subject to change annually. Required contributions will be deducted from your pension check..

The Extended Group Life Insurance Plan continues after you reach age 65. However, annual reductions of approximately 5% will begin when you reach age 65 and until age 71 at which time the face value of the policy will remain constant at approximately 2/3 of the amount selected at retirement (one, two or three times base annual salary). Deductions will continue until your death or your request to discontinue coverage. If you are over age 65 at the time of retirement, your life insurance will be adjusted to the reduced retirement benefit for that age.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# TELEPHONE DIRECTORY

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|---|---|---|
| **Health Coverage** | | |
| United Health Care | (877) 259-1391 | www.myuhc.com |
| **Prescription/Vision Coverage** | | |
| Express Scripts | (800) 467-2006 | www.express-scripts.com |
| National Vision Administrators (NVA) | (888) 682-2020 | www.e-nva.com |
| **Dental Coverage** | | |
| MetLife Dental | (888) 727-2317 | www.metlife.com/mybenefits |
| Dentcare (Healthplex) | (800) 468-0600 | www.healthplex.com |
| **Port Authority Benefits Customer Service** | (212) 435-2870 | |
| **Social Security Administration** | (800) 772-1213 | www.ssa.gov |
| **New York State Employees Retirement System** | (518) 474-7736 | www.osc.state.ny.us/retire |
| **Ceridian (Cobra)** | (800) 877-7994 | www.ceridian.com |
| **New York State Deferred Compensation** | (800) 422-8463 | www.nysdcp.com |

# Retiree Benefits Informational Sheets

Applicable to: Management, Professional, Technical & Supervisory
Under 25 years, but hired after 7/1/88
Pay Plans A, B, E, F and D (6-10)

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $200/400 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The co-pay is 15% for each prescription (minimum of $2 for generic name drugs or $5 for name brand drugs). For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-pay is 15% for each prescription ((minimum of $2 for generic name drugs or $5 for name brand drugs)for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife Dental at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 26. Please note, effective January 1, 2011, coverage for eligible dependent children will continue through the end of the calendar year in which he/she turns age 26 as long as he/she remains eligible; otherwise, coverage ends the end of the month in which the child is no longer eligible for this benefit.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
HUMAN RESOURCES DEPARTMENT
2000 BENEFIT PROGRSM CHANGE

(Employees not represented for collective negotiations)

The Executive Director has authorized an improvement in health benefits effective July 1, 2000. Specifically, non-represented Port Authority and PATH employees retiring on or after July 1, 2000 will be entitled to the reimbursement of Medicare Part B premiums annually for themselves and their eligible spouses, when the retiree reaches age 65. This benefit will be administered by Ceridian Benefits Services, Inc., P.O. Box 2023, Princeton, NJ 08543-2023. Retirees receiving reimbursement for Medicare Part B premiums through other non-Port Authority sources are not eligible for this benefit.

Retirees and their spouses become eligible for Medicare at age 65 and are required to enroll in Medicare Part A and Part B. Medicare Part A covers in-patient hospital services at no cost to the retiree, while Medicare Part B covers medical expenses such as doctor's charges, out-patient hospital care and other health services. Medicare Part B premiums change annually.

Retirees receiving a Social Security check have Medicare Part B premiums automatically deducted from their check. To receive reimbursement of Medicare Part B premium payments, please follow the guidelines that will be sent to you on an *annual* basis by Ceridian. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested. This will be the first and only request**. If documentation from the social Security Administration (SSA) has not been received, the retiree/spouse must contact SSA directly (1-800-772-1213) to request a *Benefit Verification Notice* form *or other record of Medicare Part B premium payments.* All Medicare Part B reimbursements will be made for the current year only.

Retirees not receiving a Social Security check are billed for Medicare Part B premiums on a quarterly basis. Copies of bills and cancelled checks should be sent directly to Ceridian, when requested. As above, all Medicare Part B reimbursements will be made on an annual basis for the current year only. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested.**

Please notify the Port Authority immediately of all address changes. Ceridian will mail Medicare Part B reimbursement checks to the address currently on file with the Port Authority. Retirees should send address changes to: The Port authority of NY & NJ, Employee Benefits, Attn: Retiree Address Change, 225 Park Avenue South – 10th Floor, New York, NY 10003

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

*Management (under 25 years, hired after 7/1/88)*

PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

When you retire, the Group Term Life Insurance coverage will be reduced to 2% of your base annual salary immediately prior to retirement multiplied by the number of full years of Port Authority service. The current monthly cost per $1,000 of coverage is ***$0.318*** and is subject to change annually. Required contributions will be deducted from your pension check.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# TELEPHONE DIRECTORY

| | | |
|---|---|---|
| **Health Coverage** | | |
| United Health Care | (877) 259-1391 | www.myuhc.com |
| **Prescription/Vision Coverage** | | |
| Express Scripts | (800) 467-2006 | www.express-scripts.com |
| National Vision Administrators (NVA) | (888) 682-2020 | www.e-nva.com |
| **Dental Coverage** | | |
| MetLife Dental | (888) 727-2317 | www.metlife.com/mybenefits |
| Dentcare (Healthplex) | (800) 468-0600 | www.healthplex.com |
| **Port Authority Benefits Customer Service** | (212) 435-2870 | |
| **Social Security Administration** | (800) 772-1213 | www.ssa.gov |
| **New York State Employees Retirement System** | (518) 474-7736 | www.osc.state.ny.us/retire |
| **Ceridian (Cobra)** | (800) 877-7994 | www.ceridian.com |
| **New York State Deferred Compensation** | (800) 422-8463 | www.nysdcp.com |

***RETIREE ID CARD*** –

*Please contact the Mail Center at (212) 435-6699. They are located at 233 Park Avenue South, 7th Floor.*

# Retiree Benefits Informational Sheets

Applicable to: Management, Professional, Technical & Supervisory
Under 25 years, but hired after 7/1/88
Pay Plans A, B, E, F and D (6-10)

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers members complete freedom to use either a network provider or an out-of-network provider for medical and hospital care. Members who wish to use a network provider have a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, health care delivery resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reimbursement at reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- Unlimited Lifetime Major Medical Maximum.
- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Full range of medical services including specialist care and outpatient surgery.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- A $5 co-payment if you use a United Healthcare network physician.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 (in addition to the deductible).

In addition, the United Healthcare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors who are able to answer your medical questions;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly (1-877-259-1391).

## TYPICAL QUESTIONS AND ANSWERS

1. **HOW WILL MY PRESCRIPTIONS BE FILLED?**

   Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

   The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

2. **HOW CAN I OBTAIN A PROVIDER DIRECTORY?**

   You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

3. **DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?**

   No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

4. **WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?**

   In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

   Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

5. **HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?**

   If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

   If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife Dental at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 26. Please note, effective January 1, 2011, coverage for eligible dependent children will continue through the end of the calendar year in which he/she turns age 26 as long as he/she remains eligible; otherwise, coverage ends the end of the month in which the child is no longer eligible for this benefit.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
HUMAN RESOURCES DEPARTMENT
2000 BENEFIT PROGRSM CHANGE

(Employees not represented for collective negotiations)

The Executive Director has authorized an improvement in health benefits effective July 1, 2000. Specifically, non-represented Port Authority and PATH employees retiring on or after July 1, 2000 will be entitled to the reimbursement of Medicare Part B premiums annually for themselves and their eligible spouses, when the retiree reaches age 65. This benefit will be administered by Ceridian Benefits Services, Inc., P.O. Box 2023, Princeton, NJ 08543-2023. Retirees receiving reimbursement for Medicare Part B premiums through other non-Port Authority sources are not eligible for this benefit.

Retirees and their spouses become eligible for Medicare at age 65 and are required to enroll in Medicare Part A and Part B. Medicare Part A covers in-patient hospital services at no cost to the retiree, while Medicare Part B covers medical expenses such as doctor's charges, out-patient hospital care and other health services. Medicare Part B premiums change annually.

Retirees receiving a Social Security check have Medicare Part B premiums automatically deducted from their check. To receive reimbursement of Medicare Part B premium payments, please follow the guidelines that will be sent to you on an *annual* basis by Ceridian. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested. This will be the first and only request**. If documentation from the social Security Administration (SSA) has not been received, the retiree/spouse must contact SSA directly (1-800-772-1213) to request a *Benefit Verification Notice* form *or other record of Medicare Part B premium payments*. All Medicare Part B reimbursements will be made for the current year only.

Retirees not receiving a Social Security check are billed for Medicare Part B premiums on a quarterly basis. Copies of bills and cancelled checks should be sent directly to Ceridian, when requested. As above, all Medicare Part B reimbursements will be made on an annual basis for the current year only. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested.**

Please notify the Port Authority immediately of all address changes. Ceridian will mail Medicare Part B reimbursement checks to the address currently on file with the Port Authority. Retirees should send address changes to: The Port authority of NY & NJ, Employee Benefits, Attn: Retiree Address Change, 225 Park Avenue South – 10th Floor, New York, NY 10003

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## *MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)*

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

**EXPRESS SCRIPTS**

**SUMMARY PLAN DESCRIPTION**
**(Information About Your Prescription Drug Card Benefit Plan)**

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## *YOUR IDENTIFICATION CARDS*

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Management (under 25 years, hired after 7/1/88)

PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

When you retire, the Group Term Life Insurance coverage will be reduced to 2% of your base annual salary immediately prior to retirement multiplied by the number of full years of Port Authority service. The current monthly cost per $1,000 of coverage is ***$0.318*** and is subject to change annually. Required contributions will be deducted from your pension check.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# TELEPHONE DIRECTORY

| | | |
|---|---|---|
| **Health Coverage** | | |
| United Health Care | (877) 259-1391 | www.myuhc.com |
| **Prescription/Vision Coverage** | | |
| Express Scripts | (800) 467-2006 | www.express-scripts.com |
| National Vision Administrators (NVA) | (888) 682-2020 | www.e-nva.com |
| **Dental Coverage** | | |
| MetLife Dental | (888) 727-2317 | www.metlife.com/mybenefits |
| Dentcare (Healthplex) | (800) 468-0600 | www.healthplex.com |
| **Port Authority Benefits Customer Service** | (212) 435-2870 | |
| **Social Security Administration** | (800) 772-1213 | www.ssa.gov |
| **New York State Employees Retirement System** | (518) 474-7736 | www.osc.state.ny.us/retire |
| **Ceridian (Cobra)** | (800) 877-7994 | www.ceridian.com |
| **New York State Deferred Compensation** | (800) 422-8463 | www.nysdcp.com |

***RETIREE ID CARD*** –

*Please contact the Mail Center at (212) 435-6699. They are located at 233 Park Avenue South, 7th Floor.*

THE PORT AUTHORITY OF NY & NJ

# 2011 Retiree Contributions - Group Health, Dental and Life Insurance

The **2011 Estimated Retiree Contributions for Group Health, Dental and Life Insurance** for those employees with fewer than 25 years of Port Authority service and retire after January 3, 2011 is as follows:

| **Health** | **Annual Premium** | **Monthly Premium** |
|---|---|---|
| Family Coverage | $5,268 | $439.00 |
| **Dental** | | |
| Family Coverage | $ 1,104 | $ 92.00 |

**Life Insurance**

$0.318 per $1,000 of coverage

**Note:** Family coverage includes coverage for the retiree and all eligible dependents.

**Employee Acknowledgement**

By signing below, I acknowledge that these contributions referenced above are only the initial estimated retiree contributions for 2011, and are subject to change based upon final calculations that will be made and communicated at a future date.

Employee Signature: _____

Employee Name: _____

Employee ID: _____

*225 Park Avenue South, 10 Floor*
*New York, NY 10003*
*T: (212) 435-2870 F: (212) 435-2871*

THE PORT AUTHORITY OF NY & NJ

# 2011 Retiree Contributions - Group Health, Dental and Life Insurance

The **2011 Estimated Retiree Contributions for Group Health, Dental and Life Insurance** for those employees with fewer than 25 years of Port Authority service and retire after January 3, 2011 is as follows:

| **Health** | **Annual Premium** | **Monthly Premium** |
|---|---|---|
| Individual Coverage | $2,634 | $219.50 |

| **Dental** | | |
|---|---|---|
| Individual Coverage | $ 480 | $ 40.00 |

**Life Insurance**

$0.318 per $1,000 of coverage

***Employee Acknowledgement***

By signing below, I acknowledge that these contributions referenced above are only the initial estimated retiree contributions for 2011, and are subject to change based upon final calculations that will be made and communicated at a future date.

Employee Signature: _____

Employee Name: _____

Employee ID: _____

*225 Park Avenue South, 10 Floor*
*New York, NY 10003*
*T: (212) 435-2870 F: (212) 435-2871*

**MetLife**
Metropolitan Life Insurance Company

# Dental Expense Claim

**To Be Completed by Employee** (You must review the important statements on page 2 and sign where indicated before completing this section of the form.)

| 1. Patient First Name / Middle / Last | 2. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other | 3. Sex ☐ Male ☐ Female | 4. Married? ☐ Yes ☐ No | 5. Patient Date of Birth Mo. / Day / Year | 6. For Office Use |
|---|---|---|---|---|---|

| 7. If Full Time Student (Age 19 or Over) School / City / State | 8. EMPLOYEE Social Security / ID Number | 9. If Disabled (Age 19 or Over) ☐ Yes ☐ No | 10. Name of Group Dental Program **Port Authority/PATH #302043** |
|---|---|---|---|

| 11. Employee First Name / Middle / Last | 12. Employee Date of Birth | 13. Office Phone (Area Code) |
|---|---|---|

| 14. Employee Residence Mailing Address | 15. City, State, Zip |
|---|---|

| 16. Are other Family Members Employed? ☐ Yes ☐ No<br>Name / Social Security / ID Number | 17. Date of Birth | 18. Name and Address of Employer for Item 16 |
|---|---|---|

19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:)
Dental Plan Name / Group No. / Name and Address of Carrier

| 20. I Authorize Release of any Information Relating to this Claim | 21. I Certify that the Above Information is Correct. | 22. I Authorize Payment Directly to the Below Named Dentist. |
|---|---|---|
| (Signature of Patient or Signature of Authorized Representative if Minor) / Date<br>If Authorized Representative, Relationship to Minor | Employee Signature / Date | Employee Signature / Date |

**To Be Completed by Dentist**

| 23. Dentist Name | 24. Mailing Address / City / State / Zip |
|---|---|

| 25. Dentist Social Security Number or T.I.N. | 26. Dentist License Number | 27. Dentist Phone Number |
|---|---|---|

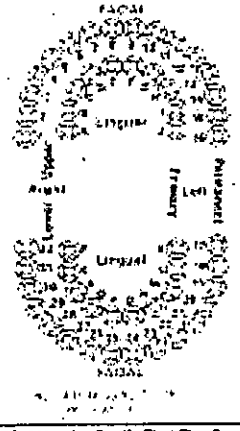
| 28. First Visit Date Current Series | 29. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other _____ | 30. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many? _____ |
|---|---|---|

| 31. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) | 32. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) |
|---|---|
| 33. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) | 34. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) |

| 35. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement) | 36. Date of Prior Replacement? |
|---|---|

| 37. Is Treatment for Orthodontics? ☐ Yes ☐ No | If Services Already Commenced, Enter Date Appliance Placed | Months of Treatment Remaining |
|---|---|---|

**Dentist's** – ☐ Pretreatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)**



38. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

| Tooth # or Letter | Surface | Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.) | Date Service Performed Mo./ Day /Year | ADA Procedure Number | Fee | For Carrier Use Only |
|---|---|---|---|---|---|---|
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39. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed
*Signature of Dentist _____ Date _____ Total Fee Actually Charged

40. Address where treatment was performed
Street _____ City _____ State _____ Zip _____

If you are covered under a self-insured plan or insured under a policy issued in any state other than those listed below, or if you reside in any state other than those listed below, then the following warning may apply to you:

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a *statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact* material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

If you are insured under a policy issued in one of the following states, or if you reside in one of the following states, one of the following state warnings may apply to you:

New York **(only applies to Accident and Health Benefits (AD&D/Disability/Dental):** I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to $5,000 plus the value of the claim.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas and Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance *or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material* thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement may have violated state law.

Employee Signature _____ Date_____

**Please Review Before Submitting Claim**

**Information for Employee**

1. Complete your section of the claim form (items 1 through 21) in full to assure positive identification and prompt payment. Please print or type. Note: Item 8 (Employee Social Security / ID Number) must be completed for the claim to be processed.
2. Patient Consent. By signing item 20 the patient (or parent or other authorized representative) consents to the use and disclosure of information relating to the services provided by the dentist or health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for dental benefits to a provider or administrator of dental benefit plans. This consent will be valid for as long as the patient is entitled to coverage under a dental plan. You are entitled to a copy of this consent. This consent may be revoked in writing delivered to your dentist or health care professional, but such revocation will not affect any action taken in reliance on this consent prior to revocation. Upon receipt of revocation or refusal to sign a consent, your dentist or health care professional may decline to provide or continue treatment. If this consent is signed by the authorized representative of the patient, the relationship of the authorized representative must be provided in item 20.
3. You must sign the claim form in item 21.
4. You can arrange for MetLife to make payment directly to the dentist by completing item 22. If you wish benefits to be paid directly to yourself, do not complete item 22. In either case, a statement of benefits paid will be sent to you.
5. If total charges for the planned course of treatment are expected to be $300 or more, a pre-treatment estimate of benefits is suggested. Please note that the pre-treatment estimate of benefits is only intended to avoid misunderstandings between the employee, dentist and insurance company concerning benefits payable. It is not intended to preclude a course of treatment agreed upon by you and your dentist.

   The form should be completed and submitted to MetLife prior to the commencement of the course of treatment for a pre-treatment estimate of benefits. MetLife will notify you of your benefits payable. (If you wish, a pre-treatment estimate may be requested for anticipated dental expenses of less than $300.)
6. If total charges for the planned course of treatment will be less than $300, the claim form should be completed when treatment is completed and mailed to the address shown below.

   **Dental Coverage is subject to specific limitations and exclusions. Please refer to your booklet for a description of covered services, schedule of benefits payable, limitations and exclusions.**

**Information for Attending Dentist**

1. Benefits are payable in accordance with four Classes of Services. It is therefore important that a separate fee is indicated for each item of service performed.
2. If total charges for the planned course of treatment are expected to be $300 or more, a pre-treatment estimate of benefits is suggested. Please note that the pre-treatment estimate of benefits is only intended to avoid misunderstandings between the employee, dentist and insurance company concerning benefits payable. It is not intended to preclude a course of treatment agreed upon by you and your patient.

   Check the box noted "Pre-treatment estimate" and complete items 23 through 39. The completed claim form should be sent to MetLife prior to the commencement of the course of treatment for a pre-treatment estimate of benefits. MetLife will notify your patient of benefits payable.
3. Generally, we do *not* request x-rays where standard filling materials are used. Pre-operative x-rays are requested *only* in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally we may request x-rays that relate to other dental services.

   In an effort to reduce your costs and inconvenience, we request your cooperation in submitting x-rays *only* in the above mentioned circumstances or when specifically requested. This will also enable us to expedite the processing of a pretreatment estimate.
4. If authorized by the employee, benefit payments will be made directly to you.

**Mail Completed form to:**
**MetLife Dental Claims**
**P.O. Box 981282**
**El Paso, TX 79998-1282**

**Employees: 1-888-727-2317**
**Dentists: 1-877-638-3379**

## Retiree Benefits Informational Sheets

**Applicable to: Communications Workers of America – CWA Local 1032 (Under 25 years)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

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Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

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A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

# UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
# &
# MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required *hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day* annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

10/2010

**CWA (Under 25 Years)**

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. Employees hired on or after October 1, 1993 are generally insured for one times their base annual salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. The current monthly cost per $1,000 of coverage is *$0.318* and is subject to change annually. Required contributions will be deducted from your pension check.

In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan (which becomes effective when you are both retired and age 65) you will be required to make contributions towards the cost of this coverage. The face value of the Insurance Continuation Plan (ICP) coverage is $20,000 and the current monthly contribution (if enrolled) is *$0.59* and is subject to change annually.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of $20,000, the amount of the ICP will continue (at no cost) until your death.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

**THE PORT AUTHORITY OF NY & NJ**

ONE WORLD TRADE CENTER
NEW YORK, NY 10048

(212) 435-7000
(973) 961-6600

October 18, 1999

Dear Port Authority Employee:

The Port Authority of New York & New Jersey is conducting the annual health and dental benefits Open Enrollment now through November 19, 1999 for all employees. The options you choose in this Open Enrollment are *effective January 1, 2000*. Attached are a brief overview of the health (Attachments I, II, III) and dental (Attachment IV) plans available to you, and 'Typical Questions and Answers' (Attachment V). I am pleased to announce the following benefit plan enhancement:

**United HealthCare PPO Plan**

- Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

After reading the attached material:

If you wish to REMAIN in your present coverage, DO NOTHING.

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If you are CHANGING health or dental coverage, please COMPLETE THE ATTACHED *BENEFIT SELECTION FORM*.

Please help us to get you enrolled properly by completing the *Benefit Selection Form* and returning it to Employee Benefits, 1WTC-61S no later than November 19, 1999. To avoid confusion and to ensure that the form is received by the due date, you can request that it be signed for upon receipt if sent through the internal PA mail. For outside delivery, you may want to request a return receipt.

If you have questions regarding a specific plan, please call the carrier directly (see Attachment VI). Employees with *general* questions can call Employee Benefits at (212) 435-6163. All coverage changes are *effective January 1, 2000* and remain in effect until the next open enrollment unless a change in family status occurs.

Sincerely,

Rosetta A. Jannotto
Manager, Employee Benefits
Human Resources Department

Attachments (represented employees)

## UNITED HEALTHCARE PLAN (PPO)
## OVERVIEW

The United HealthCare Preferred Provider Organization Plan (PPO) offers members complete freedom to use either a network provider or an out-of-network provider for medical and hospital care. Members who wish to use a network provider have a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, health care delivery resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reimbursement at reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- Unlimited Lifetime Major Medical Maximum.
- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Full range of medical services including specialist care and outpatient surgery.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United HealthCare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- A $5 co-payment if you use a United HealthCare network physician.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 (in addition to the deductible).

In addition, the United HealthCare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors who are able to answer your medical questions;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United HealthCare directly (1-888-441-9815).

## COST OF PLAN

Contributions for this plan are not required at this time.

**United HealthCare**
**Summary of Coverage**
**Port Authority of NY & NJ**

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK * ** |
|---|---|---|
| Deductible – Single | None | $50 |
| Family | None | $100 |
| Coinsurance | None | 20% |
| Maximum Out-of-Pocket per person | Not Applicable | $1,000 (excluding deductible) |
| **PREVENTIVE CARE** | | |
| Physical Examination | $5 copay per visit | No coverage |
| Routine Pediatric Care | 100% coverage | 100% of Reasonable & Customary |
| **OUTPATIENT CARE** | | |
| Physician Office Visits | $5 copay per visit | Subject to Deductible & Coinsurance |
| Surgery | 100% coverage | 100% of Reasonable & Customary |
| Laboratory Services | 100% coverage | 100% of Reasonable & Customary |
| **HOSPITAL CARE** | | |
| Semi-private room & board | 100% coverage | 120 days at 100% balance paid at 80% |
| **EMERGENCY CARE** | | |
| Ambulance Services when medically necessary | No charge | No charge |
| **AT HOSPITAL EMERGENCY ROOM** | | |
| Accident Care, Serious Illness | 100% coverage | 100% coverage |
| **MATERNITY CARE** | | |
| Prenatal & Post-natal care | $5 copay per visit | 100% of Reasonable & Customary |
| Hospital services for mother & child | 100% coverage | 100% - 120 day maximum balance at 80% per stay |
| **SHORT TERM REHABILITATION** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOME HEALTH CARE** | | |
| 60 visits in and out-of- network combined | $5 copay per visit | Subject to Deductible & Coinsurance |
| **SKILLED NURSING FACILITY** | | |
| 60 days per year combined in and out-of-network | 100% coverage | Subject to Deductible & Coinsurance |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Inpatient - 7 days detoxification, 30 days per Year, 2 confinements per lifetime | 100% coverage | 100% coverage |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Outpatient – 60 visits per year, 120 visits Per lifetime combined in and out-of- network | $5 copay per visit | Subject to Deductible & Coinsurance |
| **MENTAL HEALTH CARE** | | |
| Inpatient | 100% coverage | 100% 30 days per year balance paid at 80% |
| Outpatient | $10 copay per visit | Subject to Deductible & Coinsurance |
| **CHIROPRACTIC CARE** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOSPICE CARE** | | |
| 210 days maximum | 100% coverage | 100% coverage |
| **INFERTILITY TREATMENT** | | |
| 3 Attempt Combined Limit | $5 copay per visit | Subject to Deductible & Coinsurance |
| **OTHER COVERAGE** | | |
| Durable Medical Equipment | 100% coverage | Subject to Deductible & Coinsurance |

* All Benefits are subject to Reasonable & Customary.
** All benefits must meet medical necessity.

**This summary is not all inclusive. Please refer to your handbook which you will be receiving after enrollment.**

# POLICE
# PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
# OVERVIEW

**THIS OPTION IS NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER**

The Prudential/Blue Cross Traditional Indemnity Plan is designed to provide broad financial protection against hospital, doctor and related medical expenses. This plan offers members complete freedom in choosing their health care providers and facilities. Hospitalization is provided through Empire Blue Cross and Surgical/Major Medical coverage is provided by Prudential Insurance Company of America. Members of this plan are subject to an annual deductible of $50 for individual and $100 for family coverage. Eligible Major Medical expenses are reimbursed through Prudential Insurance Company at 80% of Reasonable and Customary Charges up to a $1,000,000 lifetime maximum per covered individual.

A more detailed explanation of this plan follows. For specific claim information, please contact the insurance carrier directly (see attached telephone directory).

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## COST OF PLAN

Contributions for this plan are not required at this time.

## PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
(Continued)

I. Plan provides basic coverage through Empire Blue Cross of Greater New York for:

A. Hospitalization
- 120 days paid at a semiprivate room rate for each period of confinement in a participating Blue Cross of Greater NY hospital.

B. Emergency Room Treatment (rendered in a participating Blue Cross of Greater N.Y. hospital by a salaried hospital staff member).
- Accidental Injury: within 72 hours of the injury
- Sudden and Serious: within 12 hours of the illness

II. Plan provides surgical/major medical coverage through The Prudential Insurance Company of America:

A. Surgical Procedures
- 100% reimbursement rate based on the reasonable and customary fee.

B. Major Medical Expenses
- 80% reimbursement rate based on the reasonable and customary fee for doctor visits, lab fees, and x-rays.
- The following primary and preventive care services are covered in full, for dependents from birth to age 19. That is, they are not subject to coinsurance or annual deductibles.
  - Initial hospital check-up for newborns.
  - Scheduled well-child visits.
  - Certain services at each well-child visit, such as physical examinations, developmental assessment and laboratory tests.
  - Appropriate immunizations including diphtheria, haemophilus, influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, and tetanus.
  - One preventive care visit every two years for children ages six up to their nineteenth birthday.
- Routine physical exams not covered.
- Vision and eye exams not covered.

## PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
(Continued)

C. Mental and Nervous Coverage

- Inpatient hospital benefits are reimbursed at 100% up to 30 days in any 12-month period in a participating accredited non-governmental hospital. Confinements in excess of 30 days are reimbursed at 80%. Confinements in a non-participating hospital are reimbursed at 80%. All confinements in a non-participating hospital and/or those reimbursed at 80% are subject to the plan maximum as stated above and must be deemed medically necessary.
- Outpatient services will be reimbursed at 80% of reasonable and customary charges.

D. Alcohol and Substance Abuse

| | |
|---|---|
| 1. Inpatient Alcohol: | 7 days detoxification reimbursed at 100%. 30 days inpatient rehabilitation reimbursed at 100%. One course of treatment in a 12-month period, twice per lifetime. |
| 2. Inpatient Substance Abuse: | 7 days detoxification and 30 days inpatient rehabilitation reimbursed at 100%, one course of treatment in 12-month period, twice per lifetime. |
| 3. Outpatient Rehabilitation: | 120 days per lifetime, combination of alcohol and substance abuse. 60-visit maximum per calendar year. Day 1-30 reimbursed at 100%, balance reimbursed at 80%. |

III. Group Health Deductibles/Maximums

A. Annual Deductibles

- Hospitalization - none
- Surgical - none
- Major Medical - $50 Individual/$100 Family

B. Major Medical Maximum - $1,000,000

- Lifetime Maximum (includes mental and nervous lifetime maximum).
- Each eligible dependent has their own major medical maximum.
- $5,000 cap - After the annual major medical deductible has been satisfied, an individual covered under the Major Medical Plan will be reimbursed at 80% of all reasonable and eligible medical expenses through the first of such expenses in a calendar year and, thereafter, for 100% of such expenses in the calendar year (dental claims not included).

Attachment III

# HEALTH MAINTENANCE ORGANIZATIONS (HMO) OVERVIEW

A Health Maintenance Organization (HMO) is a system of health care that provides managed, pre-paid hospital and medical services to its members. As an HMO member, all your care will be coordinated through a Primary Care Physician (PCP), who manages your health care needs. You can choose a physician from the HMO's provider directory that lists a network of doctors in your area. HMO members can receive health care at little or no out-of-pocket cost, provided they use network providers and facilities. There are no deductibles to meet or claim forms to file. In most HMOs, if a physician outside of the health plan is used without authorization from the HMO, the patient is responsible for all bills incurred.

The Port Authority offers the following HMOs:

- Health Insurance Plan of Greater New York (available to NY residents only);
- HMO Blue *Horizon Blue Cross Blue Shield of NJ* (available to NJ residents only);
- Prudential HealthCare HMO (available in CT, NJ, NY, and PA); and,
- Aetna US Healthcare (available in CT, NJ, NY, and PA).

A summary plan description is attached. For additional information please refer to the literature you may request by calling the specific carrier directly (see attached telephone directory).

## COST OF PLAN

Contributions for these plans are not required at this time.

## HOW TO ENROLL

To enroll in an HMO, complete the attached *Benefit Selection Form* and return it to the Employee Benefits Division, One WTC-61 South by November 19, 1999.

**Please Note:** An HMO will only allow you to enroll if they provide service to residents of your zip code. Please contact the carrier directly if you have any questions concerning service area (see attached telephone directory).

## HEALTH MAINTENANCE ORGANIZATION (HMO)
(Continued)

Plan provides basic/major medical coverage through the HMO of your choice. The available HMOs to choose from are:

- HIP New York
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*
- Prudential HealthCare HMO of New York, New Jersey, Pennsylvania and Connecticut
- Aetna US Healthcare of New York, New Jersey, Pennsylvania and Connecticut

Please note that if two Port Authority or PATH employees are married to each other, and they both choose the same HMO, they can only have one HMO contract which must cover both employees and all family members.

A. Hospitalization

Covered in full for unlimited number of days when approved by the HMO.

B. Emergency Room Treatment in the Hospital

Covered in full when service is approved and/or rendered by the HMO, subject to applicable co-payments as follows:

- HMO Blue *Horizon Blue Cross Blue Shield of NJ* has a $35 co-payment.
- Prudential HealthCare HMO has a $25 co-payment in New York and Connecticut and a $50 co-payment in New Jersey and Pennsylvania.
- Aetna US Healthcare has a $35 co-payment.

C. Surgical Procedures

Covered in full when approved by the HMO, including obstetrical care.

D. Major Medical Expenses

**Primary and Preventive Care:** covered in full subject to a $5 co-payment if you choose HMO Blue *Horizon Blue Cross Blue Shield of NJ*, Prudential HealthCare HMO or Aetna US Healthcare (except New Jersey*). HIP New York does not require a co-payment. Covers services such as routine illness and injury, physical exams, routine child care and well baby visits, immunizations (except those required for travel or work), gynecological exams and pap smears, x-rays, lab tests, routine mammograms.

***Note:** Under Aetna US Healthcare of New Jersey, primary care physician visits are covered in full subject to a $10 co-payment, specialty care office visits are covered in full subject to a $15 co-payment and preventive eye and gynecological exams are covered in full subject to a $15 co-payment.

## HEALTH MAINTENANCE ORGANIZATION (HMO)
(Continued)

**Hearing Exams:** Covered in full subject to the applicable co-payments as follows:

- HIP New York: no co-payment.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*: $5 co-payment.
- Prudential HealthCare HMO: $5 co-payment, but only available if the person is under age 18.
- Aetna US Healthcare: $5 co-payment.

**Vision Care:** Eye Exams covered in full subject to the applicable co-payment as follows:

- HIP New York: No co-payment.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*, Prudential HealthCare HMO and Aetna US Healthcare (except New Jersey): $5 co-payment.
- Aetna US Healthcare - New Jersey: $15 co-payment.

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**Eye Glasses and Contact Lenses:** Covered as follows:

- HIP New York: Not available.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*: $50 reimbursement per 24 month period.
- Prudential HealthCare HMO: New Jersey only - available at discount rates in plan affiliated optical shops.
- Aetna US Healthcare: $35 reimbursement per 24 month period.

**Preventive Dental:** Covered as follows:

- HIP New York: Preventive and diagnostic services provided by a HIP New York participating dentist. There is a $5 co-payment for services. Each family member receives two exams (including 2 bitewing x-rays) every 6 months, and one application of fluoride per year for all children up to and including age 15 free of cost. There is a $5 co-payment for one cleaning per calendar year.
- Prudential HealthCare HMO: Not available.
- Aetna US Healthcare: Children through age 12 can visit a participating dentist for 2 routine exams per year. This includes an exam and cleaning, polishing and fluoride treatment. There is a $5 co-payment per visit.

## HMO HEALTH PLAN OPTIONS
(Continued)

E. Mental and Nervous Benefit Comparison

| | Inpatient | Outpatient |
|---|---|---|
| HIP of New York | Up to 30 days per year (combined with alcohol and drug services) paid in full. | Short term outpatient therapy. Paid in full |
| HMO Blue* (New Jersey) | 30 days per year paid in full. | 100% after a $25 copayment per visit with a limit of 20 days per year. |
| Prudential HMO (New York) | Up to 30 days per year paid in full. | Reimburses 70% with a 20 visit limit per year. |
| Prudential HMO (New Jersey) | Up to 30 days per year paid in full. | 100% after a $5 copayment per visit with a limit of 20 visits per year. |
| Prudential HMO (Connecticut) | Up to 60 days per year paid in full. | 100% after a $5 copayment per visit with a limit of 20 visits per year. |
| Aetna/ US Healthcare (New York) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |
| Aetna/ US Healthcare (New Jersey) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |
| Aetna/ US Healthcare (Connecticut) | 60 days per year covered in full. | 40 visits per year with $25 copayment per visit. |
| Aetna/ US Healthcare (Pennsylvania) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |

* Combined with Mental and Nervous benefit.

## HMO HEALTH PLAN OPTIONS
(Continued)

F. Alcohol and Substance Abuse Benefit Comparison

| | Inpatient Benefits | Outpatient Benefits |
|---|---|---|
| HIP/NY | Detoxification – Up to 30 days per year, covered In full. (Combined with inpatient mental and Nervous coverage)<br>Rehabilitation – Up to 30 days for alcoholism And/or drug abuse, covered in full. | Up to 60 visits per year for alcohol and drug rehabilitation. Covered in full. |
| HMO Blue *<br>(New Jersey) | Detoxification – Covered in full<br>Rehabilitation – Covered in full (combined 30 day limit) | After a $25 copayment, covered in full with a limit of 20 visits per year. |
| Prudential HMO<br>(New York) | Detoxification – Covered in full<br>Rehabilitation – Covered in full if medically Necessary. | After $5 copayment, covered in full up to 90 days per year for rehabilitative services. 20 family member out patient visits per year. |
| Prudential HMO<br>(New Jersey) | Detoxification – Covered in full<br>Rehabilitation – Covered in full up to 90 days per year if medically necessary. The 90-day limit is combined for in and out patient services. | After $5 copayment, covered in full if medically necessary. 90 day limit for rehabilitative services if medically necessary. The 90-day limit is combined for in and out patient services. |

* Combined with Mental and Nervous benefit.

## HMO HEALTH PLAN OPTIONS
(Continued)

F. Alcohol and Substance Abuse Benefit Comparison

| | Inpatient Benefits | Outpatient Benefits |
|---|---|---|
| Prudential HMO (Connecticut) | Detoxification – Covered in full<br>Rehabilitation – Covered in full if medically Necessary. | After $5 copayment per visit, covered in full up to 90 day for rehabilitative services if medically necessary. 20 family member visits per year. |
| Aetna/US Healthcare (New York) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – Not covered. | 60 visits per year with $5 copayment per visit. |
| Aetna/US Healthcare (New Jersey) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – Not covered. | Not Covered. |
| Aetna/US Healthcare (Connecticut) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – 45 days per year. | Not Covered. |
| Aetna/US Healthcare (Pennsylvania) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – 30 days per year, lifetime maximum 90 days. | 30 visits with $5 copayment and an additional 30 visits which may be exchanged for up to 15 inpatient days per year, lifetime maximum 120 visits. A 50% copayment of the costs of services applies to second and subsequent courses of treatment for residential care. |

Attachment IV

# DENTAL OPTIONS

## 1. PRUDENTIAL REASONABLE AND CUSTOMARY DENTAL PLAN

A. Dental Expenses
- 80% reimbursement rate based on reasonable and customary charges.
- Orthodontic expenses reimbursed under a fixed schedule of allowances only (will not be applicable toward your annual deductible as indicated below). One treatment per lifetime per eligible dependent under age 19.

B. Annual Dental Deductibles
- $50/Individual
- $100/Family

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## 2. PRUDENTIAL SCHEDULE OF ALLOWANCES DENTAL PLAN

A. Expenses are reimbursed under a fixed schedule of allowances (see attached).

B. This plan does not require a deductible.

## 3. DENTCARE DENTAL PLAN

- Generally no out of pocket expenses (call Dentcare for brochure and exceptions).
- Must go to a designated Dentcare dentist.
- Pre-certification needed from the Dentcare Program for all major dental work done by a Dentcare Dentist.
- No deductibles.

If two Port Authority and/or PATH employees are married to each other, and they both choose Dentcare, they can only have one Dentcare plan which must cover both employees and all family members.

*Port Authority Group Dental Plan*
Schedule of Allowances

## Part I — Basic Services

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Diagnostic and Preventive Services** | |
| 0110 | 1. *Clinical oral examination** | $ 10.00 |
| 1110 | 2. Cleaning, scaling and polishing* | 15.00 |
| 1210 | 3. Fluoride treatment (up to age 19)* | 8.00 |
| | 4. X-RAYS — individual total not to exceed the allowance for full-mouth series | |
| 0210 | (a) Full mouth or Panorex (at least 10 times)** | 15.00 |
| 0270 | (b) Bitewing, each | 3.00 |
| 0200 | (c) *Periapical, single, each* | 2.00 |
| 0240 | (d) Intra-oral occlusal (edentulous jaw), each | 7.00 |
| 0321 | (e) Temporo-mandibular joint film | 15.00 |
| 0340 | (f) Anterior/posterior; head and jaws | 15.00 |
| 0290 | (g) Lateral, head and jaws | 15.00 |
| | *Not more than twice annually | |
| | **Not more than once in three years | |
| | ***Palliative Services*** | |
| 9110 | Emergency treatment for relief of pain | 7.00 |
| | **Restorative Services** | |
| | 1. FILLINGS | |
| | Silver Fillings | |
| 2140 | (a) One surface | 12.00 |
| 2150 | (b) Two surfaces | 18.00 |
| 2160 | (c) Three or more surfaces | 27.00 |
| | Tooth Color Fillings | |
| 2330 | (d) Per filling | 12.00 |
| | 2. STAINLESS STEEL CROWN | |
| 2830 | each (up to age 19) | 25.00 |
| | **Oral Surgery (including X-rays, anesthesia and post-operative treatment)** | |
| | 1. EXTRACTIONS | |
| 7110 | (a) Routine or simple and surgical | 10.00 |
| 7220 | (b) Soft tissue impaction | 25.00 |
| 7235 | (c) Partial bony impaction | 40.00 |
| 7245 | (d) Complete bony impaction | 55.00 |
| | (e) *Complex including bone removal and sutures* | 30.00 |
| | 2. FRACTURES | |
| 7620 | (a) Upper jaw, closed reduction | 200.00 |
| 7640 | (b) Lower jaw, closed reduction | 225.00 |
| 7610 | (c) Upper jaw, open reduction | 300.00 |
| 7630 | (d) Lower jaw, open reduction | 300.00 |
| | 3. OTHER ORAL SURGICAL PROCEDURES | |
| 7430 | (a) Removal of cysts, including necessary extractions | 35.00 |
| 7340 | (b) Alveolectomy, maximum per arch | 30.00 |
| 3410 | (c) Apicoectomy | 35.00 |
| 7285 | (d) Biopsy, including report | 25.00 |
| 7960 | (e) Removal of labial frenum | 40.00 |
| 7260 | (f) Closure of oral antral fistula | 90.00 |
| | **Root Canal Treatment (including X-rays and follow-up care)** | |
| 3315 | 1. Filling one canal | 75.00 |
| 3325 | 2. *Filling two canals* | 100.00 |
| 3335 | 3. Filling three canals | 130.00 |
| | **Space Maintainers, simple (up to age 19)** | |
| 1510 | Any type | 50.00 |
| | **Periodontic Services (treatment of gums and associated tissues)** | |
| | 1. Periodontal root scaling and planing, including medications | |
| 4341 | (a) Fewer than 12 teeth per sitting | 15.00 |
| 4340 | (b) Per arch | 22.00 |
| | 2. Gum or bone surgery, including post-operative visits, (per quadrant) | |
| 4210 | | 90.00 |
| 4220 | 3. Subgingival curettage | 10.00 |

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Repair of Dentures and Bridges** | |
| | 1. *Broken full or partial denture* | |
| 5610 | (a) No tooth damage | $ 20.00 |
| 5620 | (b) Replace one tooth | 30.00 |
| 5630 | (c) Each additional tooth | 7.00 |
| | 2. Replace broken teeth only | |
| 5630 | (a) First tooth | 20.00 |
| 5640 | (b) Each additional | 7.00 |
| 5670 | 3. *Reattaching undamaged clasp* | 20.00 |
| 5680 | 4. Replacing broken clasp with new clasp | 45.00 |
| 5650 | 5. Adding tooth to partial denture to replace natural extracted tooth, each tooth | 35.00 |
| 5725 | 6. Rebasing upper or lower full or partial denture | 50.00 |
| 2920 | 7. *Recement crowns and inlays* | 6.00 |
| 6640 | 8. Repair broken facing | 15.00 |

## Part II — Major Services

| | | |
|---|---|---|
| | **Inlays, Gold** | |
| 2510 | 1. One surface | 50.00 |
| 2520 | 2. Two surfaces | 80.00 |
| 2530 | 3. Three or more surfaces, maximum per tooth | 90.00 |
| | **Dentures, Full (including supplying, inserting, fitting and adjustments)** | |
| 5110 | 1. Upper, once in five years | 175.00 |
| 5120 | 2. Lower, once in five years | 175.00 |
| | **Dentures, Partial** | |
| 5220 | 1. Bilateral acrylic or comparable base, either jaw, two or more full clasps and rests, each | 170.00 |
| 5250 | 2. Upper bilateral, chrome cobalt alloy or gold base, two or more clasps and rests, acrylic attachments, each | 200.00 |
| 5230 | 3. Lower, bilateral chrome cobalt alloy or gold base, two or more cast clasps and tests, acrylic attachments, each | 200.00 |
| | **Crowns and Bridgework** | |
| | 1. *Bridgework, Removable (one piece casing with clasps and rests)* | |
| 5280 | (a) One tooth replaced | 100.00 |
| 5280 | (b) Two teeth replaced | 110.00 |
| | 2. Bridgework, Fixed (single abutments only) | |
| 6780 | (a) 3/4 crown | 85.00 |
| 6790 | (b) Full cast crown | 110.00 |
| 6720 | (c) *Full cast with veneer* | 140.00 |
| | 3. Pontics | |
| 6230 | (a) Tru-pontic (porcelain or acrylic facing with cast backing) | 95.00 |
| 6210 | (b) Pontic of other type | 85.00 |
| | 4. Crowns | |
| 2740 | (a) Porcelain jacket | 150.00 |
| 2710 | (b) Acrylic jacket | 115.00 |

## Part III — Orthodontic Services

8410 Initial appliance, X-rays, diagnosis, study models, etc. *Maximum — $150*

Active treatment $35 per month. Not to exceed $840.00

Passive treatment, per 6 month period — $15. Maximum of 3 periods, Total — $45.

Total benefits available ..... $1035 *per course of treatment*

Note: If a charge is incurred for a service not included in the Schedule, in connection with the dental care of a specific condition, and if the Schedule contains one or more services which, according to customary dental practices, are separately suitable for the dental care of that condition, then a charge for the least expensive of the suitable services included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.

Attachment V

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW DO I CHANGE MY COVERAGE?

If you wish to change your current coverage, please complete the attached *Benefit Selection Form* and return it to Employee Benefits, One WTC-61 South by **Friday, November 19, 1999**. To allow enough time to process your change with the carrier, forms must be received by November 19, 1999.

### 2. WHEN WILL MY NEW COVERAGE BEGIN?

Your new coverage will begin on **January 1, 2000**. All changes in health/dental coverage will be considered final and will remain in effect until the next open enrollment period.

### 3. WHAT IF I DON'T WANT TO CHANGE MY CURRENT COVERAGE?

You will automatically be continued in your present plans if no *Benefit Selection Form* is received.

### 4. HOW CAN I FIND OUT WHAT MY CURRENT COVERAGE IS?

~~If you are not sure which plan you are enrolled in, call Employee Benefits at (212) 435-6163.~~

### 5. DID THE TAKEOVER OF PRUDENTIAL HEALTHCARE BY AETNA RESULT IN ANY CHANGES?

While it may not result in changes to the level of benefits currently offered by Prudential, it may affect the level of service.

### 6. WHAT IS A PPO?

A PPO (Preferred Provider Organization) offers the best features of both a traditional indemnity plan and managed care by giving members the freedom to use any provider, either in-network or out-of-network, for medical and hospital care without requiring a referral from a primary care physician to use a specialist.

### 7. WHAT IS A NETWORK PROVIDER?

A network provider is one who participates in a network and has agreed to charge preferred rates for members who seek care. The network includes a broad range of providers including Family Practitioners, Internists, Pediatricians, Neurologists, Oncologists and OB/GYNs. Additionally, the network includes labs, X-ray facilities and mental health providers. Again, you are not restricted to only use network providers.

### 8. WHAT IS THE DIFFERENCE BETWEEN PPO AND HMO PLANS?

The difference is that the PPO is <u>not</u> a managed care plan. You are not required to choose a Primary Care Physician and you will be reimbursed if you use an out-of-network physician under a PPO plan. This allows you and your family direct access to all specialists.

## 9. HOW DO I FIND OUT IF MY DOCTOR IS A MEMBER OF THE UNITED HEALTHCARE PPO NETWORK?

- Check the Provider Directory available directly from United HealthCare;
- Call United HealthCare Member Services at 1-888-441-9815 (select the option to speak with a customer services representative) or call your doctor and ask;
- Check the Internet (www.unitedhealthcare.com). This will also give you directions and an easy to read color map showing the provider's location;

## 10. WHAT IF MY DOCTOR IS NOT A MEMBER OF THE UNITED HEALTHCARE NETWORK?

If you wish to encourage your doctor to join the United HealthCare network, simply have your doctor call United HealthCare Network/Provider Services at 1-800-638-8075 to obtain an application. Due to the thorough credentialing process, in which United checks or verifies board certification, training and education, hospital affiliation and malpractice status, the process can take up to 180 days. However, you can still go to your doctor as an out-of-network provider and be reimbursed at 80% of reasonable and customary charges.

## 11. HOW DO I GET UNITED HEALTHCARE OUT-OF-NETWORK CLAIM FORMS?

Your department can obtain claim forms through Corporate Express or you can call United HealthCare. Claim forms are also included with United's reimbursement materials.

## ~~12. WILL I BE REQUIRED TO CONTRIBUTE FOR MY HEALTH AND/OR DENTAL~~ COVERAGE?

There are no employee contributions necessary for coverage through United HealthCare, any of the HMO's or any of the dental options at this time. Employees who choose or remain in the Prudential/Blue Cross Traditional Indemnity Plan, and are currently contributing to their health coverage, can refer to the Prudential/Blue Cross Traditional Indemnity Plan Overview section of this package for biweekly pre-tax or post-tax contribution rates.

## 13. HOW DOES PRE- AND POST-TAX WORK?

Employees required to contribute to the cost of their health coverage can elect to have these contributions taken out on pre-tax basis by completing the Compensation Reduction Agreement section on the attached *Benefit Selection Form*. Contributions on a pre-tax basis result in a lower taxable income so you pay less Federal Income Tax and less NY State Income Tax. (NJ taxable income is not affected.) If you are currently having deductions taken out on a pre-tax basis and wish to continue doing so, you do not need to complete a new *Benefit Selection Form*.

## 14. HOW DOES PRE- AND POST-TAX AFFECT RETIREMENT?

Your full gross salary is reported to the New York State & Local Employees Retirement System regardless of whether you select pre- or post-tax contributions.

## 15. IF I SWITCH OUT OF THE PRUDENTIAL TRADITIONAL INDEMNITY PLAN, WHEN WILL MY EMPLOYEE CONTRIBUTION STOP?

The last deduction from your paycheck will be on January 22, 2000 (which, due to the retrospective payroll, covers the December 26, 1999 to January 8th period).

## 16. HOW WILL MY PRESCRIPTIONS BE FILLED?

National Prescription Administrators, Inc. (NPA) provides your prescription benefit regardless of the health plan selected. The cost of each prescription is either $2 for generic brand drugs or $5 for name brand. For specific information or questions, please contact NPA directly at 1-800-467-2006.

**Important Note:** CWA 1032 employees who choose or remain in the United HealthCare PPO plan will have the NPA prescription plan. However, if you chose the Prudential Traditional Indemnity Plan or any of the HMO's, your prescription benefit will be provided by that specific carrier.

## 17. WILL MY DENTAL INSURANCE PLAN CHANGE IF I SWITCH HEALTH PLANS?

No. Your dental plan will remain the same unless you choose one of the other dental options available to you on the *Benefits Selection Form.*

## 18. ARE PRE-EXISTING CONDITIONS COVERED?

Yes. There is no pre-existing condition limitation under any of the current healthcare coverage plans.

## 19. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED HEALTHCARE'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

## 20. WHO IS AN ELIGIBLE DEPENDENT?

For this purpose, eligible dependents are defined as an employee's spouse or dependent children. Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage can extend through the end of the calendar year in which the child turns age 26 provided the child is unmarried, in full-time attendance at an accredited educational institution, and dependent on the employee for support. However, your health carriers will require you to provide verification of your child's full-time student status. Domestic partners, parents and grandchildren are not considered eligible for this purpose.

## 21. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing the enclosed *Benefit Selection Form* and returning it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable documentation (i.e. state marriage certificate, divorce decree, birth certificate for children, etc.) in order for the change to be made. Failure to notify Employee Benefits within the required time frame will result in having your request denied by the insurance carrier, and you will not be permitted to add your dependents(s) to your plan coverage until the next open enrollment period.

## 22. WHAT IS A CHANGE IN FAMILY STATUS?

For this purpose, a change in status includes the marriage or divorce of the employee, death of the employee's spouse or dependent children, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, switching from part-time to full-time employment status (or vice versa) by the employee or the employee's spouse, taking of an unpaid leave

of absence by the employee or the employee's spouse, or a significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment.

## 23. HOW DO I CHANGE MY DENTCARE DENTIST, HIP CENTER, PRIMARY CARE PHYSICIAN OR PHARMACY?

Please contact your health and/or dental carriers directly for instructions.

## 24. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a Provider Directory by contacting the specific carrier directly. A list of telephone numbers is attached to this package.

## 25. CAN I WAIVE MY RIGHT TO GROUP HEALTH AND/OR DENTAL BENEFITS?

Yes, provided you are covered by other insurance, such as a spouse's plan. Should you choose to waive your right to coverage, you must complete the Benefits Waiver Section on the attached *Benefit Selection Form* and provide proof of coverage by another carrier. However, you should note that if you waive your health benefits you must also waive your dental benefits and vice versa.

## 26. IF I WAIVE COVERAGE NOW, WILL I BE ABLE TO OBTAIN COVERAGE LATER ?

Yes, provided that a change in family status has occurred within the past thirty (30) days. Otherwise, you will not be permitted to enroll until the next open enrollment period.

## 27. WHO DO I CALL WITH GENERAL QUESTIONS?

You can call Employee Benefits at 212-435-6163.

Attachment VI

# TELEPHONE DIRECTORY

## Health Coverage

| | | |
|---|---|---|
| United HealthCare | 1-888-441-9815 | |
| Prudential Indemnity Plan | 1-800-772-4683 | |
| Empire Blue Cross Blue Shield | 1-800-662-5193 | |
| HIP New York | 1-800-447-8632 | |
| HMO Blue<br>*Horizon Blue Cross Blue Shield of NJ* | 1-800-722-2583 | |
| Prudential Healthcare HMO | 1-800-422-7399 | |
| Aetna/U.S. Healthcare | 1-800-323-9930<br>1-888-277-8742 | Information<br>Enrollment<br>Packages |
| | **PIN Number in NJ:** | **111** |
| | **PIN Number in NY & other states:** | **112** |

## Dental Coverage

| | |
|---|---|
| Prudential Dental | 1-800-772-4683 |
| Dentcare | 1-800-468-0600 |

# THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
## HUMAN RESOURCES DEPARTMENT
## 2000 BENEFIT PROGRAM CHANGE

**(employees not represented for collective negotiations)**

The Executive Director has authorized an improvement in health benefits effective July 1, 2000. Specifically, non-represented Port Authority and PATH employees retiring on or after July 1, 2000 will be entitled to the reimbursement of Medicare Part B premiums annually for themselves and their eligible spouses at age 65. This benefit will be administered by Ceridian Benefits Services, Inc., One Independence Way, Princeton, NJ 08540-2030.

Retirees and their spouses become eligible for Medicare at age 65 and are required to enroll in Medicare Part A and Part B. Medicare Part A covers in-patient hospital services at no cost to the retiree, while Medicare Part B covers medical expenses such as doctor charges, outpatient hospital care and other health services. Medicare Part B currently costs $50 per month per person.

Retirees receiving a Social Security check have Medicare Part B premiums automatically deducted from the check. To receive reimbursement of Medicare Part B premium payments, please follow the guidelines that will be sent to you on an annual basis by Ceridian. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian no later than the date requested. This will be the first and only request.** If documentation from the Social Security Administration (SSA) has not been received, the retiree/spouse must contact SSA directly (1-800-772-1213) to request a *Benefit Verification Notice* form or other record of Medicare Part B premium payments. All Medicare Part B reimbursements will be made for the current year only.

Retirees not receiving a Social Security check are billed for Medicare Part B premiums on a quarterly basis. A copy of the bills and cancelled checks should be sent directly to Ceridian when requested. As above, all Medicare Part B reimbursements will be made on an annual basis for the current year only. **It is the responsibility of the retiree/spouse to submit the *necessary supporting documentation directly to Ceridian no later than the date* requested.**

Please notify the Port Authority immediately of all address changes. Ceridian will mail Medicare Part B reimbursement checks to the address currently on file with the Port Authority. Retirees should send address changes to: The Port Authority of NY & NJ, CORCOM Department, Attn: Retiree Address Change, 1 World Trade Center, 68 South, New York, NY 10048

THE PORT AUTHORITY OF NY & NJ

ONE WORLD TRADE CENTER
NEW YORK, NY 10048

(212) 435-7000
(973) 961-6600

October 16, 2000

Dear Port Authority/PATH Employee:

I am pleased to inform you that the Annual Health and Dental Open Enrollment Program is being held now through November 17, 2000. The options you choose will be effective January 1, 2001 and remain in effect until the next open enrollment period (unless a change in family status occurs – see Question #24 of Attachment I – Typical Questions & Answers).

As you review this package, please note the following significant changes that may affect you or influence your benefit selections:

- We have been notified by Aetna US Healthcare that, as a result of its acquisition of Prudential, the Prudential Healthcare HMO (PruCare) will no longer be offered effective January 1, 2001. Enrolled members should take this opportunity to select another health carrier for 2001. PruCare members who do not respond during this open enrollment period will be automatically enrolled, as previously advised, into United Healthcare effective January 1, 2001.

- Due to continuing increases in the cost of health care, bi-weekly employee contributions for the Prudential/Blue Cross traditional indemnity plan will increase effective January 1, 2001 to $47 for individuals and $95 for family on either a pre- or post-tax basis. Those employees who contribute for this plan may wish to take this opportunity to review their health carrier options.

Following employee suggestions that we streamline open enrollment material, we have reduced the number of attachments that you are receiving this year. The attachments included should adequately assist you in your open enrollment decision. Should you have questions regarding a specific plan, please call the carriers directly as they are prepared to assist you and/or provide directories (see Attachments IIa, IIb and III for carrier telephone numbers).

- If you wish to REMAIN in your present coverage, DO NOTHING.

- If you are CHANGING health or dental coverage, please COMPLETE AND RETURN THE ATTACHED BENEFIT SELECTION FORM to Employee Benefits, One WTC–61 South no later than **Friday, November 17, 2000**. To ensure the form is received by this due date, you can request that it be signed for upon receipt if sent through inter-office mail. For external delivery, you may request a return receipt.

Thank you for helping us provide you with your benefits of choice. Please feel free to call Employee Benefits at (212) 435-6163 with questions.

Sincerely,

Rosetta A. Jannotto

Rosetta A. Jannotto
Employee Benefits Manager

# United Healthcare Benefit Comparison to the Traditional Indemnity Plan

| Benefit | Traditional Indemnity Plan* | United Healthcare PPO Plan | |
|---|---|---|---|
| | | In Network | Out of Network* |
| Bi-weekly Contribution | Individual $47 / Family $95 | None | None |
| Annual Deductible | Individual $50 / Family $100 | None | Same as Indemnity |
| Out of pocket Annual Maximum excluding deductibles | $1,000 Per Person of Eligible Expenses | N/A | Same as Indemnity |
| Co-Insurance | 80% | $5 co-pay | Same as Indemnity |
| Lifetime Major Medical Maximum | $1 Million Per Person | N/A | Unlimited |
| Hospital Room and Board | 100% Semi Private Rate 120 days, balance paid at 80% | 100% unlimited | Same as Indemnity |
| Mental and Nervous | | | |
| Inpatient | 30 days per year paid at 100% balance paid at 80% at eligible hospitals | 100% unlimited | Same as Indemnity |
| Outpatient | Paid at 50% to a maximum of $45 per visit, 50 visit annual limit | $10 co-pay unlimited visits | Paid at 80% unlimited visits |
| Hospital Emergency Room, Serious Illness (Hospital Services) | 100% | 100% | Same as Indemnity |
| Alcohol / Substance Abuse | | | |
| Inpatient<br>7 Days Detoxification<br>30 Day Rehabilitation<br>One course of treatment in a 12 month period twice per lifetime | 100% | 100% | Same as Indemnity |
| Outpatient<br>120 Days per lifetime, combination of alcohol and substance abuse. 60 visit maximum per calendar year. | 30 Days reimbursed at 100% Balance reimbursed at 80% | $5 co-pay unlimited | Subject to co-insurance and deductible |
| Surgery | 100% | 100% | Same as Indemnity |
| Anesthesia | 20% of surgical allowance paid at 100%, balance paid at 80% | 100% | 100% |

# United Healthcare Benefit Comparison to the Traditional Indemnity Plan

| Benefit | Traditional Indemnity Plan* | United Healthcare PPO Plan | |
|---|---|---|---|
| | | In Network | Out of Network* |
| Physician office visit | Subject to co-insurance and deductible | $5 co-pay | Same as Indemnity |
| Routine Physical Exam, Adult | Not Covered | $5 co-pay | Same as Indemnity |
| Routine Physical Exam, Pediatric Care | 100% (annually from birth to age 5)<br>100% (one visit every two years from ages 6 to 19) | 100% (annually from birth to age 19) | 100% (annually from birth to age 19) |
| Laboratory Test and X-Rays | 80% | 100% | 100% |
| Mammography, Routine | Not Covered | 100% | 100% |
| Chiropractic Care | 80% | $5 co-pay | Same as Indemnity |



* All Charges Subject to Reasonable and Customary

THE PORT AUTHORITY OF NY & NJ

ONE WORLD TRADE CENTER
NEW YORK, NY 10048

(212) 435-7000
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October 16, 2000

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Please review the attached package. If you are a member of Prudential Healthcare HMO (PruCare), please note that as a result of Aetna US Healthcare's acquisition of Prudential, we have been notified that the Prudential Healthcare HMO (PruCare) will no longer be offered effective January 1, 2001. Enrolled members should take this opportunity to select another health carrier for 2001. PruCare members who do not respond during this open enrollment period will be automatically enrolled, as previously advised, into United Healthcare effective January 1, 2001.

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Thank you for helping us provide you with your benefits of choice. Please feel free to call Employee Benefits at (212) 435-6163 with questions.

Sincerely,

Rosetta A. Jannotto

Rosetta A. Jannotto
Employee Benefits Manager

Attachments

# TYPICAL QUESTIONS & ANSWERS

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## 3. WHAT IF I DON'T WANT TO CHANGE MY CURRENT COVERAGE?

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## 6. WHAT IS A PPO?

A PPO (Preferred Provider Organization) offers the best features of both a traditional indemnity plan and an HMO (Health Maintenance Organization) by giving members the freedom to use any provider, either in-network or out-of-network, for medical and hospital care without requiring a referral from a primary care physician to use a specialist.

## 7. WHAT IS A NETWORK PROVIDER?

A network provider is one who participates in a network and has agreed to charge preferred rates for members who seek care. The network includes a broad range of providers including Family Practitioners, Internists, Pediatricians, Neurologists, Oncologists and OB/GYNs. Additionally, the network includes labs, X-ray facilities and mental health providers. Again, you are not restricted to only use network providers.

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## 9. HOW DO I FIND OUT IF MY DOCTOR IS A MEMBER OF THE UNITED HEALTHCARE PPO NETWORK?

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- Call United Healthcare Member Services at 1-877-259-1391 (select the option to speak with a customer services representative) or call your doctor and ask;
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If you wish to encourage your doctor to join the United Healthcare network, simply have your doctor call United Healthcare Network/Provider Services at 1-800-638-8075 to obtain an application. Due to the thorough credentialing process, in which United checks or verifies board certification, training and education, hospital affiliation and malpractice status, the process can take up to 180 days. However, you can still go to your doctor as an out-of-network provider and be reimbursed at 80% of reasonable and customary charges.

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Your department can obtain claim forms through Corporate Express or you can call United Healthcare. Claim forms are also included with United's reimbursement materials.

## 12. WILL I BE REQUIRED TO CONTRIBUTE FOR MY HEALTH AND/OR DENTAL COVERAGE?

There are no employee contributions necessary for coverage through United Healthcare, any of the HMO's or any of the dental options at this time. Employees who choose or remain in the Prudential/Blue Cross Traditional Indemnity Plan, and are currently contributing to their health coverage, can refer to the Prudential/Blue Cross Traditional Indemnity Plan Overview section of this package for biweekly pre-tax or post-tax contribution rates.

## 13. HOW DOES PRE- AND POST-TAX WORK?

Employees required to contribute to the cost of their health coverage can elect to have these contributions taken out on pre-tax basis by completing the Compensation Reduction Agreement section on the attached *Benefit Selection Form*. Contributions on a pre-tax basis result in a lower taxable income so you pay less Federal Income Tax and less NY State Income Tax. (NJ taxable income is not affected.) If you are currently having deductions taken out on a pre-tax basis and wish to continue doing so, you do not need to complete a new *Benefit Selection Form*.

## 14. HOW DOES PRE- AND POST-TAX AFFECT RETIREMENT?

Your full gross salary is reported to the New York State & Local Employees Retirement System regardless of whether you select pre- or post-tax contributions.

15. **IF I SWITCH OUT OF THE PRUDENTIAL TRADITIONAL INDEMNITY PLAN, WHEN WILL MY EMPLOYEE CONTRIBUTION STOP?**

The last deduction from your paycheck will be on January 19, 2001 (due to the retrospective payroll).

16. **HOW WILL MY PRESCRIPTIONS BE FILLED?**

National Prescription Administrators, Inc. (NPA) provides your prescription benefit regardless of the health plan selected. The cost of each prescription is either $2 for generic brand drugs or $5 for name brand. For specific information or questions, please contact NPA directly at 1-800-467-2006.

**Important Note:** PATH (ARSA, ATDA, BRS, IBT, TWU & UTU) employees who choose or remain in United Healthcare PPO plan will have the NPA prescription plan. However, if you choose the Prudential Traditional Indemnity Plan, your prescription benefit will be provided by that carrier.

17. **THROUGH THE PRESCRIPTION BENEFIT (NPA), CAN I PURCHASE ORAL CONTRACEPTIVES AT THE PHARMACY AS WELL AS THROUGH MAIL ORDER (CFI)?**

Yes, you may purchase oral contraceptives at the pharmacy, although you would realize savings through the CFI mail order program (one co-payment, 90-day supply).

18. **ARE PRE-EXISTING CONDITIONS COVERED?**

Yes. There is no pre-existing condition limitation under any of the current health care coverage plans.

19. **DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED HEALTHCARE'S PPO PLAN?**

No. Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

20. **WHAT ARE MY RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998?**

As required by the Women's Health and Cancer Rights Act of 1998, all our health plans provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Please call your carrier for more information.

21. **WHO IS AN ELIGIBLE DEPENDENT?**

Eligible dependents are defined as an employee's spouse or dependent child(ren). Dependent children are covered until the end of the calendar year in which they turn age 19. Coverage may extend either through the end of the month the child graduates or up to age 26 provided the child is in full-time attendance at an accredited educational institution, unmarried, and is dependent on the employee for financial support. However, your health carriers will require you to provide verification of your child's full-time student status. Domestic partners, parents and grandchildren are not considered eligible dependents.

## 22. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing the enclosed *Benefit Selection Form* or form PA2298 (*Employee Status Change)* and returning it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (i.e. state marriage certificate, divorce decree, birth certificate for children, etc.) in order for the change to be made. Failure to notify Employee Benefits within the required time frame will result in having your request denied by the insurance carrier, and you will not be permitted to add your dependents(s) to your plan coverage until the next open enrollment period.

## 23. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent (as defined in question #21). Official notification to CobraServ (1-727-864-3300) must be received within 60 days from the end of the month in which the dependent loses eligibility. Please note that the only coverage available for purchase would be that coverage/carrier currently held by the applicable employee. For example, if an employee is enrolled in the Prudential/Blue Cross (indemnity) health plan, only that plan is initially available for purchase.

## 24. WHAT IS A CHANGE IN FAMILY STATUS?

A change in status includes the marriage or divorce of the employee, death of the employee's spouse or dependent children, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, switching from part-time to full-time employment status (or vice versa) by the employee or the employee's spouse, taking of an unpaid leave of absence by the employee or the employee's spouse, or a significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment.

## 25. HOW DO I CHANGE MY DENTCARE DENTIST, HIP CENTER, PRIMARY CARE PHYSICIAN OR PHARMACY?

Please contact your health and/or dental carriers directly for instructions.

## 26. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a Provider Directory by contacting the specific carrier directly.

## 27. CAN I WAIVE MY RIGHT TO GROUP HEALTH AND/OR DENTAL BENEFITS?

Yes, provided you are covered by other insurance, such as a spouse's plan. Should you choose to waive your right to coverage, you must complete the Benefits Waiver Section on the attached *Benefit Selection Form* and provide proof of coverage by another carrier. However, you should note that if you waive your health benefits you must also waive your dental benefits and vice versa.

## 28. IF I WAIVE COVERAGE NOW, WILL I BE ABLE TO OBTAIN COVERAGE LATER ?

Yes, provided that a change in family status has occurred within the past thirty (30) days. Otherwise, you will not be permitted to enroll until the next open enrollment period.

## 29. WHO DO I CALL WITH GENERAL QUESTIONS?

You can call Employee Benefits at 212-435-6163.

# UNITED HEALTHCARE PLAN (PPO) OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers members complete freedom in choosing their healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the United Healthcare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at 1-877-259-1391.

## COST OF PLAN

Contributions for this plan are not required at this time.

**United Healthcare**
**Summary of Coverage**

| :IT | IN-NETWORK | OUT-OF-NETWORK * ** |
|---|---|---|
| ible – Single | None | $50 |
| Family | None | $100 |
| Coinsurance | None | 20% |
| um Out-of-Pocket per person | Not Applicable | $1,000 of eligible expenses (excluding deductible) |
| **ENTIVE CARE** | | |
| ical Examination | $5 copay per visit | No coverage |
| ine Pediatric Care | 100% coverage | 100% of Reasonable & Customary |
| **ATIENT CARE** | | |
| cian Office Visits | $5 copay per visit | Subject to Deductible & Coinsurance |
| ry | 100% coverage | 100% of Reasonable & Customary |
| ratory Services | 100% coverage | 100% of Reasonable & Customary |
| **ITAL CARE** | | |
| -private room & board | 100% coverage | 120 days at 100% balance paid at 80% |
| **RGENCY CARE** | | |
| bulance Services when medically necessary | No charge | No charge |
| **OSPITAL EMERGENCY ROOM** | | |
| dent Care, Serious Illness | 100% coverage | 100% coverage |
| **ERNITY CARE** | | |
| atal & Post-natal care | $5 copay per visit | 100% of Reasonable & Customary |
| pital services for mother & child | 100% coverage | 100% - 120 day maximum balance at 80% per stay |
| **RT TERM REHABILITATION** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **IE HEALTH CARE** | | |
| visits in- and out-of- network combined | $5 copay per visit | Subject to Deductible & Coinsurance |
| **LLED NURSING FACILITY** | | |
| days per year combined in- and out-of-network | 100% coverage | Subject to Deductible & Coinsurance |
| **COHOL/SUBSTANCE ABUSE** | | |
| patient - 7 days detoxification, 30 days per ar, 2 confinements per lifetime | 100% coverage | 100% coverage |
| **COHOL/SUBSTANCE ABUSE** | | |
| tpatient – 60 visits per year, 120 visits lifetime combined in- and out-of- network | $5 copay per visit | Subject to Deductible & Coinsurance |
| **NTAL HEALTH CARE** | | |
| patient | 100% coverage | 100% 30 days per year balance paid at 80% |
| tpatient | $10 copay per visit | Subject to Deductible & Coinsurance |
| **IROPRACTIC CARE** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **SPICE CARE** | | |
| 0 days maximum | 100% coverage | 100% coverage |
| **FERTILITY TREATMENT** | | |
| Attempt Combined Limit | $5 copay per visit | Subject to Deductible & Coinsurance |
| **AMMOGRAPHY, Routine** | 100% coverage | 100% coverage |
| **THER COVERAGE** | | |
| urable Medical Equipment | 100% coverage | Subject to Deductible & Coinsurance |

*All Benefits are subject to Reasonable & Customary
**All benefits must meet medical necessity

This summary is not all inclusive

# DENTAL OPTIONS

## 1. PRUDENTIAL REASONABLE AND CUSTOMARY DENTAL PLAN

A. Dental Expenses

- 100% reimbursement of preventive dental services based on reasonable and customary charges. Coverage includes two oral examinations per year, four cleanings per year, x-rays (full mouth series) once every three years, fluoride applications, and one sealant application per tooth (permanent molars) every three years.
- 80% reimbursement for restorative services (fillings, extractions, etc.) based on reasonable and customary charges.
- Orthodontic expenses reimbursed at 80% of reasonable and customary charges up to $2,000 (will not be applicable toward your annual deductible, as indicated below). One treatment per lifetime per eligible dependent under age 19.
- If hired on or after July 1, 2000, the dental reimbursement maximum is $2,000.

B. Annual Dental Deductibles

- $50/Individual
- $100/Family

## 2. SCHEDULE OF ALLOWANCES DENTAL PLAN

A. Expenses are reimbursed based on a fixed schedule of allowances, e.g. exam $10, filling $12, extraction $10 (see attached).

B. This plan does not require a deductible.

For additional information on either plan listed above, call Prudential at 1-800-772-4683.

## 3. DENTCARE DENTAL PLAN

- Generally no out of pocket expenses (call Dentcare at 1-800-468-0608 for brochure and exceptions).
- Must go to a designated Dentcare dentist or expenses are employee's responsibility.
- Pre-certification needed from the Dentcare Program for all major dental work done by a Dentcare Dentist.
- No deductibles

If two Port Authority and/or PATH employees are married to each other, and they both choose Dentcare, they can only have one Dentcare plan which must cover both employees and all family members.

# OPTION 2 - FIXED SCHEDULE OF ALLOWANCES

## ART I – Basic Services

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **agnostic and Preventive Services** | |
| 10 | 1. Clinical oral examination* | $ 10.00 |
| 10 | 2. Cleaning, scaling and polishing* | 15.00 |
| 10 | 3. Fluoride treatment (up to age 19)* | 8.00 |
| .10 | 4. X-RAYS – individual total not to exceed the allowance for full-mouth series | |
| :10 | (a) Full mouth or Panorex (at least 10 times)** | 15.00 |
| :70 | (b) Bitewing, each | 3.00 |
| :00 | (c) Periapical, single, each | 2.00 |
| :40 | (d) Intra-oral occlusal (edentulous jaw), each | 7.00 |
| :21 | (e) Temporo-mandibular joint film | 15.00 |
| 140 | (f) Anterior/posterior: head and jaws | 15.00 |
| 290 | (g) Lateral, head and jaws | 15.00 |
| | *Not more than twice annually | |
| | **Not more than once in three years | |
| | **alliative Services** | |
| 110 | Emergency treatment for relief of pain | 7.00 |
| | **estorative Services** | |
| | 1. FILLINGS | |
| | Silver Fillings | |
| 140 | (a) One surface | 12.00 |
| 150 | (b) Two surfaces | 18.00 |
| .160 | (c) Three or more surfaces | 27.00 |
| | Tooth Color Fillings | |
| :330 | (d) Per filling | 12.00 |
| | 2. STAINLESS STEEL CROWN | |
| 830 | each (up to age 19) | 25.00 |
| | **Oral Surgery (including X-rays, anesthesia and post-operative treatment)** | |
| | 1. EXTRACTIONS | |
| 7110 | (a) Routine or simple and surgical | 10.00 |
| 7220 | (b) Soft tissue impaction | 25.00 |
| 7235 | (c) Partial bony impaction | 40.00 |
| 7245 | (d) Complex bony impaction | 55.00 |
| 7960 | (e) Complex including bone removal and sutures | 30.00 |
| | 2. FRACTURES | |
| 7620 | (a) Upper jaw, closed reduction | 200.00 |
| 7640 | (b) Lower jaw, closed reduction | 225.00 |
| 7610 | (c) Upper jaw, open reduction | 300.00 |
| 7630 | (d) Lower jaw, open reduction | 300.00 |
| | 3. OTHER ORAL SURGICAL PROCEDURES | |
| 7430 | (a) Removal of cysts, including necessary extractions | 35.00 |
| 7340 | (b) Alveolectomy, maximum per arch | 30.00 |
| 3410 | (c) Apicoectomy | 35.00 |
| 7285 | (d) Biopsy, including report | 25.00 |
| 7960 | (e) Removal of labial frenum | 40.00 |
| 7260 | (f) Closure of oral antral fistula | 90.00 |
| | **Root Canal Treatment (including X-rays and follow-up care)** | |
| 3315 | 1. Filling one canal | 75.00 |
| 3325 | 2. Filling two canals | 100.00 |
| 3335 | 3. Filling three canals | 130.00 |
| | **Space Maintainers, simple (up to age 19)** | |
| 1510 | Any type | 50.00 |
| | **Periodontic Services (treatment of gums and associated tissues)** | |
| | 1. Periodontal root scaling and planing, including medications | |
| 4341 | (a) Fewer than 12 teeth per sitting | $ 15.00 |
| 4340 | (b) Per arch | 22.00 |
| | 2. Gum or bone surgery, including post-operative | |
| 4210 | visits (per quadrant) | 90.00 |
| 4220 | 3. Subgingival curettage | 10.00 |

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Repair of Dentures and Bridges** | |
| | 1. Broken full or partial denture | |
| 5610 | (a) No tooth damage | 20.00 |
| 5620 | (b) Replace one tooth | 30.00 |
| 5630 | (c) Each additional tooth | 7.00 |
| | 2. Replace broken teeth only | |
| 5630 | (a) First tooth | 20.00 |
| 5640 | (b) Each additional | 7.00 |
| 5670 | 3. Reattaching undamaged clasp | 20.00 |
| 5680 | 4. Replacing broken clasp with new clasp | 45.00 |
| 5650 | 5. Adding tooth to partial denture to replace natural extracted tooth, each tooth | 35.00 |
| 5725 | 6. Rebasing upper or lower full or partial denture | 50.00 |
| 2920 | 7. Recement crowns and inlays | 6.00 |
| 6640 | 8. Repair broken facing | 15.00 |

## Part II – Major Services

| | | |
|---|---|---|
| | **Inlays, Gold** | |
| 2510 | 1. One surface | 50.00 |
| 2520 | 2. Two surfaces | 80.00 |
| 2530 | 3. Three or more surfaces, maximum per tooth | 90.00 |
| | ***Dentures, Full (including supplying, inserting, fitting and adjustments)*** | |
| 5110 | 1. Upper, once in five years | 175.00 |
| 5120 | 2. Lower, once in five years | 175.00 |
| | **Dentures, Partial** | |
| 5220 | 1. Bilateral acrylic or comparable base, either jaw, two or more full clasps and rests, each | 170.00 |
| 5250 | 2. Upper bilateral, chrome cobalt alloy or gold base, two or more clasps and rests, acrylic attachments, ea. | 200.00 |
| 5230 | 3. Lower, bilateral chrome cobalt alloy or gold base, base, two or more cast clasps and tests, acrylic attachments, each | 200.00 |
| | **Crowns and Bridgework** | |
| | 1. Bridgework, Removable (one piece casing with clasps rests) | |
| 5280 | (a) One tooth replaced | 100.00 |
| 5280 | (b) Two teeth replaced | 110.00 |
| | 2. Bridgework, Fixed (single abutments only) | |
| 6780 | (a) ¾ crown | 85.00 |
| 6790 | (b) Full cast crown | 110.00 |
| 6720 | (c) Full cast with veneer | 140.00 |
| | 3. Pontics | |
| 6230 | (a) Tru-pontic (porcelain or acrylic facing with cast backing) | 95.00 |
| 6210 | (b) Pontic of other type | 85.00 |
| | 4. Crowns | |
| 2740 | (a) Porcelain jacket | 150.00 |
| 2710 | (b) Acrylic jacket | 115.00 |

## Part III – Orthodontic Services

8410 Initial appliance, X-rays, diagnosis, study models, etc.
Maximum - $150
Active treatment $35 per month. Not to exceed $840.00
Passive treatment, per 6 month period - $15.
Maximum of 3 periods, Total - $45.
Total benefits available per course of treatment..... $1,035.00

Note: If a charge is incurred for a service not included in the Schedule, in connection with the dental care of a specific condition, and if the Schedule contains one or more services which, according to customary dental practices, are separately suitable for the dental care of that condition, then a charge for the least expensive of the suitable services included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.

# RETIREE BENEFITS INFORMATION SHEETS

FOR: POLICE PERSONNEL

NOTE: This summary is necessarily brief and generalized. Only the applicable PAIs, Insurance contracts and Retirement System/Laws can be considered as definitive reference sources. The following information applies only to those employees and their dependents who are fully enrolled under the Port Authority Group Health, Dental and Life Insurance Programs and covered under a Memorandum of Agreement between the Port Authority and PBA, SBA, DEA, LBA.

## GENERAL INFORMATION

For information, consult this reference and the instructions included with each United Health Care claim form or contact the appropriate health and dental carriers directly.

United Health Care Customer Service Representatives may be reached at 1-877-259-1391 for health insurance inquiries.

Prudential Customer Service Representatives may be ~~reached at 1-800 772- 4683 for~~ dental inquires.

If further help is needed, an Employee Benefits Representative may be reached at [redacted] 201-792-3951, 201-792-3918

**AT AGE 65 AND RETIRED, OR MEDICARE ELIGIBLE, MEDICARE ENROLLMENT (PART A AND PART B) IS MANDATORY AND MEDICARE WILL BECOME PRIMARY OVER UNITED HEALTH CARE COVERAGE AND IN NETWORK BENEFITS ARE NO LONGER AVAILABLE FOR THE MEDICARE ELIGBLE PARTICIPANT. FOR UNDER AGE 65 MEDICARE RECIPENTS, PLEASE NOTIFY THE BENEFITS UNIT OF THE MEDICARE ELIGIBILITY DATE.**

In the event of your death, your surviving spouse will continue to have the same coverage you elect as a retiree for life or until remarriage. In addition, any eligible dependent children will continue to have the same coverage until the end of the calendar year in which they turn age 19, if still single. Sponsored coverage for dependent children may be continued until the end of the calendar year in which they turn age 26, provided they are not married, a full time student and dependent upon the employee/spouse for support.

## UNITED HEALTHCARE PLAN (PPO)
## OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers members complete freedom in choosing their healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the United Healthcare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at 1-877-259-1391.

**United Healthcare**
**Summary of Coverage**

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK ** |
|---|---|---|
| Deductible – Single | None | $50 |
| Family | None | $100 |
| Coinsurance | None | 20% |
| Maximum Out-of-Pocket per person | Not Applicable | $1,000 of eligible expenses (excluding deductible) |
| **PREVENTIVE CARE** | | |
| Physical Examination | $5 copay per visit | No coverage |
| Routine Pediatric Care | 100% coverage | 100% of Reasonable & Customary |
| **OUTPATIENT CARE** | | |
| Physician Office Visits | $5 copay per visit | Subject to Deductible & Coinsurance |
| Surgery | 100% coverage | 100% of Reasonable & Customary |
| Laboratory Services | 100% coverage | 100% of Reasonable & Customary |
| **HOSPITAL CARE** | | |
| Semi-private room & board | 100% coverage | 120 days at 100% balance paid at 80% |
| **EMERGENCY CARE** | | |
| Ambulance Services when medically necessary | No charge | No charge |
| **AT HOSPITAL EMERGENCY ROOM** | | |
| Accident Care, Serious Illness | 100% coverage | 100% coverage |
| **MATERNITY CARE** | | |
| Prenatal & Post-natal care | $5 copay per visit | 100% of Reasonable & Customary |
| Hospital services for mother & child | 100% coverage | 100% - 120 day maximum balance at 80% per stay |
| **SHORT TERM REHABILITATION** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOME HEALTH CARE** | | |
| 200 visits in- and out-of- network combined (4 hours/visit) | $5 copay per visit | Subject to Deductible & Coinsurance |
| **SKILLED NURSING FACILITY** | | |
| 60 days per year combined in- and out-of-network | 100% coverage | Subject to Deductible & Coinsurance |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Inpatient - 7 days detoxification, 30 days per Year, 2 confinements per lifetime | 100% coverage | 100% coverage |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Outpatient – 60 visits per year, 120 visits per lifetime combined in- and out-of- network | $5 copay per visit | Subject to Deductible & Coinsurance |
| **MENTAL HEALTH CARE** | | |
| Inpatient | 100% coverage | 100% 30 days per year balance paid at 80% |
| Outpatient | $10 copay per visit | Subject to Deductible & Coinsurance |
| **CHIROPRACTIC CARE** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOSPICE CARE** | | |
| 210 days maximum | 100% coverage | 100% coverage |
| **INFERTILITY TREATMENT** | | |
| 3 Attempt Combined Limit | $5 copay per visit | Subject to Deductible & Coinsurance |
| **MAMMOGRAPHY, Routine** | 100% coverage | 100% coverage |
| **OTHER COVERAGE** | | |
| Durable Medical Equipment | 100% coverage | Subject to Deductible & Coinsurance |

*All Benefits are subject to Reasonable & Customary
**All benefits must meet medical necessity

**This summary is not all inclusive**

# TYPICAL QUESTIONS & ANSWERS

## 1. WHAT IS A PPO?

A PPO (Preferred Provider Organization) offers the best features of both a traditional indemnity plan and an HMO (Health Maintenance Organization) by giving members the freedom to use any provider, either in-network or out-of-network, for medical and hospital care without requiring a referral from a primary care physician to use a specialist.

## 2. WHAT IS A NETWORK PROVIDER?

A network provider is one who participates in a network and has agreed to charge preferred rates for members who seek care. The network includes a broad range of providers including Family Practitioners, Internists, Pediatricians, Neurologists, Oncologists and OB/GYNs. Additionally, the network includes labs, X-ray facilities and mental health providers. Again, you are not restricted to only use network providers.

## 3. WHAT IS THE DIFFERENCE BETWEEN PPO AND HMO PLANS?

The difference is that the PPO is not a managed care plan. You are not required to choose a Primary Care Physician and you will be reimbursed if you use an out-of-network physician under a PPO plan. This allows you and your family direct access to all specialists.

## 4. HOW DO I FIND OUT IF MY DOCTOR IS A MEMBER OF THE UNITED HEALTHCARE PPO NETWORK?

- Check the Provider Directory available directly from United Healthcare;
- Call United Healthcare Member Services at 1-877-259-1391 (select the option to speak with a customer services representative) or call your doctor and ask;
- Check the Internet (www.unitedhealthcare.com). This will also give you directions and an easy to read color map showing the provider's location;

## 5. WHAT IF MY DOCTOR IS NOT A MEMBER OF THE UNITED HEALTHCARE NETWORK?

If you wish to encourage your doctor to join the United Healthcare network, simply have your doctor call United Healthcare Network/Provider Services at 1-800-638-8075 to obtain an application. Due to the thorough credentialing process, in which United checks or verifies board certification, training and education, hospital affiliation and malpractice status, the process can take up to 180 days. However, you can still go to your doctor as an out-of-network provider and be reimbursed at 80% of reasonable and customary charges.

## 6. HOW WILL MY PRESCRIPTIONS BE FILLED?

National Prescription Administrators, Inc. (NPA) provides your prescription benefit regardless of the health plan selected. The cost of each prescription is either $2 for generic brand drugs or $5 for name brand. For specific information or questions, please contact NPA directly at 1-800-467-2006.

## 7. THROUGH THE PRESCRIPTION BENEFIT (NPA), CAN I PURCHASE ORAL CONTRACEPTIVES AT THE PHARMACY AS WELL AS THROUGH MAIL ORDER (CFI)?

Yes, you may purchase oral contraceptives at the pharmacy, although you would realize savings through the CFI mail order program (one co-payment, 90-day supply).

8. **ARE PRE-EXISTING CONDITIONS COVERED?**

Yes. There is no pre-existing condition limitation under any of the current health care coverage plans.

9. ***DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED HEALTHCARE'S PPO PLAN?***

No. Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

10. **WHAT ARE MY RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998?**

As required by the Women's Health and Cancer Rights Act of 1998, all our health plans provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Please call your carrier for more information.

11. **WHO IS AN ELIGIBLE DEPENDENT?**

Eligible dependents are defined as an employee's spouse or dependent child(ren). Dependent children are covered until the end of the calendar year in which they turn age 19. Coverage may extend either through the end of the month the child graduates or up to age 26 provided the child is in full-time attendance at an accredited educational institution, unmarried, and is dependent on the employee for financial support. However, your health carriers will require you to provide verification of your child's full-time student status. Domestic partners, parents and grandchildren are not considered eligible dependents.

12. **HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?**

You can add or remove eligible dependents from your coverage by completing the enclosed *Benefit Selection Form* or form PA2298 (*Employee Status Change)* and returning it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (i.e. state marriage certificate, divorce decree, birth certificate for children, etc.) in order for the change to be made. Failure to notify Employee Benefits within the required time frame will result in having your request denied by the insurance carrier, and you will not be permitted to add your dependents(s) to your plan coverage until the next open enrollment period.

13. ***HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?***

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent (as defined in question #21). Official notification to CobraServ (1-727-864-3300) must be received within 60 days from the end of the month in which the dependent loses eligibility. Please note that the only coverage available for purchase would be that coverage/carrier currently held by the applicable employee. For example, if an employee is enrolled in the Prudential/Blue Cross (indemnity) health plan, only that plan is initially available for purchase.

14. **HOW DO I GET CLAIM FORMS?**

A claim form is included in this package and can be copied. You can also request claim forms by calling United Healthcare at 1-877-259-1391.

## 15. WHAT IS A CHANGE IN FAMILY STATUS?

A change in status includes the marriage or divorce of the employee, death of the employee's spouse or dependent children, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, switching from part-time to full-time employment status (or vice versa) by the employee or the employee's spouse, taking of an unpaid leave of absence by the employee or the employee's spouse, or a significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment.

## 16. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a Provider Directory by contacting United Healthcare at 1-877-259-1391.

## 17. WHO DO I CALL WITH GENERAL QUESTIONS?

You can call Employee Benefits at 212-435-6163 or 1-800-269-4280 or United Healthcare at 1-877-259-1391.

## 18. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT IS MY SPOUSE'S COVERAGE WHEN HE/SHE IS OVER 65? UNDER 65?

- If you or your spouse is over 65, Medicare is the primary coverage (see attachment III).
- If you or your spouse are under 65 the primary coverage will be United Healthcare (unless you have other active coverage or are Medicare eligible).

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If you are over 65, you will receive a United Healthcare ID card for an *Indemnity Plan*. If you are under 65 you will receive an ID card for a *PPO Plan*. If you are over 65 and your spouse is under 65 or vice versa, you will receive one card for an *Indemnity Plan* and one card for a *PPO Plan*.

## 19. HOW DO I SUBMIT CLAIMS USING AN IN-NETWORK PROVIDER?

If you are <u>under 65 and use an in-network provider</u>, there are no claim forms to complete. Only a $5 co-payment is required.

## 20. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

- **If you are under 65 years of age** and are using an out-of-network provider, submit a copy of your bill and a claim form to United Healthcare, PO Box 740800, Atlanta, GA 30374-0800.
- **If you are over 65 years of age** or eligible for Medicare due to a disability, your provider must submit the claim to Medicare before submitting the claim to United Healthcare for reimbursement of eligible balances.

*United Healthcare also accepts claims electronically and has a Medicare crossover program. Contact United Healthcare directly @ 1-877-259-1391.*

## 21. WHAT IS MY COVERAGE IN THE EVENT OF AN EMERGENCY?

You and your family are covered on an in-network basis worldwide. If you get care by an out-of-network provider, including all providers overseas (except Puerto Rico), you will need to submit a claim form for reimbursement as per your in-network plan of benefits .

*Emergency care* is generally defined as treatment required because of a sudden medical condition for which the failure to receive immediate care could place your life in danger or could cause a serious impairment of bodily functions. Some examples are: chest pain, sever bleeding, stroke, serious burns, serious breathing conditions and loss of consciousness. Payment will be made based on your symptoms.

# YOUR PORT AUTHORITY (THROUGH UNITED HEALTHCARE) COVERAGE WHEN MEDICARE BECOMES PRIMARY

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare through the Social Security disability program. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority retiree health plan.

NOTE: *It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits* regarding the date of their Medicare eligibility.

Medicare Part A provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deductible imposed by Medicare.

The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the Port Authority coverage through United HealthCare. (When you are under age 65, United Healthcare's out-of-network benefits provides for 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the Port Authority reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

Medicare Part B covers medical expenses, for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug charges. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Whenever you incur medical expenses, all claims (with the exception of prescription drugs), must be submitted to Medicare first. After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United HealthCare along with a completed and signed United HealthCare claim form. United HealthCare will consider the charges and pay them in accordance with the major medical benefit.

GROUP HEALTH – Major Medical: Under the Major Medical, the annual deductible is $50 for an individual and $100 for a family ($50 in eligible expenses for the first family member and $50 in combined eligible expenses for all other family members). Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees for each individual up to $5,000 and at 100% thereafter during the calendar year.

The maximum lifetime Major Medical benefit for each eligible individual is unlimited.

Major Medical provides treatment of mental and nervous disorders, with outpatient visits reimbursed at 80% of reasonable and customary charges.

NOTE: Should you travel outside the Continental United States and require medical treatment, Medicare will not pay for those services, however your pre-65 (pre Medicare) coverage will be reinstated to process any claims if necessary.

THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
GA-197512
PPO PLAN
888-441-9815

UNITEDhealthcare

P.O. BOX 740800
ATLANTA, GA 30374-0800

# HEALTH CLAIM TRANSMITTAL

Employee Name: _____ SSN: ___ — ___ — ___ Date of Birth: ___ / ___ / ___

Employee Address: _____ Check If New Address ☐

Employee Phone Number: ( ) _____ Status: ☐ Active ☐ Retired ☐ Continued (COBRA)
Area Code Number

Spouse Name: _____ Spouse Date of Birth: ___ / ___ / ___

Patient Name: _____ Patient Date of Birth: ___ / ___ / ___ Relationship: _____

Nature of Illness or Injury: _____

IF CLAIM IS DUE TO INJURY STATE WHEN, WHERE AND HOW INJURY OCCURRED

Do You Have More Than One Employer? Yes ☐ No ☐

Is Your Spouse Employed? Yes ☐ No ☐ Is Patient Employed? Yes ☐ No ☐

If you answered "yes" to any of the above questions, please provide the following information

Employed Person: _____ Social Security Number: ___ — ___ — ___

Employer: _____

Employer Address: _____ Phone Number: ( ) _____
Area Code Number

Insurance Company & Policy Number: _____

**ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.**

Employee Signature: _____ Date ___ / ___ / ___

## HINTS FOR SUBMITTING CLAIMS TO UNITED HEALTHCARE

- **If you want United HealthCare to pay benefits directly to the provider of medical services, write "pay directly" prominently on the bill(s).**
- Attach your bills to this completed form and mail them to United HealthCare at the address shown above.
  *COBRA continuees mail to the United HealthCare claim office you used as an active employee (or as a dependent of an active employee).*
- Make sure all bills indicate the reason (diagnosis) for treatment and list the date, type and cost of each service.
- Send additional bills periodically or when they total $50.00 or more.

**For UNITED HEALTHCARE USE ONLY**

| DATE BENEFITS BECAME EFFECTIVE | | | DATE BENEFITS TERMINATED | | | SUFFIX | ACCOUNT |
|---|---|---|---|---|---|---|---|
| | MO. DAY YEAR | | | MO. DAY YEAR | | | |
| Emp. | Dep. | | Emp. | Dep. | | | |

| SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS: | DATE | MO. | DAY | YEAR |
|---|---|---|---|---|
| | | | | |

NATIONAL PRESCRIPTION ADMINISTRATORS, INC.

Information About Your Prescription Drug Card Benefit Plan

FOR NPA CUSTOMER SERVICE, CALL (800) 467-2006

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contacting NPA. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the NPA card or misplace it, the pharmacy can still identify you as an NPA customer if you can provide the social security number of the covered Port Authority employee and the Port Authority sponsor number which is 1395. Lost cards can be replaced by contacting NPA at the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Copayment for generic drugs is $2 and copayment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through your prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription - excluding insulin / Devices or appliances - support garments or other non-medicinal substances / Administration charges for drugs or insulin / Investigational or experimental drugs / Unauthorized refills / Prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / Medications for eligibles confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / Medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of NPA's participating pharmacies. NPA can assist you with the name of a pharmacy located in your area if you are not familiar with one. Network pharmacies display a green "NPA" decal in the window or near the Pharmacy Department.

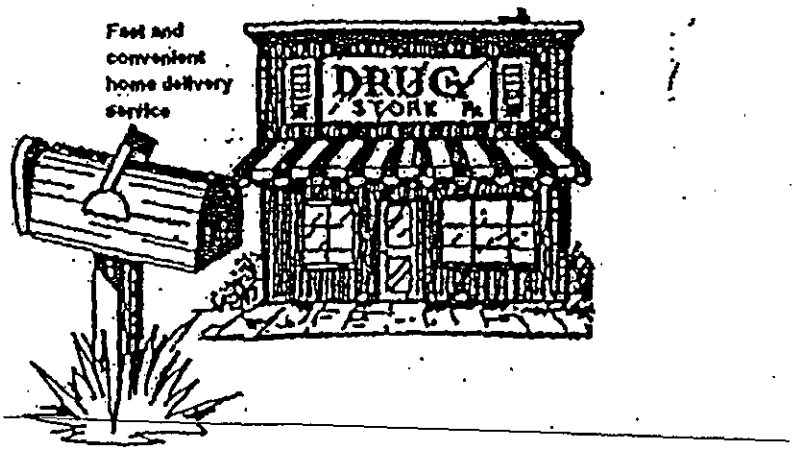
At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 copayment for a generic drug or a $5.00 copayment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will be required to use the CFI Mail Order Program to fill your prescription after the first refill.

## CFI MAIL ORDER PROGRAM

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The copayment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See CFI Pharmacy Service brochure).

## OUT OF NETWORK USAGE

If you are travelling and cannot locate an NPA pharmacy or experience an emergency which necessitates the use of a pharmacy that is not part of the NPA network, you may do so by paying the full cost of the prescription to the pharmacy and submitting a claim form to NPA. Claim forms can be obtained by calling NPA's customer service line. Following your claim submission, you will be reimbursed all but the applicable




# CFI PHARMACY SERVICE

AN ADDED FEATURE
TO YOUR
PRESCRIPTION DRUG PLAN

## INTRODUCTION

The CFI Pharmacy Service has been created to provide you with the convenience of receiving prescription maintenance medication, in large quantities, right at your home. This service covers any prescription medication your doctor requests to be taken on a long term continual schedule.

## WHO IS COVERED

You and your dependents are covered as long as your eligibility continues in the Program.

## WHAT IS COVERED

Your mail order service covers all medications which require a prescription by either state or federal law and are prescribed by a licensed practitioner. This service may be used to purchase any prescription drug but its primary aim is to offer maintenance drugs used for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc.

## WHAT IS NOT COVERED

Please check the "Exclusions" portion of the Prescription Plan brochures you received with your Employee Benefits Kit.

## WHY USE A MAIL ORDER SERVICE

Participating in the mail order service helps you in several ways. First is the convenience. If you have a chronic condition which requires the taking of medication frequently and for a long period of time, a three or six months supply can be delivered to your house – we absorb all postage. This should be particularly helpful to retiree participants. Secondly, your mail order pharmacy will provide a monitoring service. All you have to do is fill out the allergy information on the mailing envelope enclosed with this brochure.

It asks for general information, but more importantly, requests information, regarding allergies and /or drug sensitivities. When your doctor prescribes a medication, the pharmacist will check to see whether it may conflict with other drugs you are taking.

## GENERIC DRUGS

Under the law, generic equivalent drugs will be dispensed for a brand name drug unless you or your doctor request otherwise. A generic drug is one that is defined by its official pharmaceutical name rather than its advertised brand name. In most cases there is a great difference in price between brand name drugs and generic drugs -- but that is the only difference between them.

## HOW TO USE THE SERVICE

- Fill out the information on the envelope. Don't forget to include the allergy information.

- Enclose your doctor's prescription for up to a three or six months supply of medication, depending upon the quantity limitations established by your plan.

- Remember to enclose the copayment for each prescription (if applicable).

- Enter your return address on the envelope including your apt. no. if applicable.

Your order should be delivered by United Parcel Service or U.S. Mail within seven business days from receipt at the pharmacy. You will also receive another mailing envelope with your shipment.

Please remember, reorders should be sent about two weeks before your medication is due to run out.

## WHAT HAPPENS IF THE DRUGS NEVER ARRIVE

If you fail to receive your medication within the time prescribed, contact CFI:

973-560-2700 1-800-628-0717

Give your name, the name of your doctor, the type of prescription mailed to the pharmacy and the date you mailed it. An immediate trace will be made. If it is determined that your prescription or shipment has been lost, a CFI representative will contact your doctor to arrange for a new prescription which will be phoned in directly to the pharmacy.

## WHAT ABOUT GENERAL INQUIRIES

If you have any questions regarding your program, please call your Fund office or CFI.

INSERT THIS PAMPHLET IN YOUR
EMPLOYEE BENEFIT KIT
FOR FUTURE REFERENCE

CFI
P.O. BOX 2000
EAST HANOVER, NJ 07936-2000

973-560-2700 1-800-628-0717

## NPASelect PREFERRED MEDICATION LIST

The NPASelect Preferred Medication List is an extensive list of medications that will effectively treat virtually all diagnosed conditions at a lower cost than drugs not on the preferred list due to manufacturer discounts and rebates. You are encouraged to share the NPASelect Preferred Medication List (see enclosed pocket version) with your doctor. NPA's participating pharmacies may request the opportunity to call your doctor about prescribing a medication that is on the list. Use of the medications on the Preferred Medication List will help to ensure the financial health of the plan and still provide you with effective medication. Of course, your physician will always make the final decision on the best drug for you and the plan will cover all eligible prescriptions, whether or not they are on the preferred list.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Your unmarried dependent full time student will be covered until the end of the calendar year in which he/she turns 26. If you have a dependent over the age of 19, NPA will write to you twice a year to request that you provide them with documentation of your dependent's full time student status. The first request for such documentation will be made by NPA on or around February 1, 1998 with a due date of March 1, 1998.

## YOUR PHARMACIST

Pharmacists are more than just experts on drugs. Their professional role in the health care field is expanding dramatically and they are, more than ever, becoming a vital part of the health care delivery system.

Remember they are always willing to assist you or your physician with the best possible pharmaceutical advice available. Ask your pharmacist any questions regarding your prescription.

ALL POLICE CLASSES



# DENTAL OPTIONS

## I. PRUDENTIAL REASONABLE AND CUSTOMARY DENTAL PLAN N/C

A. Dental Expenses

- 80% reimbursement rate based on the reasonable and customary fee.
- Orthodontic expenses reimbursed under a fixed schedule of allowances only (will not be applicable toward your annual deductible, as indicated below). One treatment per lifetime per eligible dependent under age 19.

B. Annual Dental Deductibles

- $ 50/Individual
- $100/Family

## II. PRUDENTIAL SCHEDULE OF ALLOWANCES DENTAL PLAN $21.98

A. Expenses are reimbursed under a fixed schedule of allowances.

B. This plan does not require a deductible.

## III. DENTCARE DENTAL PLAN $24.00

If two Port Authority and/or PATH employees are married to each other and both choose Dentcare, they can only have one Dentcare plan which must cover both employees and all family members.

- Generally no out of pocket expenses (See Dentcare brochure for exceptions).
- Must go to a designated Dentcare dentist (see Healthplex listings).
- Pre-certification needed from the Dentcare Program for all major dental work done by a Dentcare Dentist.
- No deductibles

GROUP DENTAL BENEFIT (80% Reasonable and Customary Plan) - Prudential

Under the Group Dental Benefit (80% Reasonable and Customary Plan), the annual deductible is $50 for an individual and $100 for a family. It provides reimbursement for basic and major dental services in excess of the annual deductible at 80% of usual and prevailing charges. You and your eligible dependents may also be covered for orthodontic services, if they began before age 19, up to a maximum of $1,035 for a full course of treatment in accordance with the following schedule. Any reimbursement for services covered under the orthodontic schedule is not applied towards the annual deductible.

Initial appliance, X-rays, diagnosis, study models, etc.
Maximum.....$ 150
Active treatment calculated at a maximum of $34 per month for a total
Maximum.....$ 840
Passive treatment, per six month period - $15
Maximum of 3 periods.....$ 45
Total benefits available.....$1,035
Per course of treatment

Your claim will be paid in equal installments, beginning when the orthodontic appliances are first inserted, and quarterly thereafter for the estimated duration of the treatment plan, as long as the treatment begins while the patient is under 19 years of age. Coverage for orthodontia ceases at the end of the year in which the covered individual reaches 19 years of age unless eligible for sponsored coverage.

GROUP DENTAL BENEFIT (Schedule of Allowances) - Prudential

There is no deductible for this Group Dental Benefit coverage, which provides you and your eligible dependents with benefits under a Schedule of Allowances for a broad range of dental services, (see attached schedule of allowances). You and your eligible dependents may also be covered for orthodontic services, if they began before age 19, for up to a lifetime maximum of $1,035 for a full course of treatment in accordance with the attached schedule.

# OPTION 2 - FIXED SCHEDULE OF ALLOWANCES

## PART I – Basic Services

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Diagnostic and Preventive Services** | |
| 0110 | 1. Clinical oral examination* | $ 10.00 |
| 1110 | 2. Cleaning, scaling and polishing* | 15.00 |
| 1210 | 3. Fluoride treatment (up to age 19)* | 8.00 |
| 1210 | 4. X-RAYS – individual total not to exceed the allowance for full-mouth series | |
| 0210 | (a) Full mouth or Panorex (at least 10 times)** | 15.00 |
| 0270 | (b) Bitewing, each | 3.00 |
| 0200 | (c) Periapical, single, each | 2.00 |
| 0240 | (d) Intra-oral occlusal (edentulous jaw), each | 7.00 |
| 0321 | (e) Temporo-mandibular joint film | 15.00 |
| 0340 | (f) Anterior/posterior: head and jaws | 15.00 |
| 0290 | (g) Lateral, head and jaws | 15.00 |
| | *Not more than twice annually | |
| | **Not more than once in three years | |
| | **Palliative Services** | |
| 9110 | Emergency treatment for relief of pain | 7.00 |
| | **Restorative Services** | |
| | 1. FILLINGS | |
| | Silver Fillings | |
| 2140 | (a) One surface | 12.00 |
| 2150 | (b) Two surfaces | 18.00 |
| 2160 | (c) Three or more surfaces | 27.00 |
| | Tooth Color Fillings | |
| 2330 | (d) Per filling | 12.00 |
| | 2. STAINLESS STEEL CROWN | |
| 2830 | each (up to age 19) | 25.00 |
| | ***Oral Surgery (including X-rays, anesthesia and post-operative treatment)*** | |
| | 1. EXTRACTIONS | |
| 7110 | (a) Routine or simple and surgical | 10.00 |
| 7220 | (b) Soft tissue impaction | 25.00 |
| 7235 | (c) Partial bony impaction | 40.00 |
| 7245 | (d) Complex bony impaction | 55.00 |
| 7960 | (e) Complex including bone removal and sutures | 30.00 |
| | 2. FRACTURES | |
| 7620 | (a) Upper jaw, closed reduction | 200.00 |
| 7640 | (b) Lower jaw, closed reduction | 225.00 |
| 7610 | (c) Upper jaw, open reduction | 300.00 |
| 7630 | (d) Lower jaw, open reduction | 300.00 |
| | 3. OTHER ORAL SURGICAL PROCEDURES | |
| 7430 | (a) Removal of cysts, including necessary extractions | 35.00 |
| 7340 | (b) Alveolectomy, maximum per arch | 30.00 |
| 3410 | (c) Apicoectomy | 35.00 |
| 7285 | (d) Biopsy, including report | 25.00 |
| 7960 | (e) Removal of labial frenum | 40.00 |
| 7260 | (f) Closure of oral antral fistula | 90.00 |
| | **Root Canal Treatment (including X-rays and follow-up care)** | |
| 3315 | 1. Filling one canal | 75.00 |
| 3325 | 2. Filling two canals | 100.00 |
| 3335 | 3. Filling three canals | 130.00 |
| | **Space Maintainers, simple (up to age 19)** | |
| 1510 | Any type | 50.00 |
| | **Periodontic Services (treatment of gums and associated tissues)** | |
| | 1. Periodontal root scaling and planing, including medications | |
| 4341 | (a) Fewer than 12 teeth per sitting | $ 15.00 |
| 4340 | (b) Per arch | 22.00 |
| | 2. Gum or bone surgery, including post-operative | |
| 4210 | visits (per quadrant) | 90.00 |
| 4220 | 3. Subgingival curettage | 10.00 |

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Repair of Dentures and Bridges** | |
| | 1. Broken full or partial denture | |
| 5610 | (a) No tooth damage | 20.00 |
| 5620 | (b) Replace one tooth | 30.00 |
| 5630 | (c) Each additional tooth | 7.00 |
| | 2. Replace broken teeth only | |
| 5630 | (a) First tooth | 20.00 |
| 5640 | (b) Each additional | 7.00 |
| 5670 | 3. Reattaching undamaged clasp | 20.00 |
| 5680 | 4. Replacing broken clasp with new clasp | 45.00 |
| 5650 | 5. Adding tooth to partial denture to replace natural extracted tooth, each tooth | 35.00 |
| 5725 | 6. Rebasing upper or lower full or partial denture | 50.00 |
| 2920 | 7. Recement crowns and inlays | 6.00 |
| 6640 | 8. Repair broken facing | 15.00 |

## Part II – Major Services

| | | |
|---|---|---|
| | **Inlays, Gold** | |
| 2510 | 1. One surface | 50.00 |
| 2520 | 2. Two surfaces | 80.00 |
| 2530 | 3. Three or more surfaces, maximum per tooth | 90.00 |
| | **Dentures, Full (including supplying, inserting, fitting and adjustments)** | |
| 5110 | 1. Upper, once in five years | 175.00 |
| 5120 | 2. Lower, once in five years | 175.00 |
| | **Dentures, Partial** | |
| 5220 | 1. Bilateral acrylic or comparable base, either jaw, two or more full clasps and rests, each | 170.00 |
| 5250 | 2. Upper bilateral, chrome cobalt alloy or gold base, two or more clasps and rests, acrylic attachments, ea. | 200.00 |
| 5230 | 3. Lower, bilateral chrome cobalt alloy or gold base, base, two or more cast clasps and tests, acrylic attachments, each | 200.00 |
| | **Crowns and Bridgework** | |
| | 1. Bridgework, Removable (one piece casing with clasps rests) | |
| 5280 | (a) One tooth replaced | 100.00 |
| 5280 | (b) Two teeth replaced | 110.00 |
| | 2. Bridgework, Fixed (single abutments only) | |
| 6780 | (a) ¾ crown | 85.00 |
| 6790 | (b) Full cast crown | 110.00 |
| 6720 | (c) Full cast with veneer | 140.00 |
| | 3. Pontics | |
| 6230 | (a) Tru-pontic (porcelain or acrylic facing with cast backing) | 95.00 |
| 6210 | (b) Pontic of other type | 85.00 |
| | 4. Crowns | |
| 2740 | (a) Porcelain jacket | 150.00 |
| 2710 | (b) Acrylic jacket | 115.00 |

## Part III – Orthodontic Services

8410 *Initial appliance, X-rays, diagnosis, study models, etc.*
Maximum - $150
Active treatment $35 per month. Not to exceed $840.00
Passive treatment, per 6 month period - $15.
Maximum of 3 periods, Total - $45.
Total benefits available per course of treatment..... $1,035.00

Note: If a change is incurred for a service not included in the Schedule, in connection with the dental care of a specific condition, and if the Schedule contains one or more services which, according to customary dental practices, are separately suitable for the dental care of that condition, then a charge for the least expensive of the suitable services included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.

# DENTAL EXPENSE BENEFITS — CLAIM INSTRUCTIONS

"Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts."

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY PAYMENT OF YOUR CLAIM.

## TO THE EMPLOYEE

1. Complete items one (1) through fifteen (15a) in full. Be certain to sign the authorization to release information block and the certification block (15b and 15c).

2. If you wish to have your benefits for this claim paid directly to your dentist, sign the "Direction to pay benefits to dentist" block located below the dentist certification.

If total charges for the planned course of treatment are expected to exceed the minimum Predetermination dollar amount stated in your dental plan booklet, it is suggested you file for Predetermination of Benefits. Prudential will notify your dentist of the benefits payable.

NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR DENTAL BOOKLET FOR A DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND COPAYMENT INFORMATION, AND LIMITATIONS AND EXCLUSIONS.

## TO THE DENTIST

1. COMPLETED SERVICES — Check the box noted "STATEMENT OF ACTUAL SERVICES" and complete items 16 through 32. When entering the treatment plan on the form, please indicate a *separate* fee for each individual service rendered. When the work is finished, sign the form and mail to the address shown in the upper right hand corner of the reverse side of this form.

2. PREDETERMINATION OF BENEFITS — If total charges for this claim are to exceed the minimum Predetermination dollar amount indicated in the employee's Dental Plan Booklet (and treatment is not emergency in nature), Predetermination of Benefits is suggested. Check the box marked "PRETREATMENT ESTIMATE", and complete items 16 through 32. Please be sure to answer questions 28 and 29 if the claim includes metal restorations, crowns, bridgework or dentures.*

   The completed form should be sent to the address shown in the upper right hand corner of the reverse side of this form. Prudential will notify you of the benefits payable for this course of treatment.

   When treatment has been completed, fill in the date each service was provided, sign the form and return to the address shown in the upper right hand corner of the reverse side of this form for payment.

NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE EMPLOYEE, DENTIST AND INSURANCE COMPANY CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.

3. If the employee indicates that benefits should be paid directly to the dentist, then these benefits will be sent directly to you with an information copy of the transaction to the employee.

*X-rays taken for metal restorations and crowns should be submitted with treatment plan. They may also be requested for other services. X-rays will be reviewed by practicing Dentists and returned promptly.

Aetna US Healthcare

# Dental Benefits Request

Mail to: Aetna U.S. Healthcare
P.O. Box 14094
Lexington, KY 40512-4094

## TO BE COMPLETED BY EMPLOYEE

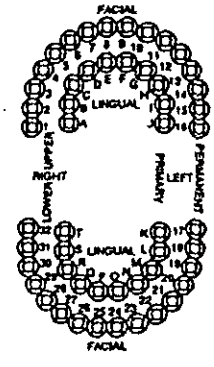
1. Employer's Name: The Port Authority of New York and New Jersey
2. Policy/Group Number: 14910 Branch Number
3. Employee's Social Security Number
4. Employee's Name
5. Employee's Birthdate (MM/DD/YYYY)
6. ☐ Active ☐ Retired Date of Retirement
7. Employee's Address (include zip code) ☐ Address is new
8. Employee's Daytime Telephone Number ( )
9. Patient's Name
10. Patient's Social Security Number
11. Patient's Birthdate (MM/DD/YYYY)
12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)
14. Patient's Sex ☐ Male ☐ Female
15. Full Time Student ☐ No ☐ Yes
16. Patient's Expected Graduation Date
17. Name of School City
18. Patient's Marital Status ☐ Married ☐ Single
19. Is patient employed? ☐ No ☐ Yes
20. Name & Address of Employer
21. Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes
22. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:
23. Member's Social Security Number
24. Member's Name
25. Member's Birthdate (MM/DD/YYYY)
26. Is claim related to an accident? ☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm
27. Is claim related to employment? ☐ No ☐ Yes
28. To all providers of dental care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting dental professionals and utilization review organizations with whom Aetna has contracted, information concerning dental care, advice, treatment or supplies provided the patient. This information will be used to evaluate claims for dental benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted.
I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.
Patient's or Authorized Person's Signature _____ Date _____
29. I authorize payment of dental benefits to the dentist or supplier of service.
Patient's or Authorized Person's Signature _____ Date _____

## TO BE COMPLETED BY DENTIST

30. This is a ☐ Request for Pre-Treatment Estimate ☐ Statement of Services Rendered
31. Dentist's Name & Address (include zip code)
32. Telephone No. ( )
33. Dentist License No.
34. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
35. First Visit Date Current Series
36. Place of Treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other
37. Radiographs or models enclosed? ☐ No ☐ Yes How many?

| Is treatment result of: | No | Yes | If yes, enter brief description and dates |
|---|---|---|---|
| 38. occupational illness or injury? | | | |
| 39. auto accident? | | | |
| 40. other accident? | | | |
| 41. Are any services covered by another plan? | | | |
| 42. If prosthesis, is this initial placement? | | | If no, date of prior placement and reason for replacement |
| 43. Is treatment for orthodontics? | | | Date appliance placed: _____ Initial Appliance Fee: _____<br>No. of months of treatment: _____ Monthly Fee: _____<br>Mos. of treatment remaining: _____ Total Case Fee: _____ |

44. To expedite claim handling, identify all missing teeth with "X"




45. Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. Use charting system shown.

| Tooth # or Letter | If Previously Extracted, Give Date | Surface | Description of Service (x-rays, prophylaxis, materials used, etc.) | Date Service Performed MM DD YYYY | Procedure Number | Fee |
|---|---|---|---|---|---|---|
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46. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.
Dentist's Signature _____ Date _____

Total charge $ _____
Amount paid $ _____
Balance due $ _____

DENTCARE DENTAL PLAN

Under this plan, dental coverage is provided by Dentcare Delivery Systems, Inc. (Dentcare). Dentcare provides a system for furnishing dental care services within the states of New York and New Jersey and offers services through participating dentists at approximately 200 locations in various communities in New York and New Jersey, generally with no out-of-pocket cost to the patient.

Where there is a charge for certain services, there is a predetermined maximum amount (see Dentcare brochure, under "Charges"). You must go to a participating dentist (see Healthplex listing), and you may change your dentist at any time. However, you may not change dental coverage.

You should be aware that any dental services which are not rendered, prescribed, arranged, or approved by a Dentcare dentist (except in cases of emergency dental care as explained in the Dentcare brochure) will not be covered by the Dentcare Dental Plan. In addition, pre-certification by a Dentcare dentist with the approval of the Dentcare Dental Director is necessary before any prosthetic or periodontal service is provided. Orthodontic services (provided for children under 19 years of age unless eligible for sponsored coverage) must also be pre-certified by a Dentcare orthodontist. In addition, pre-certification is needed for all major dental work done by a Dentcare dentist.

For Dentcare inquiries, please call Dentcare directly at (516) 794-3000 or 1-800-468-0600.

# THE PORT AUTHORITY

OF NY & NJ

## VISION CARE BROCHURE

*Administered by*

NATIONAL VISION ADMINISTRATORS
A DIVISION OF
NATIONAL PRESCRIPTION
ADMINISTRATORS, INC.

*Effective 01/01/98*

The Port Authority of New York and New Jersey has selected NATIONAL VISION ADMINISTRATORS (NVA) as administrators of the Vision Benefit Program effective January 1, 1998. We have designed this Benefit Program along with NVA, an innovative leader in the field with your convenience in mind. NVA's highly qualified staff will assist you when needed.
Please read this brochure completely and keep it for future reference.

## HOW TO OBTAIN YOUR BENEFITS

NVA has a network of participating Ophthalmologists, Optometrists, and Opticians to serve you. A directory of local participating providers will be supplied to each eligible employee.

When making your appointment with an NVA Participating Provider, please notify them that your coverage is administered by NVA and sponsored by The Port Authority of New York and New Jersey. When you arrive for your vision care appointment, simply present your NVA Vision Care identification card. You do not need to obtain a vision claim form. The provider will telephone NVA to verify your vision care eligibility and inform you of your eligibility status prior to rendering services. To verify benefit eligibility yourself prior to scheduling your eye care appointment, you may contact NVA's Customer Service Department at the following toll free number 1-800-672-7723.

## PARTICIPATING PROVIDERS

If you use a Participating Provider your eye exam will be covered in full. If corrective eyewear is necessary, you will be covered up to the plan allowance for lenses, frames or contact lenses after meeting a $25.00 materials deductable. Any costs exceeding the plan allowance are the responsibility of the patient.

ELIGIBILITY

EMPLOYEES: Eligibility for and termination of benefits under this vision care plan is determined by the same rules that apply to your other health care benefits. Employees who have elected to waive any Port Authority Health Coverage can still use vision benefits if desired. Benefits become effective on the 31st day after starting employment.

DEPENDENTS are defined as the spouse, unmarried dependent children through the end of the year in which they turn 19; unmarried dependent children who are full-time students through the end of the year in which they turn 26.

HOW OFTEN BENEFITS ARE PROVIDED

EXAMINATION: Once every 12 months

LENSES: Once every 12 months

FRAMES: Once every 24 months

CONTACT LENSES: Once every 12 months

This benefit includes disposables and is available in lieu of the lenses and frames benefit. (When contact lenses are selected the frame benefit is depleted for the following 24 months).

COVERED BENEFITS

VISION EXAMINATION: A complete analysis of eyes and related structures; prescribing corrective lenses as needed.

LENSES: To correct vision problems - lenses may be plastic or impact resistant glass.

FRAMES: The plan offers a wide selection of frames, at no cost to you after the materials deductable is met.

CONTACT LENSES: The plan will contribute an allowance towards the purchase of contacts. (In lieu of lenses and frames.)

Medically Necessary Contacts: This enhanced allowance (within the plan limits) will be considered for payment by NVA when an NVA Participating Provider secures prior authorization for the following conditions: a) Following cataract surgery, b) To correct extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, c) Anisometropia, d) Keratoconus.

VISION SERVICES AND MATERIALS THAT ADD EXTRA COSTS

This plan is designed to cover your basic visual needs rather than cosmetic materials. Extra materials that are not covered by the Plan may be purchased through the NVA participating doctor at a controlled cost.

Lenses - The wholesale cost plus 25%.

Example: Gradient Tint wholesale cost $10.00 plus 25% ($2.50) = $12.50

Frames - the difference between the wholesale cost of the frame and the maximum allowance plus 20% of the difference.

Example: $60.00 wholesale cost - $40.00 plan allowance = $20.00 difference. $20.00 difference + (20%) $4.00 = $24.00.

Photochromatic (gray and brown) light or dark; Tinted (other than Pink #1 or #2),gradient or fashion colors; Progressive or no-line multifocals; A frame costing more than the plan allowance; Coatings: Mirror, Anti-reflective, Super A.R., Color, Edge, Ultra Violet; Polish edges;Smart Segment; Scratch resistant (lab or manufacturer applied); Rimless; Polycarbonate; Prescription Sunglasses.

NON-COVERED ITEMS

There are no benefits for professional services or materials connected with:

Medical or surgical treatments (These may, however, be covered under your Medical Benefit Plan); Drugs or medications (These may, however, be covered by your Prescription Drug Plan);Non-prescription lenses including sunglasses; Examinations or materials not listed as a covered service; Replacement of lost, stolen, broken, or damaged lenses; Services or materials provided by Federal, State, Local Government or Worker's Compensation; Examination, procedures training or materials not listed; Industrial 3(mm) safety lenses and safety frames with side shields; Parts or repair of frame.

NON-PARTICIPATING PROVIDERS

If you select a non-participating provider you must pay the provider's full fee and obtain an itemized receipt which must contain the following information:

a) Employee's name and Social Security number
b) Patient's name
c) Date service began
d) The services and materials you received.
e) Signature of employee or spouse

Mail to:

NVA
P.O. Box 1981
East Hanover, NJ 07936

NON-PARTICIPATING REIMBURSEMENT SCHEDULE

| | | |
|---|---|---|
| Vision Examination, up to | $32.00 | |
| Tonometry | | $ 3.00 |
| MATERIALS (pair) | | |
| Single Vision Lenses, up to | $15.00 | |
| Bifocal Lenses, up to | | $25.00 |
| Trifocal Lenses, up to | | $35.00 |
| Lenticular Lenses, up to | $60.00 | |
| Frames, up to | | $40.00 |
| CONTACT LENSES | | |
| Contact Lenses, with exam up to | $75.00 | |
| Including Disposables | | |

Medically Necessary Contacts, up to the enhanced plan allowance.

THERE IS NO ASSURANCE THE NON-PARTICIPATING REIMBURSEMENT SCHEDULE WILL COVER THE ENTIRE COST OF THE EXAMINATION, LENSES, FRAMES OR CONTACTS.

This brochure is written in layman's language for your convenience. It is not intended to interpret,

extend, or change the rules and regulations of the plan. Should any differences arise in interpretation between the plan and this brochure, the plan shall govern.

Any and all questions or requests for information should be directed to:

National Vision Administrators
A Division of
National Prescription Administrators, Inc.
P.O. Box 1981
East Hanover, NJ 07936-1981
Toll Free Line 800-672-7723

DEA, PBA, SBA, LBA

PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base annual salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. To be certain of the amount of your coverage, you should check with Employee Benefits. The current monthly cost per $1,000 of coverage is $.325 and is subject to change from time to time. Required contributions will be deducted from the retirement check.

The Extended Group Life Insurance Plan continues after you reach age 65. However, yearly reductions of approximately 10% will begin when you reach age 65, until age 71, at which time the Face Value of the policy will remain constant at approximately 1/3 of the amount selected at retirement (one, two, or three times base annual compensation). Deductions will continue until your death or your request to discontinue coverage. If you are over age 65 at the time of retirement, your life insurance will be adjusted to the reduced retirement benefit for that age.

The retiree retains the right upon each reduction of the Term Life Insurance Policy to convert a portion or the full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of the Prudential Insurance Company who will determine premiums according to age, sex, and occupation (if applicable) of the applicant at the time of the conversion.

GROUP LIFE INSURANCE IMPUTED INCOME AND FICA LIABILITY - PORT AUTHORITY RETIREES

Under Federal Guidelines imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the employer is reportable as taxable income and may be subject to FICA Tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age at December 31 of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

DEDUCTIONS

The total Life Insurance deductions and/or the Dental Deductions will appear in the Insurance Premium Box on your first regular retirement check (usually four months after retirement).

## Prudential Life Insurance Extension of Coverage/ Premium Waiver Due to Disability

### Instructions

If you are permanently disabled and unable to work, you may be eligible for Premium Waiver for your Port Authority Group Life Insurance Coverage with the Prudential Insurance Company. If you application is approved the full amount of life insurance coverage which you elected in retirement is continued in-force for the period of your disability even beyond its normal termination/reduction in retirement at age 65. Further, if your application is approved, there will be not cost to you for the coverage effective from the date of approval and for as long as the approval is in effect.

There are two forms involved:

(a) The form titled "Claim for Total Disability Benefits" must be completed by you.

(b) The form titled "Attending Physician's Statement of Disability" should be completed by the physician treating you for your disabling condition.

THE PORT AUTHORITY OF NY & NJ BUCKSLIP

TO: Retirees

SUBJECT: ADDRESS CHANGE

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Please send address change information including a signature, employee number and telephone number to:

Port Authority of NY and NJ
Att:Brenda Jimenez

Public Affairs Dept.
Journal Square Transportation Center (JSTC)
1 PATH PLAZA - 6th floor
Jersey City, NJ 07306

Tel: 201-963-7518

THE PORT AUTHORITY OF NY & NJ

Dear Retiree:

Please use this form when your are ready to order a book of personal passes.

NAME: _____

ADDRESS: _____

_____

_____

EMPLOYEE NUMBER: _____

DATE OF REQUEST: _____

This form should be returned to: PORT AUTHORITY OF NY + NJ
PATC - ROOM 315
241 ERIE STREET
JERSEY CITY, NJ 07310

Attn: Supervisor, Payroll & Administrator Svcs.

If you have any quetsions, please contact the Supervisor, Payroll and Administrative Services at 201-239-1510

# RETIREE BENEFITS INFORMATION SHEETS

FOR: CWA - 1032 (Over 25 years)

NOTE: This summary is necessarily brief and generalized. Only the applicable PAIs, Insurance contracts and Retirement System/Laws can be considered as definitive reference sources. The following information applies only to those employees and their dependents who are fully enrolled under the Port Authority Group Health, Dental and Life Insurance Programs and covered under a Memorandum of Agreement between the Port Authority and CWA/1032.

## GENERAL INFORMATION

For information, consult this reference and the instructions included with each United Health Care claim form or contact the appropriate health and dental carriers directly.

United Health Care Customer Service Representatives may be reached at 1-877-259-1391 for health insurance inquiries.

Prudential Customer Service Representatives may be reached at 1-800 772- 4683 for dental inquires.

If further help is needed, an Employee Benefits Representative may be reached at 201-792-3951 or 201-792-3418

**AT AGE 65 AND RETIRED, OR MEDICARE ELIGIBLE, MEDICARE ENROLLMENT (PART A AND PART B) IS MANDATORY AND MEDICARE WILL BECOME PRIMARY OVER UNITED HEALTH CARE COVERAGE AND IN NETWORK BENEFITS ARE NO LONGER AVAILABLE FOR THE MEDICARE ELIGBLE PARTICIPANT. FOR UNDER AGE 65 MEDICARE RECIPENTS, PLEASE NOTIFY THE BENEFITS UNIT OF THE MEDICARE ELIGIBILITY DATE.**

SS tel # 1-800-772-1213

In the event of your death, your surviving spouse will continue to have the same coverage you elect as a retiree for life or until remarriage. In addition, any eligible dependent children will continue to have the same coverage until the end of the calendar year in which they turn age 19, if still single. Sponsored coverage for dependent children may be continued until the end of the calendar year in which they turn age 26, provided they are not married, a full time student and dependent upon the employee/spouse for support.

# UNITED HEALTHCARE PLAN (PPO)
## OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers members complete freedom in choosing their healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the United Healthcare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at 1-877-259-1391.

**United Healthcare**
**Summary of Coverage**

| NEFIT | IN-NETWORK | OUT-OF-NETWORK * ** |
|---|---|---|
| luctible – Single | None | $50 |
| Family | None | $100 |
| Coinsurance | None | 20% |
| timum Out-of-Pocket per person | Not Applicable | $1,000 of eligible expenses (excluding deductible) |
| **EVENTIVE CARE** | | |
| hysical Examination | $5 copay per visit | No coverage |
| outine Pediatric Care | 100% coverage | 100% of Reasonable & Customary |
| **TPATIENT CARE** | | |
| hysician Office Visits | $5 copay per visit | Subject to Deductible & Coinsurance |
| urgery | 100% coverage | 100% of Reasonable & Customary |
| aboratory Services | 100% coverage | 100% of Reasonable & Customary |
| **SPITAL CARE** | | |
| emi-private room & board | 100% coverage | 120 days at 100% balance paid at 80% |
| **IERGENCY CARE** | | |
| mbulance Services when medically necessary | No charge | No charge |
| **HOSPITAL EMERGENCY ROOM** | | |
| ccident Care, Serious Illness | 100% coverage | 100% coverage |
| **ATERNITY CARE** | | |
| renatal & Post-natal care | $5 copay per visit | 100% of Reasonable & Customary |
| ospital services for mother & child | 100% coverage | 100% - 120 day maximum balance at 80% per stay |
| **IORT TERM REHABILITATION** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **OME HEALTH CARE** | | |
| 0 visits in- and out-of- network combined (4 hours each visit) | $5 copay per visit | Subject to Deductible & Coinsurance |
| **ILLED NURSING FACILITY** | | |
| 0 days per year combined in- and out-of-network | 100% coverage | Subject to Deductible & Coinsurance |
| **LCOHOL/SUBSTANCE ABUSE** | | |
| Inpatient - 7 days detoxification, 30 days per Year, 2 confinements per lifetime | 100% coverage | 100% coverage |
| **LCOHOL/SUBSTANCE ABUSE** | | |
| Outpatient – 60 visits per year, 120 visits per lifetime combined in- and out-of- network | $5 copay per visit | Subject to Deductible & Coinsurance |
| **ENTAL HEALTH CARE** | | |
| npatient | 100% coverage | 100% 30 days per year balance paid at 80% |
| Outpatient | $10 copay per visit | Subject to Deductible & Coinsurance |
| **HIROPRACTIC CARE** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **OSPICE CARE** | | |
| 210 days maximum | 100% coverage | 100% coverage |
| **FERTILITY TREATMENT** | | |
| 3 Attempt Combined Limit | $5 copay per visit | Subject to Deductible & Coinsurance |
| **AMMOGRAPHY, Routine** | 100% coverage | 100% coverage |
| **THER COVERAGE** | | |
| Durable Medical Equipment | 100% coverage | Subject to Deductible & Coinsurance |

*All Benefits are subject to Reasonable & Customary
**All benefits must meet medical necessity

**This summary is not all inclusive**

# TYPICAL QUESTIONS & ANSWERS

## 1. WHAT IS A PPO?

A PPO (Preferred Provider Organization) offers the best features of both a traditional indemnity plan and an HMO (Health Maintenance Organization) by giving members the freedom to use any provider, either in-network or out-of-network, for medical and hospital care without requiring a referral from a primary care physician to use a specialist.

## 2. WHAT IS A NETWORK PROVIDER?

A network provider is one who participates in a network and has agreed to charge preferred rates for members who seek care. The network includes a broad range of providers including Family Practitioners, Internists, Pediatricians, Neurologists, Oncologists and OB/GYNs. Additionally, the network includes labs, X-ray facilities and mental health providers. Again, you are not restricted to only use network providers.

## 3. WHAT IS THE DIFFERENCE BETWEEN PPO AND HMO PLANS?

The difference is that the PPO is not a managed care plan. You are not required to choose a Primary Care Physician and you will be reimbursed if you use an out-of-network physician under a PPO plan. This allows you and your family direct access to all specialists.

## 4. HOW DO I FIND OUT IF MY DOCTOR IS A MEMBER OF THE UNITED HEALTHCARE PPO NETWORK?

- Check the Provider Directory available directly from United Healthcare;
- Call United Healthcare Member Services at 1-877-259-1391 (select the option to speak with a customer services representative) or call your doctor and ask;
- Check the Internet (www.unitedhealthcare.com). This will also give you directions and an easy to read color map showing the provider's location;

## 5. *WHAT IF MY DOCTOR IS NOT A MEMBER OF THE UNITED HEALTHCARE NETWORK?*

If you wish to encourage your doctor to join the United Healthcare network, simply have your doctor call United Healthcare Network/Provider Services at 1-800-638-8075 to obtain an application. Due to the thorough credentialing process, in which United checks or verifies board certification, training and education, hospital affiliation and malpractice status, the process can take up to 180 days. However, you can still go to your doctor as an out-of-network provider and be reimbursed at 80% of reasonable and customary charges.

## 6. HOW WILL MY PRESCRIPTIONS BE FILLED?

National Prescription Administrators, Inc. (NPA) provides your prescription benefit regardless of the health plan selected. The cost of each prescription is either $2 for generic brand drugs or $5 for name brand. For specific information or questions, please contact NPA directly at 1-800-467-2006.

## 7. THROUGH THE PRESCRIPTION BENEFIT (NPA), CAN I PURCHASE ORAL CONTRACEPTIVES AT THE PHARMACY AS WELL AS THROUGH MAIL ORDER (CFI)?

Yes, you may purchase oral contraceptives at the pharmacy, although you would realize savings through the CFI mail order program (one co-payment, 90-day supply).

8. ARE PRE-EXISTING CONDITIONS COVERED?

Yes. There is no pre-existing condition limitation under any of the current health care coverage plans.

9. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED HEALTHCARE'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

10. WHAT ARE MY RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998?

As required by the Women's Health and Cancer Rights Act of 1998, all our health plans provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Please call your carrier for more information.

11. WHO IS AN ELIGIBLE DEPENDENT?

Eligible dependents are defined as an employee's spouse or dependent child(ren). Dependent children are covered until the end of the calendar year in which they turn age 19. Coverage may extend either through the end of the month the child graduates or up to age 26 provided the child is in full-time attendance at an accredited educational institution, unmarried, and is dependent on the employee for financial support. However, your health carriers will require you to provide verification of your child's full-time student status. Domestic partners, parents and grandchildren are not considered eligible dependents.

12. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing the enclosed *Benefit Selection Form* or form PA2298 (*Employee Status Change)* and returning it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (i.e. state marriage certificate, divorce decree, birth certificate for children, etc.) in order for the change to be made. Failure to notify Employee Benefits within the required time frame will result in having your request denied by the insurance carrier, and you will not be permitted to add your dependents(s) to your plan coverage until the next open enrollment period.

13. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent (as defined in question #21). Official notification to CobraServ (1-727-864-3300) must be received within 60 days from the end of the month in which the dependent loses eligibility. Please note that the only coverage available for purchase would be that coverage/carrier currently held by the applicable employee. For example, if an employee is enrolled in the Prudential/Blue Cross (indemnity) health plan, only that plan is initially available for purchase.

14. HOW DO I GET CLAIM FORMS?

A claim form is included in this package and can be copied. You can also request claim forms by calling United Healthcare at 1-877-259-1391.

## 15. WHAT IS A CHANGE IN FAMILY STATUS?

A change in status includes the marriage or divorce of the employee, death of the employee's spouse or dependent children, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, switching from part-time to full-time employment status (or vice versa) by the employee or the employee's spouse, taking of an unpaid leave of absence by the employee or the employee's spouse, or a significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment.

## 16. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a Provider Directory by contacting United Healthcare at 1-877-259-1391.

## 17. WHO DO I CALL WITH GENERAL QUESTIONS?

You can call Employee Benefits at 212-435-6163 or 1-800-269-4280 or United Healthcare at 1-877-259-1391.

## 18. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT IS MY SPOUSE'S COVERAGE WHEN HE/SHE IS OVER 65? UNDER 65?

- If you or your spouse is over 65, Medicare is the primary coverage (see attachment III).
- If you or your spouse are under 65 the primary coverage will be United Healthcare (unless you have other active coverage or are Medicare eligible).

If you are over 65, you will receive a United Healthcare ID card for an *Indemnity Plan*. If you are under 65 you will receive an ID card for a *PPO Plan*. If you are over 65 and your spouse is under 65 or vice versa, you will receive one card for an *Indemnity Plan* and one card for a *PPO Plan*.

## 19. HOW DO I SUBMIT CLAIMS USING AN IN-NETWORK PROVIDER?

If you are under 65 and use an in-network provider, there are no claim forms to complete. Only a $5 co-payment is required.

## 20. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

- **If you are under 65 years of age and are using an out-of-network provider, submit a copy of your bill and a claim form to United Healthcare, PO Box 740800, Atlanta, GA 30374-0800.**
- **If you are over 65 years of age or eligible for Medicare due to a disability, your provider must submit the claim to Medicare before submitting the claim to United Healthcare for reimbursement of eligible balances.**

*United Healthcare also accepts claims electronically and has a Medicare crossover program. Contact United Healthcare directly @ 1-877-259-1391.*

## 21. WHAT IS MY COVERAGE IN THE EVENT OF AN EMERGENCY?

You and your family are covered on an in-network basis worldwide. If you get care by an out-of-network provider, including all providers overseas (except Puerto Rico), you will need to submit a claim form for reimbursement as per your in-network plan of benefits .

*Emergency care* is generally defined as treatment required because of a sudden medical condition for which the failure to receive immediate care could place your life in danger or could cause a serious impairment of bodily functions. Some examples are: chest pain, sever bleeding, stroke, serious burns, serious breathing conditions and loss of consciousness. Payment will be made based on your symptoms.

# YOUR PORT AUTHORITY (THROUGH UNITED HEALTHCARE) COVERAGE WHEN MEDICARE BECOMES PRIMARY

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare through the Social Security disability program. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority retiree health plan.

NOTE: It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits regarding the date of their Medicare eligibility.

Medicare Part A provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deductible imposed by Medicare.

The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the Port Authority coverage through United HealthCare. (When you are under age 65, United Healthcare's out-of-network benefits provides for 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the Port Authority reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

Medicare Part B covers medical expenses, for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug charges. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Whenever you incur medical expenses, all claims (with the exception of prescription drugs), must be submitted to Medicare first. After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United HealthCare along with a completed and signed United HealthCare claim form. United HealthCare will consider the charges and pay them in accordance with the major medical benefit.

GROUP HEALTH – Major Medical: Under the Major Medical, the annual deductible is $50 for an individual and $100 for a family ($50 in eligible expenses for the first family member and $50 in combined eligible expenses for all other family members). Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees for each individual up to $5,000 and at 100% thereafter during the calendar year.

The maximum lifetime Major Medical benefit for each eligible individual is unlimited.

Major Medical provides treatment of mental and nervous disorders, with outpatient visits reimbursed at 80% of reasonable and customary charges.

NOTE: Should you travel outside the Continental United States and require medical treatment, Medicare will not pay for those services, however your pre-65 (pre Medicare) coverage will be reinstated to process any claims if necessary.

:he Port Authority of NY & NJ
97512

UNITEDhealthcare
P.O. Box 740800
Atlanta, GA 30374-0800
1-877-259-1391

# HEALTH CLAIM TRANSMITTAL

Employee Name: _____ SSN: ___-___-___ Date of Birth: ___/___/___

Employee Address: _____ Check If New Address ☐

Employee Phone Number: (___) _____ (Area Code, Number) Status: ☐ Active ☐ Retired ☐ Continued (COBRA)

Spouse Name: _____ Spouse Date of Birth: ___/___/___

Patient Name: _____ Patient Date of Birth: ___/___/___ Relationship _____

Nature of Illness or Injury: _____

_____

*IF CLAIM IS DUE TO INJURY STATE WHEN, WHERE AND HOW INJURY OCCURRED*

Do You Have More Than One Employer? Yes ☐ No ☐

Is Your Spouse Employed? Yes ☐ No ☐ Is Patient Employed? Yes ☐ No ☐

If you answered "yes" to any of the above questions, please provide the following information:

Employed Person: _____ Social Security Number ___-___-___

Employer _____

Employer Address: _____ Phone Number: (___) _____ (Area Code, Number)

Insurance Company & Policy Number: _____

**ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.**

Employee Signature: _____ Date: ___/___/___

## HINTS FOR SUBMITTING CLAIMS TO UNITED HEALTHCARE

- *If you want United HealthCare to pay benefits directly to the provider of medical services, write "pay directly" prominently on the bill(s).*
- *Attach your bills to the completed form and mail them to United HealthCare at the address shown above. COBRA continuees mail to the United HealthCare claim office you used as an active employee (or as a dependent of an active employee).*
- *Make sure all bills indicate the reason (diagnosis) for treatment and list the date, type and cost of each service.*
- *Send additional bills periodically or when they total $50.00 or more.*

## FOR UNITED HEALTHCARE USE ONLY

| DATE BENEFITS BECAME EFFECTIVE | DATE BENEFITS TERMINATED | SUFFIX | ACCOUNT |
|---|---|---|---|
| MO. DAY YR Emp. / MO. DAY YR Dep. | MO. DAY YR Emp. / MO. DAY YR Dep. | | |

| SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS: | DATE MO. DAY YR |
|---|---|
| | |

NATIONAL PRESCRIPTION ADMINISTRATORS, INC.

Information About Your Prescription Drug Card Benefit Plan

FOR NPA CUSTOMER SERVICE, CALL (800) 467-2006

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contacting NPA. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the NPA card or misplace it, the pharmacy can still identify you as an NPA customer if you can provide the social security number of the covered Port Authority employee and the Port Authority sponsor number which is 1395. Lost cards can be replaced by contacting NPA at the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Copayment for generic drugs is $2 and copayment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order .

There is no limit to the number of prescriptions allowable through your prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription - excluding insulin / Devices or appliances - support garments or other non-medicinal substances / Administration charges for drugs or insulin / Investigational or experimental drugs / Unauthorized refills / Prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / Medications for eligibles confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / Medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of NPA's participating pharmacies. NPA can assist you with the name of a pharmacy located in your area if you are not familiar with one. Network pharmacies display a green "NPA" decal in the window or near the Pharmacy Department.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 copayment for a generic drug or a $5.00 copayment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will be required to use the CFI Mail Order Program to fill your prescription after the first refill.

## CFI MAIL ORDER PROGRAM

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The copayment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See CFI Pharmacy Service brochure).

## OUT OF NETWORK USAGE

If you are travelling and cannot locate an NPA pharmacy or experience an emergency which necessitates the use of a pharmacy that is not part of the NPA network, you may do so by paying the full cost of the prescription to the pharmacy and submitting a claim form to NPA. Claim forms can be obtained by calling NPA's customer service line. Following your claim submission, you will be reimbursed all but the applicable

## NPASelect PREFERRED MEDICATION LIST

The NPASelect Preferred Medication List is an extensive list of medications that will effectively treat virtually all diagnosed conditions at a lower cost than drugs not on the preferred list due to manufacturer discounts and rebates. You are encouraged to share the NPASelect Preferred Medication List (see enclosed pocket version) with your doctor. NPA's participating pharmacies may request the opportunity to call your doctor about prescribing a medication that is on the list. Use of the medications on the Preferred Medication List will help to ensure the financial health of the plan and still provide you with effective medication. Of course, your physician will always make the final decision on the best drug for you and the plan will cover all eligible prescriptions, whether or not they are on the preferred list.

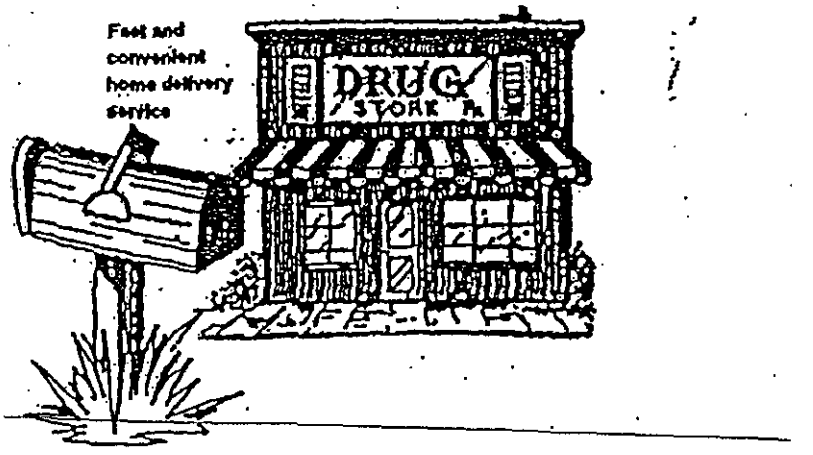
## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Your unmarried dependent full time student will be covered until the end of the calendar year in which he/she turns 26. If you have a dependent over the age of 19, NPA will write to you twice a year to request that you provide them with documentation of your dependent's full time student status. The first request for such documentation will be made by NPA on or around February 1, 1998 with a due date of March 1, 1998.

## YOUR PHARMACIST

Pharmacists are more than just experts on drugs. Their professional role in the health care field is expanding dramatically and they are, more than ever, becoming a vital part of the health care delivery system.

Remember they are always willing to assist you or your physician with the best possible pharmaceutical advice available. Ask your pharmacist any questions regarding your prescription.




# CFI PHARMACY SERVICE

AN ADDED FEATURE
TO YOUR
PRESCRIPTION DRUG PLAN

## INTRODUCTION

The CFI Pharmacy Service has been created to provide you with the convenience of receiving prescription maintenance medication, in large quantities, right at your home. This service covers any prescription medication your doctor requests to be taken on a long term continual schedule.

## WHO IS COVERED

You and your dependents are covered as long as your eligibility continues in the Program.

## WHAT IS COVERED

Your mail order service covers all medications which require a prescription by either state or federal law and are prescribed by a licensed practitioner. This service may be used to purchase any prescription drug but its primary aim is to offer maintenance drugs used for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc.

## WHAT IS NOT COVERED

Please check the "Exclusions" portion of the Prescription Plan brochures you received with your Employee Benefits Kit.

## WHY USE A MAIL ORDER SERVICE

Participating in the mail order service helps you in several ways. First is the convenience. If you have a chronic condition which requires the taking of medication frequently and for a long period of time, a three or six months supply can be delivered to your house – we absorb all postage. This should be particularly helpful to retiree participants. Secondly, your mail order pharmacy will provide a monitoring service. All you have to do is fill out the allergy information on the mailing envelope enclosed with this brochure.

It asks for general information, but more importantly, requests information, regarding allergies and /or drug sensitivities. When your doctor prescribes a medication, the pharmacist will check to see whether it may conflict with other drugs you are taking.

## GENERIC DRUGS

Under the law, generic equivalent drugs will be dispensed for a brand name drug unless you or your doctor request otherwise. A generic drug is one that is defined by its official pharmaceutical name rather than its advertised brand name. In most cases there is a great difference in price between brand name drugs and generic drugs – but that is the only difference between them.

## HOW TO USE THE SERVICE

- Fill out the information on the envelope. Don't forget to include the allergy information.
- Enclose your doctor's prescription for up to a three or six months supply of medication, depending upon the quantity limitations established by your plan.
- Remember to enclose the copayment for each prescription (if applicable).
- Enter your return address on the envelope including your apt. no. if applicable.

Your order should be delivered by United Parcel Service or U.S. Mail within seven business days from receipt at the pharmacy. You will also receive another mailing envelope with your shipment.

Please remember, reorders should be sent about two weeks before your medication is due to run out.

## WHAT HAPPENS IF THE DRUGS NEVER ARRIVE

If you fail to receive your medication within the time prescribed, contact CFI:

973-560-2700 1-800-628-0717

Give your name, the name of your doctor, the type of prescription mailed to the pharmacy and the date you mailed it. An immediate trace will be made. If it is determined that your prescription or shipment has been lost, a CFI representative will contact your doctor to arrange for a new prescription which will be phoned in directly to the pharmacy.

## WHAT ABOUT GENERAL INQUIRIES

If you have any questions regarding your program, please call your Fund office or CFI.

INSERT THIS PAMPHLET IN YOUR
EMPLOYEE BENEFIT KIT
FOR FUTURE REFERENCE

CFI
P.O. BOX 2000
EAST HANOVER, NJ 07936-2000

973-560-2700 1-800-628-0717

## DENTAL OPTIONS

### 1. *PRUDENTIAL REASONABLE AND CUSTOMARY DENTAL PLAN*

A. Dental Expenses

- 80% reimbursement for restorative services (fillings, extractions, etc.) based on reasonable and customary charges.
- Orthodontic expenses reimbursed under a fixed schedule of allowances only (will not be applicable toward your annual deductible, as indicated below). One treatment per lifetime per eligible dependent under age 19.

B. Annual Dental Deductibles

- $50/Individual
- $100/Family

---

### 2. *SCHEDULE OF ALLOWANCES DENTAL PLAN*

A. Expenses are reimbursed based on a fixed schedule of allowances, e.g. exam $10, filling $12, extraction $10 (see attached).

B. This plan does not require a deductible.

For additional information on either plan listed above, call Prudential at 1-800-772-4683.

### 3. *DENTCARE DENTAL PLAN*

- Generally no out of pocket expenses (call Dentcare at 1-800-468-0608 for brochure and exceptions).
- Must go to a designated Dentcare dentist or expenses are employee's responsibility.
- Pre-certification needed from the Dentcare Program for all major dental work done by a Dentcare Dentist.
- No deductibles

If two Port Authority and/or PATH employees are married to each other, and they both choose Dentcare, they can only have one Dentcare plan which must cover both employees and all family members.

GROUP DENTAL BENEFIT (80% Reasonable and Customary Plan) - Prudential

Under the Group Dental Benefit (80% Reasonable and Customary Plan), the annual deductible is $50 for an individual and $100 for a family. It provides reimbursement for basic and major dental services in excess of the annual deductible at 80% of usual and prevailing charges. You and your eligible dependents may also be covered for orthodontic services, if they began before age 19, up to a maximum of $1,035 for a full course of treatment in accordance with the following schedule. Any reimbursement for services covered under the orthodontic schedule is not applied towards the annual deductible.

Initial appliance, X-rays, diagnosis, study models, etc.
Maximum.....$ 150
Active treatment calculated at a maximum of $34 per month for a total
Maximum.....$ 840
Passive treatment, per six month period - $15
Maximum of 3 periods.....$ 45
Total benefits available.....$1,035
Per course of treatment

Your claim will be paid in equal installments, beginning when the orthodontic appliances are first inserted, and quarterly thereafter for the estimated duration of the treatment plan, as long as the treatment begins while the patient is under 19 years of age. Coverage for orthodontia ceases at the end of the year in which the covered individual reaches 19 years of age unless eligible for sponsored coverage.

GROUP DENTAL BENEFIT (Schedule of Allowances) - Prudential

There is no deductible for this Group Dental Benefit coverage, which provides you and your eligible dependents with benefits under a Schedule of Allowances for a broad range of dental services, (see attached schedule of allowances). You and your eligible dependents may also be covered for orthodontic services, if they began before age 19, for up to a lifetime maximum of $1,035 for a full course of treatment in accordance with the attached schedule.

# OPTION 2 - FIXED SCHEDULE OF ALLOWANCES

## PART I – Basic Services

| DENTAL SERVICES | | MAXIMUM ALLOWANCE |
|---|---|---|
| **Diagnostic and Preventive Services** | | |
| 0110 | 1. Clinical oral examination* | $ 10.00 |
| 1110 | 2. Cleaning, scaling and polishing* | 15.00 |
| 1210 | 3. Fluoride treatment (up to age 19)* | 8.00 |
| 1210 | 4. X-RAYS – individual total not to exceed the allowance for full-mouth series | |
| 0210 | (a) Full mouth or Panorex (at least 10 times)** | 15.00 |
| 0270 | (b) Bitewing, each | 3.00 |
| 0200 | (c) Periapical, single, each | 2.00 |
| 0240 | (d) Intra-oral occlusal (edentulous jaw), each | 7.00 |
| 0321 | (e) Temporo-mandibular joint film | 15.00 |
| 0340 | (f) Anterior/posterior: head and jaws | 15.00 |
| 0290 | (g) Lateral, head and jaws | 15.00 |
| | *Not more than twice annually | |
| | **Not more than once in three years | |
| **Palliative Services** | | |
| 9110 | Emergency treatment for relief of pain | 7.00 |
| **Restorative Services** | | |
| | 1. FILLINGS | |
| | Silver Fillings | |
| 2140 | (a) One surface | 12.00 |
| 2150 | (b) Two surfaces | 18.00 |
| 2160 | (c) Three or more surfaces | 27.00 |
| | Tooth Color Fillings | |
| 2330 | (d) Per filling | 12.00 |
| | 2. STAINLESS STEEL CROWN | |
| 2830 | each (up to age 19) | 25.00 |
| **Oral Surgery (including X-rays, anesthesia and post-operative treatment)** | | |
| | 1. EXTRACTIONS | |
| 7110 | (a) Routine or simple and surgical | 10.00 |
| 7220 | (b) Soft tissue impaction | 25.00 |
| 7235 | (c) Partial bony impaction | 40.00 |
| 7245 | (d) Complex bony impaction | 55.00 |
| 7960 | (e) Complex including bone removal and sutures | 30.00 |
| | 2. FRACTURES | |
| 7620 | (a) Upper jaw, closed reduction | 200.00 |
| 7640 | (b) Lower jaw, closed reduction | 225.00 |
| 7610 | (c) Upper jaw, open reduction | 300.00 |
| 7630 | (d) Lower jaw, open reduction | 300.00 |
| | 3. OTHER ORAL SURGICAL PROCEDURES | |
| 7430 | (a) Removal of cysts, including necessary extractions | 35.00 |
| 7340 | (b) Alveolectomy, maximum per arch | 30.00 |
| 3410 | (c) Apicoectomy | 35.00 |
| 7285 | (d) Biopsy, including report | 25.00 |
| 7960 | (e) Removal of labial frenum | 40.00 |
| 7260 | (f) Closure of oral antral fistula | 90.00 |
| **Root Canal Treatment (including X-rays and follow-up care)** | | |
| 3315 | 1. Filling one canal | 75.00 |
| 3325 | 2. Filling two canals | 100.00 |
| 3335 | 3. Filling three canals | 130.00 |
| **Space Maintainers, simple (up to age 19)** | | |
| 1510 | Any type | 50.00 |
| **Periodontic Services (treatment of gums and associated tissues)** | | |
| | 1. Periodontal root scaling and planing, including medications | |
| 4341 | (a) Fewer than 12 teeth per sitting | $ 15.00 |
| 4340 | (b) Per arch | 22.00 |
| | 2. Gum or bone surgery, including post-operative | |
| 4210 | visits (per quadrant) | 90.00 |
| 4220 | 3. Subgingival curettage | 10.00 |

| DENTAL SERVICES | | MAXIMUM ALLOWANCE |
|---|---|---|
| **Repair of Dentures and Bridges** | | |
| | 1. Broken full or partial denture | |
| 5610 | (a) No tooth damage | 20.00 |
| 5620 | (b) Replace one tooth | 30.00 |
| 5630 | (c) Each additional tooth | 7.00 |
| | 2. Replace broken teeth only | |
| 5630 | (a) First tooth | 20.00 |
| 5640 | (b) Each additional | 7.00 |
| 5670 | 3. Reattaching undamaged clasp | 20.00 |
| 5680 | 4. Replacing broken clasp with new clasp | 45.00 |
| 5650 | 5. Adding tooth to partial denture to replace natural extracted tooth, each tooth | 35.00 |
| 5725 | 6. Rebasing upper or lower full or partial denture | 50.00 |
| 2920 | 7. Recement crowns and inlays | 6.00 |
| 6640 | 8. Repair broken facing | 15.00 |

## Part II – Major Services

| | | |
|---|---|---|
| **Inlays, Gold** | | |
| 2510 | 1. One surface | 50.00 |
| 2520 | 2. Two surfaces | 80.00 |
| 2530 | 3. Three or more surfaces, maximum per tooth | 90.00 |
| **Dentures, Full (including supplying, inserting, fitting and adjustments)** | | |
| 5110 | 1. Upper, once in five years | 175.00 |
| 5120 | 2. Lower, once in five years | 175.00 |
| **Dentures, Partial** | | |
| 5220 | 1. Bilateral acrylic or comparable base, either jaw, two or more full clasps and rests, each | 170.00 |
| 5250 | 2. Upper bilateral, chrome cobalt alloy or gold base, two or more clasps and rests, acrylic attachments, ea. | 200.00 |
| 5230 | 3. Lower, bilateral chrome cobalt alloy or gold base, base, two or more cast clasps and tests, acrylic attachments, each | 200.00 |
| **Crowns and Bridgework** | | |
| | 1. Bridgework, Removable (one piece casing with clasps rests) | |
| 5280 | (a) One tooth replaced | 100.00 |
| 5280 | (b) Two teeth replaced | 110.00 |
| | 2. Bridgework, Fixed (single abutments only) | |
| 6780 | (a) ¾ crown | 85.00 |
| 6790 | (b) Full cast crown | 110.00 |
| 6720 | (c) Full cast with veneer | 140.00 |
| | 3. Pontics | |
| 6230 | (a) Tru-pontic (porcelain or acrylic facing with cast backing) | 95.00 |
| 6210 | (b) Pontic of other type | 85.00 |
| | 4. Crowns | |
| 2740 | (a) Porcelain jacket | 150.00 |
| 2710 | (b) Acrylic jacket | 115.00 |

## Part III – Orthodontic Services

8410 Initial appliance, X-rays, diagnosis, study models, etc.
Maximum - $150
Active treatment $35 per month. Not to exceed $840.00
Passive treatment, per 6 month period - $15.
Maximum of 3 periods, Total - $45.
Total benefits available per course of treatment..... $1,035.00

Note: If a change is incurred for a service not included in the Schedule, in connection with the dental care of a specific condition, and if the Schedule contains one or more services which, according to customary dental practices, are separately suitable for the dental care of that condition, then a charge for the least expensive of the suitable services included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.

# DENTAL EXPENSE BENEFITS — CLAIM INSTRUCTIONS

**"Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts."**

**NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY PAYMENT OF YOUR CLAIM.**

## TO THE EMPLOYEE

1. Complete items one (1) through fifteen (15a) in full. Be certain to sign the authorization to release information block and the certification block (15b and 15c).

2. If you wish to have your benefits for this claim paid directly to your dentist, sign the "Direction to pay benefits to dentist" block located below the dentist certification.

If total charges for the planned course of treatment are expected to exceed the minimum Predetermination dollar amount stated in your dental plan booklet, it is suggested you file for Predetermination of Benefits. Prudential will notify your dentist of the benefits payable.

**NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR DENTAL BOOKLET FOR A DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND COPAYMENT INFORMATION, AND LIMITATIONS AND EXCLUSIONS.**

## TO THE DENTIST

1. COMPLETED SERVICES — Check the box noted "STATEMENT OF ACTUAL SERVICES" and complete items 16 through 32. When entering the treatment plan on the form, please indicate a *separate* fee for each individual service rendered. When the work is finished, sign the form and mail to the address shown in the upper right hand corner of the reverse side of this form.

2. PREDETERMINATION OF BENEFITS — If total charges for this claim are to exceed the minimum Predetermination dollar amount indicated in the employee's Dental Plan Booklet (and treatment is not emergency in nature), Predetermination of Benefits is suggested. Check the box marked "PRETREATMENT ESTIMATE", and complete items 16 through 32. Please be sure to answer questions 28 and 29 if the claim includes metal restorations, crowns, bridgework or dentures.*

   The completed form should be sent to the address shown in the upper right hand corner of the reverse side of this form. Prudential will notify you of the benefits payable for this course of treatment.

   When treatment has been completed, fill in the date each service was provided, sign the form and return to the address shown in the upper right hand corner of the reverse side of this form for payment.

**NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE EMPLOYEE, DENTIST AND INSURANCE COMPANY CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.**

3. If the employee indicates that benefits should be paid directly to the dentist, then these benefits will be sent directly to you with an information copy of the transaction to the employee.

*X-rays taken for metal restorations and crowns should be submitted with treatment plan. They may also be requested for other services. X-rays will be reviewed by practicing Dentists and returned promptly.

Aetna US Healthcare

# Dental Benefits Request

P.O. Box 14094
Lexington, KY 40512-4094

## TO BE COMPLETED BY EMPLOYEE

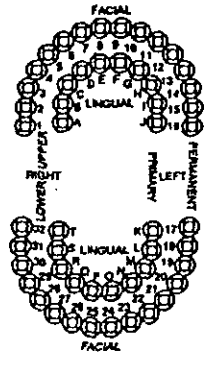
1. Employer's Name: The Port Authority of New York and New Jersey
2. Policy/Group Number: 14910 Branch Number
3. Employee's Social Security Number
4. Employee's Name
5. Employee's Birthdate (MM/DD/YYYY)
6. ☐ Active ☐ Retired Date of Retirement
7. Employee's Address (include zip code) ☐ Address is new
8. Employee's Daytime Telephone Number ( )
9. Patient's Name
10. Patient's Social Security Number
11. Patient's Birthdate (MM/DD/YYYY)
12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)
14. Patient's Sex ☐ Male ☐ Female
15. Full Time Student ☐ No ☐ Yes
16. Patient's Expected Graduation Date
17. Name of School City
18. Patient's Marital Status ☐ Married ☐ Single
19. Is patient employed? ☐ No ☐ Yes
20. Name & Address of Employer
21. Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes
22. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:
23. Member's Social Security Number
24. Member's Name
25. Member's Birthdate (MM/DD/YYYY)
26. Is claim related to an accident? ☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm
27. Is claim related to employment? ☐ No ☐ Yes
28. To all providers of dental care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting dental professionals and utilization review organizations with whom Aetna has contracted, information concerning dental care, advice, treatment or supplies provided the patient. This information will be used to evaluate claims for dental benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted.
I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.
*Patient's or Authorized Person's Signature* _____ Date _____
29. I authorize payment of dental benefits to the dentist or supplier of service.
Patient's or Authorized Person's Signature _____ Date _____

## TO BE COMPLETED BY DENTIST

30. This is a ☐ *Request for Pre-Treatment Estimate* ☐ *Statement of Services Rendered*
31. Dentist's Name & Address (include zip code)
32. Telephone No. ( )
33. Dentist License No.
34. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
35. First Visit Date Current Series
36. Place of Treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other
37. Radiographs or models enclosed? ☐ No ☐ Yes How many?

| Is treatment result of: | No | Yes | If yes, enter brief description and dates |
|---|---|---|---|
| 38. occupational illness or injury? | | | |
| 39. auto accident? | | | |
| 40. other accident? | | | |
| 41. Are any services covered by another plan? | | | |
| 42. If prosthesis, is this initial placement? | | | If no, date of prior placement and reason for replacement |
| 43. Is treatment for orthodontics? | | | Date appliance placed: _____ Initial Appliance Fee: _____<br>No. of months of treatment: _____ Monthly Fee: _____<br>Mos. of treatment remaining: _____ Total Case Fee: _____ |

44. To expedite claim handling, identify all missing teeth with "X"




45. Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. Use charting system shown.

| Tooth # or Letter | If Previously Extracted, Give Date | Surface | Description of Service (x-rays, prophylaxis, materials used, etc.) | Date Service Performed MM DD YYYY | Procedure Number | Fee |
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46. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.
Dentist's Signature _____ Date _____

Total charge $ _____
Amount paid $ _____
Balance due $ _____

## DENTCARE DENTAL PLAN

Under this plan, dental coverage is provided by Dentcare Delivery Systems, Inc. (Dentcare). Dentcare provides a system for furnishing dental care services within the states of New York and New Jersey and offers services through participating dentists at approximately 200 locations in various communities in New York and New Jersey, generally with no out-of-pocket cost to the patient.

Where there is a charge for certain services, there is a predetermined maximum amount (see Dentcare brochure, under "Charges"). You must go to a participating dentist (see Healthplex listing), and you may change your dentist at any time. However, you may not change dental coverage.

You should be aware that any dental services which are not rendered, prescribed, arranged, or approved by a Dentcare dentist (except in cases of emergency dental care as explained in the Dentcare brochure) will not be covered by the Dentcare Dental Plan. In addition, pre-certification by a Dentcare dentist with the approval of the Dentcare Dental Director is necessary before any prosthetic or periodontal service is provided. Orthodontic services (provided for children under 19 years of age unless eligible for sponsored coverage) must also be pre-certified by a Dentcare orthodontist. In addition, pre-certification is needed for all major dental work done by a Dentcare dentist.

For Dentcare inquiries, please call Dentcare directly at (516) 794-3000 or 1-800-468-0600.

# THE PORT AUTHORITY

# OF NY & NJ

## VISION CARE BROCHURE

*Administered by*

NATIONAL VISION ADMINISTRATORS
A DIVISION OF
NATIONAL PRESCRIPTION
ADMINISTRATORS, INC.

*Effective 01/01/98*

The Port Authority of New York and New Jersey has selected NATIONAL VISION ADMINISTRATORS (NVA) as administrators of the Vision Benefit Program effective January 1, 1998. We have designed this Benefit Program along with NVA, an innovative leader in the field with your convenience in mind. NVA's highly qualified staff will assist you when needed.
Please read this brochure completely and keep it for future reference.

HOW TO OBTAIN YOUR BENEFITS

NVA has a network of participating Ophthalmologists, Optometrists, and Opticians to serve you. A directory of local participating providers will be supplied to each eligible employee.

When making your appointment with an NVA Participating Provider, please notify them that your coverage is administered by NVA and sponsored by The Port Authority of New York and New Jersey. When you arrive for your vision care appointment, simply present your NVA Vision Care identification card. You do not need to obtain a vision claim form. The provider will telephone NVA to verify your vision care eligibility and inform you of your eligibility status prior to rendering services. To verify benefit eligibility yourself prior to scheduling your eye care appointment, you may contact NVA's Customer Service Department at the following toll free number 1-800-672-7723.

PARTICIPATING PROVIDERS

If you use a Participating Provider your eye exam will be covered in full. If corrective eyewear is necessary, you will be covered up to the plan allowance for lenses, frames or contact lenses after meeting a $25.00 materials deductable. Any costs exceeding the plan allowance are the responsibility of the patient.

ELIGIBILITY

EMPLOYEES: Eligibility for and termination of benefits under this vision care plan is determined by the same rules that apply to your other health care benefits. Employees who have elected to waive any Port Authority Health Coverage can still use vision benefits if desired. Benefits become effective on the 31st day after starting employment.

DEPENDENTS are defined as the spouse, unmarried dependent children through the end of the year in which they turn 19; unmarried dependent children who are full-time students through the end of the year in which they turn 26.

HOW OFTEN BENEFITS ARE PROVIDED

EXAMINATION: Once every 12 months

LENSES: Once every 12 months

FRAMES: Once every 24 months

CONTACT LENSES: Once every 12 months

This benefit includes disposables and is available in lieu of the lenses and frames benefit. (When contact lenses are selected the frame benefit is depleted for the following 24 months).

COVERED BENEFITS

VISION EXAMINATION: A complete analysis of eyes and related structures; prescribing corrective lenses as needed.

LENSES: To correct vision problems - lenses may be plastic or impact resistant glass.

FRAMES: The plan offers a wide selection of frames, at no cost to you after the materials deductable is met.

CONTACT LENSES: The plan will contribute an allowance towards the purchase of contacts. (In lieu of lenses and frames.)

Medically Necessary Contacts: This enhanced allowance (within the plan limits) will be considered for payment by NVA when an NVA Participating Provider secures prior authorization for the following conditions: a) Following cataract surgery, b) To correct extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, c) Anisometropia, d) Keratoconus.

## VISION SERVICES AND MATERIALS THAT ADD EXTRA COSTS

This plan is designed to cover your basic visual needs rather than cosmetic materials. Extra materials that are not covered by the Plan may be purchased through the NVA participating doctor at a controlled cost.

Lenses - The wholesale cost plus 25%.

Example: Gradient Tint wholesale cost $10.00 plus 25% ($2.50) = $12.50

Frames - the difference between the wholesale cost of the frame and the maximum allowance plus 20% of the difference.

Example: $60.00 wholesale cost - $40.00 plan allowance = $20.00 difference. $20.00 difference + (20%) $4.00 = $24.00.

Photochromatic (gray and brown) light or dark; Tinted (other than Pink #1 or #2),gradient or fashion colors; Progressive or no-line multifocals; A frame costing more than the plan allowance; Coatings: Mirror, Anti-reflective, Super A.R., Color, Edge, Ultra Violet; Polish edges;Smart Segment; Scratch resistant (lab or manufacturer applied); Rimless; Polycarbonate; Prescription Sunglasses.

## NON-COVERED ITEMS

There are no benefits for professional services or materials connected with:

Medical or surgical treatments (These may, however, be covered under your Medical Benefit Plan); Drugs or medications (These may, however, be covered by your Prescription Drug Plan);Non-prescription lenses including sunglasses; Examinations or materials not listed as a covered service; Replacement of lost, stolen, broken, or damaged lenses; Services or materials provided by Federal, State, Local Government or Worker's Compensation; Examination, procedures training or materials not listed; Industrial 3(mm) safety lenses and safety frames with side shields; Parts or repair of frame.

NON-PARTICIPATING PROVIDERS

If you select a non-participating provider you must pay the provider's full fee and obtain an itemized receipt which must contain the following information:

a) Employee's name and Social Security number
b) Patient's name
c) Date service began
d) The services and materials you received.
e) Signature of employee or spouse

Mail to:

NVA
P.O. Box 1981
East Hanover, NJ 07936

NON-PARTICIPATING REIMBURSEMENT SCHEDULE

| | | |
|---|---|---|
| Vision Examination, up to | $32.00 | |
| Tonometry | | $ 3.00 |
| MATERIALS (pair) | | |
| Single Vision Lenses, up to | $15.00 | |
| Bifocal Lenses, up to | | $25.00 |
| Trifocal Lenses, up to | | $35.00 |
| Lenticular Lenses, up to | $60.00 | |
| Frames, up to | | $40.00 |
| CONTACT LENSES | | |
| Contact Lenses, with exam up to | | $75.00 |
| Including Disposables | | |
| Medically Necessary Contacts, up to the enhanced plan allowance. | | |

THERE IS NO ASSURANCE THE NON-PARTICIPATING REIMBURSEMENT SCHEDULE WILL COVER THE ENTIRE COST OF THE EXAMINATION, LENSES, FRAMES OR CONTACTS.

This brochure is written in layman's language for your convenience. It is not intended to interpret,

extend, or change the rules and regulations of the plan. Should any differences arise in interpretation between the plan and this brochure, the plan shall govern.

Any and all questions or requests for information should be directed to:

National Vision Administrators
A Division of
National Prescription Administrators, Inc.
P.O. Box 1981
East Hanover, NJ 07936-1981
Toll Free Line 800-672-7723

CWA/1032 (Over 25 years)

PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base annual salary. Employees hired on or after October 1, 1993 are generally insured for one times their base annual salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. To be certain of the amount of your coverage, you should check with employee Benefits. The current monthly cost per $1,000 of coverage is $.000 and is subject to change from annually. Required contributions will be deducted from your retirement check.

In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan (which becomes effective when you are both retired and age age 65) you will be required to make contributions towards the cost of this coverage. The Face Value of the Insurance Continuation Plan is $10,000 if you are fully insured. The current monthly contribution is $.000 for this coverage.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you had elected the Insurance Continuation Plan coverage, the amount of ICP coverage will continue until your death, and you will no longer be required to make contributions for this coverage.

The retiree retains the right upon termination of the Term Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company of America, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

GROUP LIFE INSURANCE IMPUTED INCOME AND FICA LIABILITY - PORT AUTHORITY RETIREES

Under Federal Guidelines imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the employer is reportable as taxable income and may be subject to FICA Tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age at December 31 of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

## Prudential Life Insurance Extension of Coverage/ Premium Waiver Due to Disability

### Instructions

If you are permanently disabled and unable to work, you may be eligible for Premium Waiver for your Port Authority Group Life Insurance Coverage with the Prudential Insurance Company. If you application is approved the full amount of life insurance coverage which you elected in retirement is continued in-force for the period of your disability even beyond its normal termination/reduction in retirement at age 65. Further, if your application is approved, there will be not cost to you for the coverage effective from the date of approval and for as long as the approval is in effect.

There are two forms involved:

(a) The form titled "Claim for Total Disability Benefits" must be completed by you.

(b) The form titled "Attending Physician's Statement of Disability" should be completed by the physician treating you for your disabling condition.

THE PORT AUTHORITY OF NY & NJ

Dear Retiree:

Please use this form when your are ready to order a book of personal passes.

NAME: _____

ADDRESS: _____

_____

_____

EMPLOYEE NUMBER: _____

DATE OF REQUEST: _____

This form should be returned to: PORT AUTHORITY OF NY & NJ
PATC - ROOM 315
241 ERIE STREET
JERSEY CITY, NJ 07310

Attn: Supervisor, Payroll & Administrator Svcs.

If you have any quetsions, please contact the Supervisor, Payroll and Administrative Services at 201-239-1510

THE PORT AUTHORITY OF NY & NJ BUCKSLIP

TO: Retirees

SUBJECT: ADDRESS CHANGE

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Please send address change information including a signature, employee number and telephone number to:

Port Authority of NY and NJ
Att: Brenda Jimenez

Public Affairs Dept.
Journal Square Transportation Center (JSTC)
1 PATH PLAZA - 1st floor
Jersey City, NJ 07306

Tel: 201-963-7518

# Retiree Benefits Informational Sheets

**Applicable to: Communications Workers of America 1177 (Over 25 years)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## *MAIL ORDER PROGRAM*

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

NOTE: It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

NOTE: If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

**CWA (Over 25 Years)**

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. Employees hired on or after April 14, 1994 are generally insured for one times their base annual salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of $10,000, the amount of the ICP will continue (at no cost) until your death.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31$^{ST}$ of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

## Retiree Benefits Informational Sheets

**Applicable to: Communications Workers of America 1177 (Under 25 years)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## *VERIFICATION OF FULL TIME STUDENTS OVER AGE 19*

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
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## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. *Major Medical provides treatment of mental and nervous disorders with* outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

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**CWA (Under 25 Years)**

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. Employees hired on or after October 1, 1993 are generally insured for one times their base annual salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. The current monthly cost per $1,000 of coverage is *$0.318* and is subject to change annually. Required contributions will be deducted from your pension check.

In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan (which becomes effective when you are both retired and age 65) you will be required to make contributions towards the cost of this coverage. The face value of the Insurance Continuation Plan (ICP) coverage is $20,000 and the current monthly contribution (if enrolled) is *$0.59* and is subject to change annually.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of $10,000, the amount of the ICP will continue (at no cost) until your death.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informa[illegible]

## Applicable to: IBEW (Over 25 Years)

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

*You can obtain a provider directory by contacting* United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

**IBEW (Over 25 Years)**

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, the Extended Group Life Insurance Plan coverage (2% of your annual base salary multiplied by the number of full years of Port Authority service) will continue until your death (at no contribution).

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive a W-2 form from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informational Sheets

## Applicable to: IBEW (Under 25 Years)

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. *HOW WILL MY PRESCRIPTIONS BE FILLED?*

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. *HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?*

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

***Medicare Part B:*** *Covers medical expenses for such things as doctors' charges, out-patient hospital* care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

**IBEW (Under 25 Years)**

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. The current monthly cost per $1,000 of coverage is $0.318 and is subject to change annually. Required contributions will be deducted from your pension check.

In retirement, if you are under age 65 and have elected to participate in the Extended Group Life Insurance Plan after age 65, you will be required to make contributions towards the cost of this coverage (2% of your annual base salary multiplied by the number of full years of Port Authority service).

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Extended Group Life Insurance Plan coverage, the amount of that coverage will continue until your death (at the current contribution amount).

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31 st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive a W-2 form from the Port Authority for the amount of FICA tax due.

**Retiree Benefits Informational Sheets**

Applicable to: Management, Professional, Technical & Supervisory
Under 25 years, but hired before 7/1/88
Pay Plans A, B, E, F and D (6-10)

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies to only those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

2/19/2002

# HUMAN RESOURCES POLICY RETIREE BENEFITS
# (EMPLOYEES NOT REPRESENTED FOR COLLECTIVE NEGOTIATIONS)

This policy will serve as a consolidation and update to Office Memorandum 6-96, dated March 22, 1996 regarding retiree benefits for employees not represented for collective negotiations.

## Group Health Insurance

Affected employees who retire after July 1, 1996 are eligible to participate in the Preferred Provider health option, with a separate prescription program. Employees will also have the option to be enrolled in the vision program. These benefits are provided both on an individual and family basis at no cost into retirement. The current indemnity health plan and any health maintenance organizations are not available options into retirement. Affected employees who retire on or after July 1, 2000 will also be reimbursed Medicare Part B premiums for themselves and their spouse.

## Group Life Insurance

Affected employees retiring on or after July I, 1996 who have 25 or more years of Port Authority service will be eligible to continue their group life insurance into retirement with no required contributions. Affected employees retiring with less than 25 years of Port Authority service will be eligible to continue their group insurance into retirement, however, they will be required to contribute 50% of the retiree cost of providing that insurance benefit.

Effective April 1, 2001, there is an additional death benefit for staff who are Tier 1 members of the New York State and Local Employees' Retirement System and have attained 55 years of age with at least 30 years of Port Authority service. Effective January 1, 2002 this benefit may be continued into retirement without the declining balance provision of the Group term life insurance program.

## Group Dental Benefit

Affected employees who retire on or after July 1, 1996 may be enrolled in the Reasonable and Customary group dental insurance plan. This benefit is provided on an individual and family basis for employees with 25 or more years of Port Authority service with no required contributions. Affected employees with less than 25 years of Port Authority service will be required to contribute 50% of the retiree cost of providing that insurance. All affected employees may be enrolled in the Schedule of Allowance Plan or Dentcare, with no required contribution.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

**EXPRESS SCRIPTS**

**SUMMARY PLAN DESCRIPTION**
**(Information About Your Prescription Drug Card Benefit Plan)**

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## *YOUR PHARMACIST*

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. *HOW DO I GET CLAIM FORMS?*

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. *HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?*

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

*Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age* 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under *age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to* be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that *is more beneficial for you and wish to opt-out of the Port Authority prescription plan.*

**NOTE**: If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

10/2010

**THE PORT AUTHORITY OF NEW YORK & NEW JERSEY**
**HUMAN RESOURCES DEPARTMENT**
**2000 BENEFIT PROGRAM CHANGE**

**(Employees not represented for collective negotiations)**

The Executive Director has authorized an improvement in health benefits effective July 1, 2000. Specifically, non-represented Port Authority and PATH employees retiring on or after July 1, 2000 will be entitled to the reimbursement of Medicare Part B premiums annually for themselves and their eligible spouses, when the retiree reaches age 65. This benefit will be administered by Ceridian Benefits Services, Inc., P.O. Box 2023, Princeton, NJ 08543-2023. Retirees receiving reimbursement for Medicare Part B premiums through other non-Port Authority sources are not eligible for this benefit.

Retirees and their spouses become eligible for Medicare at age 65 and are required to enroll in Medicare Part A and Part B. Medicare Part A covers in-patient hospital services at no cost to the retiree, while Medicare Part B covers medical expenses such as doctor's charges, outpatient hospital care and other health services. Medicare Part B premiums change annually.

Retirees receiving a Social Security check have Medicare Part B premiums automatically deducted from their check. To receive reimbursement of Medicare Part B premium payments, please follow the guidelines that will be sent to you on an annual basis by Ceridian. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested. This will be the first and only request.** If (documentation from the Social Security Administration (SSA) has not been received, the retiree/spouse must contact SSA directly (1-800-772-1213) to request a *Benefit Verification Notice* form or *other record of Medicare Part B premium payments*. All Medicare Part B reimbursements will be made for the current year only.

Retirees not receiving a Social Security check are billed for Medicare Part B premiums on a quarterly basis. Copies of bills and cancelled checks should be sent directly to Ceridian, when requested. As above, all Medicare Part B reimbursements will be made on an annual basis for the current year only. It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested.

Please notify the Port Authority immediately of all address changes. Ceridian will mail Medicare Part B reimbursement checks to the address currently on file with the Port Authority. Retirees should send address changes to: The Port authority of NY & NJ, Employee Benefits, Attn: Retiree Address Change, 225 Park Avenue South - 10th Floor, New York, NY 10003

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

MANAGEMENT (5% Reduction)

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

The Extended Group Life Insurance Plan continues after you reach age 65. However, annual reductions of approximately 5% will begin when you reach age 65 and until age 71 at which time the face value of the policy will remain constant at approximately 2/3 of the amount selected at retirement (one, two or three times base annual salary). If you are over age 65 at the time of retirement, your life insurance will be adjusted to the reduced retirement benefit for that age.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informational Sheets

Applicable to: Management, Professional, Technical & Supervisory
Under 25 years, but hired after 7/1/88
Pay Plans A, B, E, F and D (6-10)

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

2/19/2002

# HUMAN RESOURCES POLICY RETIREE BENEFITS
# (EMPLOYEES NOT REPRESENTED FOR COLLECTIVE NEGOTIATIONS)

This policy will serve as a consolidation and update to Office Memorandum 6-96, dated March 22, 1996 regarding retiree benefits for employees not represented for collective negotiations.

## Group Health Insurance

Affected employees who retire after July 1, 1996 are eligible to participate in the Preferred Provider health option, with a separate prescription program. Employees will also have the option to be enrolled in the vision program. These benefits are provided both on an individual and family basis at no cost into retirement. The current indemnity health plan and any health maintenance organizations are not available options into retirement. Affected employees who retire on or after July 1, 2000 will also be reimbursed Medicare Part B premiums for themselves and their spouse.

## Group Life Insurance

Affected employees retiring on or after July I, 1996 who have 25 or more years of Port Authority service will be eligible to continue their group life insurance into retirement with no required contributions. Affected employees retiring with less than 25 years of Port Authority service will be eligible to continue their group insurance into retirement, however, they will be required to contribute 50% of the retiree cost of providing that insurance benefit.

Effective April 1, 2001, there is an additional death benefit for staff who are Tier 1 members of the New York State and Local Employees' Retirement System and have attained 55 years of age with at least 30 years of Port Authority service. Effective January 1, 2002 this benefit may be continued into retirement without the declining balance provision of the Group term life insurance program.

## Group Dental Benefit

Affected employees who retire on or after July 1, 1996 may be enrolled in the Reasonable and Customary group dental insurance plan. This benefit is provided on an individual and family basis for employees with 25 or more years of Port Authority service with no required contributions. Affected employees with less than 25 years of Port Authority service will be required to contribute 50% of the retiree cost of providing that insurance. All affected employees may be enrolled in the Schedule of Allowance Plan or Dentcare, with no required contribution.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

**EXPRESS SCRIPTS**
**SUMMARY PLAN DESCRIPTION**
**Information About Your Prescription Drug Card Benefit Plan**

**For Customer Service Call (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contacting Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the card or misplace it, the pharmacy can still identify you as a customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1396, PATH 1420). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications that require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

The co-pay is 15% (minimum of $2 for generic drugs and minimum of $5 for name brand drugs).

Insulin is covered by prescription only.

Insulin syringes and needles are by prescription only.

Prescriptions will be dispensed as written by the physician up to a 30-day supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through your prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription excluding: insulin/devices or appliances–support garments or other non-medicinal substances/administration charges for drugs or insulin/ investigation or experimental drugs/unauthorized refills/prescriptions covered without charge under Federal, State or local programs including Workman's Compensation/medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity/medication used for cosmetic purposes are excluded (e.g., Rogaine/Monoxidil for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay 15% (minimum of $2 for generic drugs and minimum of $5 for name brand drugs) for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The cost is 15% (minimum of $2 for generic drugs and minimum of $5 for name brand drugs) for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed on April 14, 2003, and available upon request.

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Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

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### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

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If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife Dental at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 26. Please note, effective January 1, 2011, coverage for eligible dependent children will continue through the end of the calendar year in which he/she turns age 26 as long as he/she remains eligible; otherwise, coverage ends the end of the month in which the child is no longer eligible for this benefit.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITED HEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, United Healthcare's out-of-network benefits provided for 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" is sent to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees for each individual up to $5,000 and at 100% thereafter during the calendar year. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt out of the Port Authority prescription plan.

**NOTE:** If you travel outside the Continental United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to United Healthcare for reimbursement (as per your out-of-network plan of benefits).

**THE PORT AUTHORITY OF NEW YORK & NEW JERSEY**
**HUMAN RESOURCES DEPARTMENT**
**2000 BENEFIT PROGRAM CHANGE**

**(Employees not represented for collective negotiations)**

The Executive Director has authorized an improvement in health benefits effective July 1, 2000. Specifically, non-represented Port Authority and PATH employees retiring on or after July 1, 2000 will be entitled to the reimbursement of Medicare Part B premiums annually for themselves and their eligible spouses, when the retiree reaches age 65. This benefit will be administered by Ceridian Benefits Services, Inc., P.O. Box 2023, Princeton, NJ 08543-2023. Retirees receiving reimbursement for Medicare Part B premiums through other non-Port Authority sources are not eligible for this benefit.

Retirees and their spouses become eligible for Medicare at age 65 and are required to enroll in Medicare Part A and Part B. Medicare Part A covers in-patient hospital services at no cost to the retiree, while Medicare Part B covers medical expenses such as doctor's charges, outpatient hospital care and other health services. Medicare Part B premiums change annually.

Retirees receiving a Social Security check have Medicare Part B premiums automatically deducted from their check. To receive reimbursement of Medicare Part B premium payments, please follow the guidelines that will be sent to you on an annual basis by Ceridian. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested. This will be the first and only request.** If (documentation from the Social Security Administration (SSA) has not been received, the retiree/spouse must contact SSA directly (1-800-772-1213) to request a *Benefit Verification Notice* form or *other record of Medicare Part B premium payments*. All Medicare Part B reimbursements will be made for the current year only.

Retirees not receiving a Social Security check are billed for Medicare Part B premiums on a quarterly basis. Copies of bills and cancelled checks should be sent directly to Ceridian, when requested. As above, all Medicare Part B reimbursements will be made on an annual basis for the current year only. It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested.

Please notify the Port Authority immediately of all address changes. Ceridian will mail Medicare Part B reimbursement checks to the address currently on file with the Port Authority. Retirees should send address changes to: The Port authority of NY & NJ, Employee Benefits, Attn: Retiree Address Change, 225 Park Avenue South - 10th Floor, New York, NY 10003

Management (under 25 years, hired after 7/1/88)

PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

When you retire, the Group Term Life Insurance coverage will be reduced to 2% of your *base annual salary immediately prior to retirement multiplied by the number of full years* of Port Authority service. The current monthly cost per $1,000 of coverage is ***$0.318*** and is subject to change annually. Required contributions will be deducted from your pension check.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

*If it is determined that your imputed income in retirement is subject to FICA tax, you will* receive an invoice from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informational Sheets

Applicable to: Management, Professional, Technical & Supervisory
Over 25 years, but hired before 7/1/88
Pay Plans A, B, E, F and D (6-10)

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies to only those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

2/19/2002

# HUMAN RESOURCES POLICY RETIREE BENEFITS
# (EMPLOYEES NOT REPRESENTED FOR COLLECTIVE NEGOTIATIONS)

This policy will serve as a consolidation and update to Office Memorandum 6-96, dated March 22, 1996 regarding retiree benefits for employees not represented for collective negotiations.

## Group Health Insurance

Affected employees who retire after July 1, 1996 are eligible to participate in the Preferred Provider health option, with a separate prescription program. Employees will also have the option to be enrolled in the vision program. These benefits are provided both on an individual and family basis at no cost into retirement. The current indemnity health plan and any health maintenance organizations are not available options into retirement. Affected employees who retire on or after July 1, 2000 will also be reimbursed Medicare Part B premiums for themselves and their spouse.

## Group Life Insurance

Affected employees retiring on or after July I, 1996 who have 25 or more years of Port Authority service will be eligible to continue their group life insurance into retirement with no required contributions. Affected employees retiring with less than 25 years of Port Authority service will be eligible to continue their group insurance into retirement, however, they will be required to contribute 50% of the retiree cost of providing that insurance benefit.

Effective April 1, 2001, there is an additional death benefit for staff who are Tier 1 members of the New York State and Local Employees' Retirement System and have attained 55 years of age with at least 30 years of Port Authority service. Effective January 1, 2002 this benefit may be continued into retirement without the declining balance provision of the Group term life insurance program.

## Group Dental Benefit

Affected employees who retire on or after July 1, 1996 may be enrolled in the Reasonable and Customary group dental insurance plan. This benefit is provided on an individual and family basis for employees with 25 or more years of Port Authority service with no required contributions. Affected employees with less than 25 years of Port Authority service will be required to contribute 50% of the retiree cost of providing that insurance. All affected employees may be enrolled in the Schedule of Allowance Plan or Dentcare, with no required contribution.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

**EXPRESS SCRIPTS**

**SUMMARY PLAN DESCRIPTION**
**(Information About Your Prescription Drug Card Benefit Plan)**

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

1. **HOW WILL MY PRESCRIPTIONS BE FILLED?**

   Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

   The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

2. **HOW CAN I OBTAIN A PROVIDER DIRECTORY?**

   You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

3. **DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?**

   No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

4. **WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?**

   In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

   Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

5. **HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?**

   If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

   If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

**THE PORT AUTHORITY OF NEW YORK & NEW JERSEY**
**HUMAN RESOURCES DEPARTMENT**
**2000 BENEFIT PROGRAM CHANGE**

**(Employees not represented for collective negotiations)**

The Executive Director has authorized an improvement in health benefits effective July 1, 2000. Specifically, non-represented Port Authority and PATH employees retiring on or after July 1, 2000 will be entitled to the reimbursement of Medicare Part B premiums annually for themselves and their eligible spouses, when the retiree reaches age 65. This benefit will be administered by Ceridian Benefits Services, Inc., P.O. Box 2023, Princeton, NJ 08543-2023. Retirees receiving reimbursement for Medicare Part B premiums through other non-Port Authority sources are not eligible for this benefit.

Retirees and their spouses become eligible for Medicare at age 65 and are required to enroll in Medicare Part A and Part B. Medicare Part A covers in-patient hospital services at no cost to the retiree, while Medicare Part B covers medical expenses such as doctor's charges, outpatient hospital care and other health services. Medicare Part B premiums change annually.

Retirees receiving a Social Security check have Medicare Part B premiums automatically deducted from their check. To receive reimbursement of Medicare Part B premium payments, please follow the guidelines that will be sent to you on an annual basis by Ceridian. **It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested. This will be the first and only request.** If (documentation from the Social Security Administration (SSA) has not been received, the retiree/spouse must contact SSA directly (1-800-772-1213) to request a *Benefit Verification Notice* form or *other record of Medicare Part B premium payments*. All Medicare Part B reimbursements will be made for the current year only.

Retirees not receiving a Social Security check are billed for Medicare Part B premiums on a quarterly basis. Copies of bills and cancelled checks should be sent directly to Ceridian, when requested. As above, all Medicare Part B reimbursements will be made on an annual basis for the current year only. It is the responsibility of the retiree/spouse to submit the necessary supporting documentation directly to Ceridian, no later than the date requested.

Please notify the Port Authority immediately of all address changes. Ceridian will mail Medicare Part B reimbursement checks to the address currently on file with the Port Authority. Retirees should send address changes to: The Port authority of NY & NJ, Employee Benefits, Attn: Retiree Address Change, 225 Park Avenue South - 10th Floor, New York, NY 10003

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

MANAGEMENT (5% Reduction)

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

The Extended Group Life Insurance Plan continues after you reach age 65. However, annual reductions of approximately 5% will begin when you reach age 65 and until age 71 at which time the face value of the policy will remain constant at approximately 2/3 of the amount selected at retirement (one, two or three times base annual salary). If you are over age 65 at the time of retirement, your life insurance will be adjusted to the reduced retirement benefit for that age.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informational Sheets

**Applicable to: Non-Represented Clerical (Over 25 Years)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

***Medicare Part B:*** *Covers medical expenses for such things as doctors' charges, out-patient hospital* care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

**Non-Represented Clerical (OVER 25 YEARS)**

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan (which becomes effective when you are both retired and age 65) you will be required to make contributions towards the cost of this coverage. The face value of the Insurance Continuation Plan (ICP) coverage is $10,000.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of$10,000, the amount of the ICP will continue until your death, and you will no longer be required to make contributions.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## *GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)*

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of$50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

## Retiree Benefits Informational Sheets

**Applicable to: Non-Represented Clerical (Under 25 Years)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

# SUMMARY PLAN DESCRIPTION
## (Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE**: If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

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**Non-Represented Clerical (Under 25 Years)**

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. The current monthly cost per $1,000 of coverage is *$0.318* and is subject to change from time to time. Required contributions will be deducted from your pension check.

In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan (which becomes effective when you are both retired and age 65) you will be required to make contributions towards the cost of this coverage. The face value of the Insurance Continuation Plan (ICP) coverage is $10,000 and the current monthly contribution (if enrolled) is *$0.59* and is subject to change annually.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of$10,000, the amount of the ICP will continue until your death, and you will no longer be required to make contributions.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31 st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informational Sheets

**Applicable to:** **Transport Workers Union (TWU)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, life and dental insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

**EXPRESS SCRIPTS**

**SUMMARY PLAN DESCRIPTION**
**(Information About Your Prescription Drug Card Benefit Plan)**

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. *DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?*

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

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## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. *The current monthly cost per $1,000 of coverage is $0.635 and is subject to change from time to time.* Required contributions will be deducted from your pension check.

In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan (which becomes effective when you are both retired and age 65) you will be required to make contributions towards the cost of this coverage. The face value of the Insurance Continuation Plan (ICP) coverage is $20,000 and the current monthly contribution (if enrolled) is $1.18 and is subject to change annually.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the *Insurance Continuation Plan (ICP) coverage of $20,000, the amount of the ICP will continue until your* death, and you will no longer be required to make contributions.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

## GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informational Sheets

**Applicable to: UOAT (Under 25 Years)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

*Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you* are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim *form to United Healthcare (to the address noted on the form).*

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

## UOAT (Under 25 Years)

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. The current monthly cost per $1,000 of coverage is *$0.318* and is subject to change from time to time. Required contributions will be deducted from your pension check.

In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan (which becomes effective when you are both retired and age 65) you will be required to make contributions towards the cost of this coverage. The face value of the Insurance Continuation Plan (ICP) coverage is $50,000(effective 9/1/00) and the current monthly contribution (if enrolled) is $1.18 and is subject to change annually.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage of $50,000, the amount of the ICP will continue until your death, and you will no longer be required to make contributions.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

### GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1 ,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive a W-2 form from the Port Authority for the amount of FICA tax due.

## Retiree Benefits Informational Sheets

**Applicable to: UOAT (Over 25 Years)**

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
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For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

**EXPRESS SCRIPTS**

**SUMMARY PLAN DESCRIPTION**
**(Information About Your Prescription Drug Card Benefit Plan)**

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

*All refills will be dispensed according to your physician's directions.*

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## HOW TO USE THE BENEFIT

To fill a prescription, present your identification card to one of the participating pharmacies. Express Scripts can assist you with the name of a pharmacy located in your area if you are not familiar with one.

At the pharmacy, you will be asked to sign for the prescription and pay a $2.00 co-payment for a generic drug or a $5.00 co-payment for a brand name drug for each prescription or refill up to a thirty-day supply. If you are using a maintenance medication on a long-term basis for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., you will save money by using the Mail Order Program to fill your prescription.

## MAIL ORDER PROGRAM

The Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic drugs and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage (See Pharmacy Service Brochure).

## OUT OF NETWORK USAGE

If you are traveling or experience an emergency which necessitates the use of a pharmacy that is not part of the network, you can get reimbursed by paying the full cost of the prescription to the pharmacy and submitting a claim form to Express Scripts. Claim forms can be obtained by calling the customer service line and from the Express Scripts or HRD Enet websites. Please bear in mind that your use of pharmacies within the network help keep plan costs in line and, thereby, preserve current benefit levels.

## VERIFICATION OF FULL TIME STUDENTS OVER AGE 19

Dependent children are covered until the end of the calendar year in which they turn age 19. This coverage may be extended through the end of the month in which the child graduates from college, or through the end of the calendar year the child turns age 26, if he or she is single, attending an accredited educational institution full time and dependent on the employee for support.

## YOUR PHARMACIST

Pharmacists are willing to assist you or your physician with pharmaceutical advice. If you have questions about your medication, you may wish to contact your physician and/or your pharmacist.

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW WILL MY PRESCRIPTIONS BE FILLED?

Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

### 2. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

### 3. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

### 4. WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?

In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

### 5. HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?

If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

## 6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife (Reasonable & Customary Dental) at 1-888-727-2317.

## 7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage may be extended through the end of the calendar year in which the child turns age 26 provided the child is unmarried; in full-time attendance at an accredited educational institution, and dependent upon the employee for support.

Please be advised that information regarding any changes in dependent eligibility as required by the recently passed federal healthcare reform law Patient Protection and Affordable Care Act (PPAC Act) will be communicated in further detail later this year.

## 8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

## 9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

**NOTE:** It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

**NOTE:** If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

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## UOAT (Over 25 Years)

## PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

*In retirement, if you are under age 65 and have elected to participate in the Insurance Continuation Plan you* will be required to make contributions towards the cost of this coverage. The face value of the Insurance Continuation Plan (ICP) coverage is $50,000 (effective 9/1/00) and the current monthly contribution (if enrolled) is **$1.18,** *which* is subject to change annually.

When you reach age 65, the Group Term Life Insurance coverage will terminate. However, if you elected the Insurance Continuation Plan (ICP) coverage, the amount of the ICP will continue (at no cost) until your death.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

### GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31 of the covered year) for coverage in excess of$50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# Retiree Benefits Informational Sheets

Applicable to: PBA, SBA, DEA, LBA
Under 25 years

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
## OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

## UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
## &
## MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

NOTE: It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

NOTE: If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

## TYPICAL QUESTIONS AND ANSWERS

1. **HOW WILL MY PRESCRIPTIONS BE FILLED?**

   Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

   The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

2. **HOW CAN I OBTAIN A PROVIDER DIRECTORY?**

   You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

3. **DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?**

   No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

4. **WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?**

   In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

   Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

5. **HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?**

   If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

   If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

6. **HOW DO I GET CLAIM FORMS?**

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife Dental at 1-888-727-2317.

7. **WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?**

Dependent children are covered until the end of the calendar year in which the child turns age 26. Please note, effective January 1, 2011, coverage for eligible dependent children will continue through the end of the calendar year in which he/she turns age 26 as long as he/she remains eligible; otherwise, coverage ends the end of the month in which the child is no longer eligible for this benefit.

8. **HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?**

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

9. **HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?**

Continuation of health or dental coverage (COBRA) may be purchased at group rates for a spouse or a child who is no longer an eligible dependent. Official notification to Ceridian (1-800-877-7994) must be received within 60 days from the end of the month in which the dependent loses eligibility.

EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

PBA, SBA, DEA, LBA (under 25 years)

PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. The current monthly cost per $1,000 of coverage is ***$0.318*** and is subject to change from time to time. Required contributions will be deducted from your pension check.

The Extended Group Life Insurance Plan continues after you reach age 65. However, annual reductions of approximately 10% will begin when you reach age 65 and until age 71 at which time the face value of the policy will remain constant at approximately 1/3 of the amount selected at retirement (one, two or three times base annual salary). Deductions will continue until your death or your request to discontinue coverage. If you are over age 65 at the time of retirement, your life insurance will be adjusted to the reduced retirement benefit for that age.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

# TELEPHONE DIRECTORY

| | | |
|---|---|---|
| **Health Coverage** | | |
| United Health Care | (877) 259-1391 | www.myuhc.com |
| **Prescription/Vision Coverage** | | |
| Express Scripts | (800) 467-2006 | www.express-scripts.com |
| National Vision Administrators (NVA) | (888) 682-2020 | www.e-nva.com |
| **Dental Coverage** | | |
| MetLife Dental | (888) 727-2317 | www.metlife.com/mybenefits |
| Dentcare (Healthplex) | (800) 468-0600 | www.healthplex.com |
| **Port Authority Benefits Customer Service** | (212) 435-2870 | |
| **Social Security Administration** | (800) 772-1213 | www.ssa.gov |
| **New York State Employees Retirement System** | (518) 474-7736 | www.osc.state.ny.us/retire |
| **Ceridian (Cobra)** | (800) 877-7994 | www.ceridian.com |
| **New York State Deferred Compensation** | (800) 422-8463 | www.nysdcp.com |

# Retiree Benefits Informational Sheets

Applicable to: PBA, SBA, DEA, LBA
Over 25 years

The attached summary is necessarily brief and generalized. Only the applicable Port Authority policies, insurance contracts, Retirement System legislation can be considered as definitive reference sources.

The following information applies only to those employees and their eligible dependents who are fully enrolled under the Port Authority Group health, dental and life insurance programs.

# UNITED HEALTHCARE PLAN (PPO)
# OVERVIEW

The United Healthcare Preferred Provider Organization Plan (PPO) offers complete freedom in choosing healthcare providers and facilities. Members can use a network provider for a $5 co-payment, and can also see specialists or other physicians (for second opinions) without a referral from a primary care physician. If an out-of-network provider is used, reimbursement resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

Highlights of coverage under the PPO plan:

- No requirement to choose a primary care physician.
- No pre-certification required in- or out-of-network.
- Freedom to use a specialist (or any doctor) without a referral.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Unlimited Lifetime Major Medical Maximum.
- Single carrier that pays for hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United Healthcare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 of eligible expenses (in addition to the deductible).
- A customer service team and phone number dedicated solely to servicing Port Authority/PATH employees.

In addition, the following health promotion benefits are provided through United Healthcare's OPTUM program:

- A 24-hour nurse advice line;
- A toll-free medical tape library;
- Bi-monthly issues of Taking Care, an informative health care newsletter;
- A copy of Taking Care, a self-help guide to your family's health care.

For additional information on the PPO plan, call United Healthcare directly at (877) 259-1391.

# UNITEDHEALTHCARE COVERAGE WHEN MEDICARE BECOMES PRIMARY
# &
# MEDICARE PART D (PRESCRIPTION DRUG BENEFITS)

Medicare benefits become effective the first of the month in which the retiree and/or spouse turn age 65 or become eligible for Medicare. At the time of Medicare eligibility, the retiree or spouse must enroll in Medicare Part A and Part B to ensure full continuation under the Port Authority/PATH retiree health plan. A copy of your Medicare card with your Medicare Identification Number must be provided to Employee Benefits.

NOTE: It is the responsibility of the Medicare recipient under age 65 to notify Employee Benefits of the date of their Medicare eligibility and to provide a copy of your Medicare card.

**Medicare Part A:** Provides for the payment of in-patient hospital services. For each required hospitalization, Medicare Part A will pay for all eligible hospital charges, except for a first day annual deducible imposed by Medicare. The Medicare Part A deductible not paid by Medicare will be reimbursed in full by the PA/PATH coverage through United Healthcare. (When you are under age 65, UnitedHealthcare's out-of-network benefits provides 120 days of semiprivate room care to be paid in full. Therefore, when you are over age 65, coverage under Medicare, coupled with the PA/PATH reimbursement of the hospital deductible, essentially provides you with the same coverage). Reimbursements of deductibles are not charged to your Major Medical Maximum.

**Medicare Part B:** Covers medical expenses for such things as doctors' charges, out-patient hospital care, and other health services but does not include prescription drug costs. After an individual has more than $100 of eligible medical charges, Medicare Part B will pay 80% of the reasonable charges for the remainder of the calendar year.

Your Medicare Part A & B medical claims must be submitted to Medicare first (see below for prescription drugs). After Medicare makes its payment, they forward an "Explanation of Benefits" to the individual indicating all charges and the allowance made by Medicare. A copy of this "Explanation of Benefits" and a copy of the original charge (i.e., doctor bill and any other eligible charges) should be submitted to United Healthcare along with a completed and signed United Healthcare claim form. United Healthcare will consider the charges and pay them in accordance with the major medical benefit.

Group Health – Major Medical: Eligible Major Medical expenses related to health services incurred during a calendar year in excess of the annual deductible will be reimbursed at 80% of reasonable and customary fees. Major Medical provides treatment of mental and nervous disorders with outpatient visits reimbursed at 80% of reasonable and customary charges. Prescription drug expenses should be submitted to Express Scripts.

**Medicare Part D and Prescription Drug Coverage:** Port Authority/PATH retirees and their eligible dependents are covered for prescription drug benefits under the Port Authority's Retiree Prescription Drug Plan – Express Scripts, Medicare approved Part D Prescription Drug Plan that has been determined to provide coverage that, in most cases, is better than the standard Medicare Part D coverage. Please contact us in writing if you believe you are eligible for a Medicare Part D plan that is more beneficial for you and wish to opt-out of the Port Authority prescription plan.

NOTE: If you travel outside the United States and require medical treatment, Medicare will not pay for those services. However, you should submit a claim form to UnitedHealthcare for reimbursement (as per your out-of-network plan of benefits).

## TYPICAL QUESTIONS AND ANSWERS

1. **HOW WILL MY PRESCRIPTIONS BE FILLED?**

   Your prescription benefit is provided by Express Scripts (with maintenance-type prescriptions available through their pharmacy division of CFI). The cost of each prescription is either $2 for generic brand drugs or $5 for name brand drugs. For specific information or questions, please contact Express Scripts directly at 1-800-467-2006 (Sponsor #1395).

   The CFI Mail Order Program allows members to receive large quantities of maintenance medications delivered directly to their residence or other specified location. The co-payment is $2.00 for generic and $5.00 for brand name drugs for each mail order prescription or refill that is dispensed, up to a 90-day supply. There is no charge to the employee for postage.

2. **HOW CAN I OBTAIN A PROVIDER DIRECTORY?**

   You can obtain a provider directory by contacting United Healthcare at 1-877-259-1391.

3. **DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED'S PPO PLAN?**

   No. Pre-certification for hospital stays and emergency room services is not required whether in or out-of-network.

4. **WHAT IS MY COVERAGE IF I AM OVER 65 YEARS OF AGE? UNDER 65? WHAT ABOUT MY SPOUSE?**

   In general, if you or your spouse is over 65, Medicare is the primary coverage. If you or your spouse are under 65, primary coverage is provided by United Healthcare (unless you have other active coverage or become Medicare eligible due to disability).

   Once you are on Medicare, you will receive a United Healthcare ID card for an Indemnity Plan. If you are not yet eligible for Medicare, your ID card is for PPO Plan. If you are on Medicare and your spouse is not (or vice versa), you will receive one card for an Indemnity Plan and one card for a PPO Plan.

5. **HOW DO I SUBMIT CLAIMS USING AN OUT-OF-NETWORK PROVIDER?**

   If you are under age 65 and not eligible for Medicare: submit a copy of your bill and a completed claim form to United Healthcare (to the address noted on the form).

   If you are over age 65 or eligible for Medicare: your provider must submit the claim to Medicare first (as your primary coverage). The balance is then submitted to United Healthcare for reimbursement of eligible balances. United Healthcare will accept claims electronically from Medicare. This process is called Medicare Crossover. Contact United Healthcare directly for an application.

6. HOW DO I GET CLAIM FORMS?

Health and dental claim forms are included in this package and may be copied. You may also request claim forms by contacting United Healthcare at 1-877-259-1391 or MetLife Dental at 1-888-727-2317.

7. WHEN IS MY CHILD CONSIDERED AN ELIGIBLE DEPENDENT?

Dependent children are covered until the end of the calendar year in which the child turns age 26. Please note, effective January 1, 2011, coverage for eligible dependent children will continue through the end of the calendar year in which he/she turns age 26 as long as he/she remains eligible; otherwise, coverage ends the end of the month in which the child is no longer eligible for this benefit.

8. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing an Employee Personal Status Change Form (P A 2298) and returning it to the Employee Benefits Division within thirty (30) days of a change in family status. However, you will be required to provide applicable legal documentation (e.g., state marriage certificate, divorce decree, birth certificate for children, etc.).

9. HOW DO I PURCHASE HEALTH OR DENTAL COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE UNDER MY COVERAGE?

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EXPRESS SCRIPTS

SUMMARY PLAN DESCRIPTION
(Information About Your Prescription Drug Card Benefit Plan)

**FOR CUSTOMER SERVICE, CALL (800) 467-2006**

## YOUR IDENTIFICATION CARDS

One identification card will be provided for single employees and two cards will be provided for family coverage. If you have an eligible dependent living away from home, you may request an additional identification card by contact Express Scripts. Bring your card with you each time you need to fill a prescription at your local participating pharmacy. In the event you or an eligible dependent forget the Express Scripts card or misplace it, the pharmacy can still identify you as an Express Scripts customer if you can provide the social security number of the covered Port Authority/PATH employee and the Plan sponsor number (PA 1395, PATH 1419). Lost cards can be replaced by calling the number above.

## THE BENEFIT

Your program covers all medications which require a prescription by either State or Federal law and are prescribed by a licensed medical practitioner.

Co-payment for generic drugs is $2 and co-payment for brand name drugs is $5.

Insulin is covered by prescription only.

Insulin syringes and needles are prescription only.

Prescriptions will be dispensed as written by the physician up to a 30 days supply.

All refills will be dispensed according to your physician's directions.

Contraceptives are available through mail order only.

Maintenance drugs used on a long-term basis must be filled through mail order after the first refill. Prescription vitamins can be filled once at retail pharmacist and then refilled through mail order.

There is no limit to the number of prescriptions allowable through you prescription drug program.

## EXCLUSIONS

Medications lawfully obtainable without a prescription – excluding insulin / devices or appliances – support garments or other non-medicinal substances / administration charges for drugs or insulin / investigation or experimental drugs / unauthorized refills / prescriptions covered without charge under Federal, State or local programs including Workman's Compensation / medications for eligible confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity / medication used for cosmetic purposes are excluded (e.g., Rogaine (Monoxidil) for hair restoration and Retin-A for individuals over 25 years old).

## DENIED CLAIMS

If coverage is denied, you can contact Express Scripts at 1-800-467-2006. Express Scripts will send you a written decision explaining the reason for the denial.

## HIPAA / PRIVACY STATEMENT

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans (Plan) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Port Authority/PATH sponsored group health plans' privacy notice, distributed April 14, 2003, and available upon request.

This Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required Express Scripts to also observe HIPAA's privacy rules. Further, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

# TELEPHONE DIRECTORY

| | | |
|---|---|---|
| **Health Coverage** | | |
| United Health Care | (877) 259-1391 | www.myuhc.com |
| **Prescription/Vision Coverage** | | |
| Express Scripts | (800) 467-2006 | www.express-scripts.com |
| National Vision Administrators (NVA) | (888) 682-2020 | www.e-nva.com |
| **Dental Coverage** | | |
| MetLife Dental | (888) 727-2317 | www.metlife.com/mybenefits |
| Dentcare (Healthplex) | (800) 468-0600 | www.healthplex.com |
| **Port Authority Benefits Customer Service** | (212) 435-2870 | |
| **Social Security Administration** | (800) 772-1213 | www.ssa.gov |
| **New York State Employees Retirement System** | (518) 474-7736 | www.osc.state.ny.us/retire |
| **Ceridian (Cobra)** | (800) 877-7994 | www.ceridian.com |
| **New York State Deferred Compensation** | (800) 422-8463 | www.nysdcp.com |

PBA, SBA, DEA, LBA (over 25 years)

PORT AUTHORITY GROUP LIFE INSURANCE PROGRAM

If you retire before age 65, the Port Authority Group Term Life Insurance continues until you reach age 65. Generally, employees are insured for three times their base salary. However, if at the time of retirement you are fully insured, an option of electing one, two or three times salary as a retirement benefit will be offered. There are no required contributions.

The Extended Group Life Insurance Plan continues after you reach age 65. However, annual reductions of approximately 10% will begin when you reach age 65 and until age 71 at which time the face value of the policy will remain constant at approximately 1/3 of the amount selected at retirement (one, two or three times base annual salary). *Deductions will continue until your death or your request to discontinue coverage.* If you are over age 65 at the time of retirement, your life insurance will be adjusted to the reduced retirement benefit for that age.

The retiree retains the right upon termination of the Life Insurance Policy to convert a portion or full amount reduced to a Direct Payment Policy with the insurance carrier without a medical examination. This right will be governed by the rules and regulations of The Prudential Insurance Company, who will determine premiums according to the age, sex and occupation (if applicable) of the applicant at the time of the conversion.

GROUP LIFE INSURANCE IMPUTED INCOME & FICA LIABILITY (RETIREES)

Under the federal guidelines, imputed income resulting from the cost of Group Term Life Insurance coverage in excess of $50,000 provided by the Employer is reportable as taxable income and may be subject to FICA tax payments.

The amount of imputed income is based on a rate per $1,000 (determined by the amount of employer provided life insurance and age effective December 31st of the covered year) for coverage in excess of $50,000, less any contribution made by you for this coverage.

Individuals retiring from Port Authority service will receive a W2 form from Port Authority Payroll reflecting earnings for the year and the imputed income, if applicable, that they must also report as income.

If it is determined that your imputed income in retirement is subject to FICA tax, you will receive an invoice from the Port Authority for the amount of FICA tax due.

MetLife Dental - Plan Benefit Summary as of
Calendar Year Benefit Period Start Date: January 01

Participant's Name: Effective Date of Current Coverage:
Patient: Self

| Group Name: | Group Num: | Sub: | Branch: | Plan: | Coverage: |
|---|---|---|---|---|---|
| THE PORT AUTHORITY OF NEW YORK | 0302043 | 0001 | 0001 | 99 | |

Eligibility is not a guarantee of coverage as actual benefit payments are determined only when a claim is processed. Please fax claims to 1-859-389-6505 or mail claims to: MetLife Dental, P.O. Box 981282, El Paso, TX 79998-1282. The mailing address for Appeal and Reconsideration claims is MetLife Group Claims Review, P.O. Box 14589, Lexington, KY 40512. Please bring this fax to your dentist. This fax will provide the dentist with a comprehensive understanding of your dental benefits plan and assist with planning your dental care.

**MAXIMUMS - If applicable, please refer to the footnotes below.**

| | Benefit Period Individual | Benefit Period Family | Lifetime Individual | Lifetime Family |
|---|---|---|---|---|
| Basic Plan | NONE | NONE | NONE | NONE |
| Used to Date | Not App. | Not App. | Not App. | Not App. |
| Orthodontics | NONE | NONE | $2000 | NONE |
| Used to Date | Not App. | Not App. | $0 | Not App. |
| Periodontics | NONE | NONE | NONE | NONE |
| Used to Date | Not App. | Not App. | Not App. | Not App. |

The maximums may be combined with other types of procedures, such as TMJ or Perio.

**DEDUCTIBLES - If applicable, please refer to the footnotes below.**

| | Benefit Period Individual | Benefit Period Family | Lifetime Individual | Lifetime Family |
|---|---|---|---|---|
| Basic Plan | $50 | $100 | NONE | NONE |
| Met to Date | $50 | $50 | Not App. | Not App. |
| Orthodontics | NONE | NONE | NONE | NONE |
| Met to Date | Not App. | Not App. | Not App. | Not App. |
| Periodontics | $50 | $100 | NONE | NONE |
| Met to Date | $50 | $50 | Not App. | Not App. |

The deductibles may be combined with other types of procedures, such as TMJ or Perio.

This section provides information on the level of coverage and how often the services are covered. This listing is not an all-inclusive listing of all possible covered procedures under this plan. Benefits are based on the MetLife determined reasonable and customary amounts. Please note the information herein is not a guarantee of coverage. A patient's eligibility and benefits will only be determined at the time a claim is processed by MetLife.

Please note frequency limitations may be combined for like services.

**Diagnostic and Preventive Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Up to Age | Last Date of Service |
|---|---|---|---|---|---|
| Periodic Oral Evaluation (D0120) | 100% | 4 IN 1 CY | NO | | |
| Limited Oral Evaluation - problem focused (D0140) | 100% | 4 IN 1 CY | NO | | |
| Comprehensive Oral Evaluation (D0150) | 100% | 4 IN 1 CY | NO | | |
| Intraoral - Complete Series (D0210) | 100% | 1 IN 3 CY | NO | | |
| Panoramic Film (D0330) | 100% | 1 IN 3 CY | NO | | |
| Bitewing - Single Film (D0270) | 100% | 2 IN 1 CY | NO | | |
| Intraoral Periapical First Film (D0220) | 100% | | NO | | |
| Prophylaxis Adult (D1110) | 100% | 4 IN 1 CY | NO | | |
| Prophylaxis Child (D1120) | 100% | 4 IN 1 CY | NO | 14 | |
| Topical Application of Fluoride - Child (D1203) | 100% | 2 IN 1 CY | NO | 14 | |
| Topical Application of Fluoride - Adult (D1204) | 100% | 2 IN 1 CY | NO | 19 | |
| Space Maintainer - Fixed - Unilateral (D1510) | 80% | | YES | 19 | |
| Sealant - Per Tooth (D1351) | 100% | 1 IN 3 CY | NO | 19 | |

Sealant coverage is limited to permanent molars excluding wisdom teeth.

**Restorative and Major Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Additional Information Required for Review |
|---|---|---|---|---|
| Amalgam 1 Surface Filling - Adult/Child (D2140) | 80% | | YES | |
| Resin-Based Composite - 1 Surface, Posterior (D2391) | 80% | | YES | |
| Inlay - Metallic - 1 Surface (D2510) | N/AVAIL | | | Pre-treatment X-rays |
| Crown - Porcelain fused to noble metal (D2752) | N/AVAIL | | | Pre-treatment X-rays |
| Crown - Full case noble metal (D2792) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Recement Crown (D2920) | 80% | | YES | |
| Cast Post and Core in Addition to Crown (D2952) | 80% | | YES | |
| Crown Repair, by report (D2980) | 80% | | YES | |
| Root Canal Therapy - Anterior (D3310) | 80% | | YES | |
| Root Canal Therapy - Bicuspid (D3320) | 80% | | YES | |
| Root Canal Therapy - Molar (D3330) | 80% | | YES | |
| Osseous Surgery (D4260) | 80% | 1 IN 1 CY | YES | Pre-treat X-rays & Perio Cht. |
| Free Soft Tissue Graft Procedure (including donor site surgery) (D4271) | 80% | | YES | Location, Nature & Extent |
| Periodontal Scaling and Root Planing - Quadrant (D4341) | 80% | 1 IN 1 CY | YES | Pre-treat X-rays & Perio Cht. |
| Periodontal Maintenance (Following Active Therapy) (D4910) | 80% | | YES | Prior Dates of Active Therapy |
| Complete Denture - Maxillary (Upper) (D5110) | 80% | 1 IN 5 CY | YES | |
| Complete Denture - Mandibular (Lower) (D5120) | 80% | 1 IN 5 CY | YES | |
| Maxillary (Upper) Partial Denture (D5213) | 80% | 1 IN 5 CY | YES | |
| Mandibular (Lower) Partial Denture (D5214) | 80% | 1 IN 5 CY | YES | |
| Reline Complete Maxillary Denture (Chairside) (D5730) | 80% | N/AVAIL | YES | |
| Surgical placement of implant: Endosteal implant (D6010) | 80% | | YES | Pre-treatment X-rays |
| Prefabricated abutment, includes placement (D6056) | 80% | | YES | |
| Abutment supported porcelain fused to metal crown (high noble metal) (D6059) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |

**Restorative and Major Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Additional Information Required for Review |
|---|---|---|---|---|
| Pontic - Cast high noble metal (D6210) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Pontic - Porcelain fused to high noble metal (D6240) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Crown - Porcelain fused to high noble metal (D6750) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Crown - Full cast high noble metal (D6790) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Extraction, Erupted Tooth or Exposed Root (D7140) | 80% | | YES | |
| Surgical Removal of Erupted Tooth (D7210) | 80% | | YES | |
| Removal of Impacted Tooth - Completely Bony (D7240) | 80% | | YES | |
| Oroantral Fistula Closure (D7260) | 80% | | YES | |
| Occlusal Orthotic Device, by Report (D7880) | 0% | Not Covered | | |
| Removable Appliance Therapy (D8210) | 80% | | YES | |
| Palliative (Emergency) Treatment of Dental Pain (D9110) | 80% | | YES | |
| Deep Sedation / General Anesthesia (D9220) | 80% | | YES | |
| Consultation (Diagnostic Service Provided by Dentist or Physician Other Than Practitioner Providing Treatment) (D9310) | 80% | 2 IN 1 CY | YES | |
| Occlusal Guards, by report (D9940) | 80% | | YES | |
| External Bleaching - per Arch (D9972) | 0% | Not Covered | | |

**Plan Provisions**

Maximum Age for Non-Orthodontic Services (Up to Age) Child - 19, Student -26
Coordination of Benefits: Birthday Rule Applies
Coordination of Benefits with any other Dental Plan: This plan coordinates benefits based on the above provision.
Missing Tooth Exclusion/Prior Loss Clause: Are plan benefits available for teeth lost prior to effective date? NO
This plan provides the alternate benefit of an amalgam filling for composite fillings performed on molar teeth. NO
This plan provides the alternate benefit of a full cast restoration for porcelain or veneer materials on molar teeth. NO
This plan provides the alternate benefit of a full cast restoration for porcelain or veneer crowns on bicuspid teeth. NO
This plan combines the frequency limitation for cleanings and perio maintenance visits. NO
This plan pays benefits based on the service: Completion Date.
Extractions performed for orthodontic purposes may be subject to Orthodontic benefit levels.
Benefits for Anesthesia are based on medical necessity.

**Orthodontic Services**

Payment Method is: Monthly Repetitive
Percentage Considered at Initial Placement: 20
Orthodontic Benefit Level: 80%
Remaining benefits for the appliance adjustment visits will be paid automatically an a periodic basis provided that the patient is still eligible for coverage, active treatment is still being rendered, and the lifetime orthodontic maximum benefits have not been exceeded.
Maximum age for Orthodontics (Up to Age) Child - 19, Student - 19, Adult - NC

Like most dental benefit plans, MetLife's dental plans contain certain exclusions and limitations. The patient should refer to his/her plan booklet for complete plan details. All claims submitted are subject to MetLife's standard processing guidelines and reviews. In some cases it may be determined that an alternative method of treatment is as appropriate and cost-effective. A pretreatment estimate is recommended before the start of extensive dental treatment such as crowns, veneers, bridgework, implants or treatment related to periodontal services, TMJ or orthodontics.

MetLife Dental - Plan Benefit Summary as of
Calendar Year Benefit Period Start Date: January 01

Participant's Name: Effective Date of Current Coverage:
Patient: Self

| Group Name: | Group Num: | Sub: | Branch: | Plan: | Coverage: |
|---|---|---|---|---|---|
| THE PORT AUTHORITY OF NEW YORK | 0302043 | 0001 | 0002 | 99 | |

Eligibility is not a guarantee of coverage as actual benefit payments are determined only when a claim is processed. Please fax claims to 1-859-389-6505 or mail claims to: MetLife Dental, P.O. Box 981282, El Paso, TX 79998-1282. The mailing address for Appeal and Reconsideration claims is MetLife Group Claims Review, P.O. Box 14589, Lexington, KY 40512. Please bring this fax to your dentist. This fax will provide the dentist with a comprehensive understanding of your dental benefits plan and assist with planning your dental care.

**MAXIMUMS - If applicable, please refer to the footnotes below.**

| | Benefit Period Individual | Benefit Period Family | Lifetime Individual | Lifetime Family |
|---|---|---|---|---|
| Basic Plan | $2000 | NONE | NONE | NONE |
| Used to Date | $0 | Not App. | Not App. | Not App. |
| Orthodontics | NONE | NONE | $2000 | NONE |
| Used to Date | Not App. | Not App. | $0 | Not App. |
| Periodontics | $2000 | NONE | NONE | NONE |
| Used to Date | $0 | Not App. | Not App. | Not App. |

The maximums may be combined with other types of procedures, such as TMJ or Perio.

***DEDUCTIBLES* - If applicable, please refer to the footnotes below.**

| | Benefit Period Individual | Benefit Period Family | Lifetime Individual | Lifetime Family |
|---|---|---|---|---|
| Basic Plan | $50 | $100 | NONE | NONE |
| Met to Date | $0 | $0 | Not App. | Not App. |
| Orthodontics | NONE | NONE | NONE | NONE |
| Met to Date | Not App. | Not App. | Not App. | Not App. |
| Periodontics | $50 | $100 | NONE | NONE |
| Met to Date | $0 | $0 | Not App. | Not App. |

The deductibles may be combined with other types of procedures, such as TMJ or Perio.

This section provides information on the level of coverage and how often the services are covered. This listing is not an all-inclusive listing of all possible covered procedures under this plan. Benefits are based on the MetLife determined reasonable and customary amounts. Please note the information herein is not a guarantee of coverage. A patient's eligibility and benefits will only be determined at the time a claim is processed by MetLife.

Please note frequency limitations may be combined for like services.

**Diagnostic and Preventive Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Up to Age | Last Date of Service |
|---|---|---|---|---|---|
| Periodic Oral Evaluation (D0120) | 100% | 4 IN 1 CY | NO | | |
| Limited Oral Evaluation - problem focused (D0140) | 100% | 4 IN 1 CY | NO | | |
| Comprehensive Oral Evaluation (D0150) | 100% | 4 IN 1 CY | NO | | |
| Intraoral - Complete Series (D0210) | 100% | 1 IN 3 CY | NO | | |
| Panoramic Film (D0330) | 100% | 1 IN 3 CY | NO | | |
| Bitewing - Single Film (D0270) | 100% | 2 IN 1 CY | NO | | |
| Intraoral Periapical First Film (D0220) | 100% | | NO | | |
| Prophylaxis Adult (D1110) | 100% | 4 IN 1 CY | NO | | |
| Prophylaxis Child (D1120) | 100% | 4 IN 1 CY | NO | 14 | |
| Topical Application of Fluoride - Child (D1203) | 100% | 2 IN 1 CY | NO | 14 | |
| Topical Application of Fluoride - Adult (D1204) | 100% | 2 IN 1 CY | NO | 19 | |
| Space Maintainer - Fixed - Unilateral (D1510) | 80% | | YES | 19 | |
| Sealant - Per Tooth (D1351) | 100% | 1 IN 3 CY | NO | 19 | |

Sealant coverage is limited to permanent molars excluding wisdom teeth.

**Restorative and Major Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Additional Information Required for Review |
|---|---|---|---|---|
| Amalgam 1 Surface Filling - Adult/Child (D2140) | 80% | | YES | |
| Resin-Based Composite - 1 Surface, Posterior (D2391) | 80% | | YES | |
| Inlay - Metallic - 1 Surface (D2510) | N/AVAIL | | | Pre-treatment X-rays |
| Crown - Porcelain fused to noble metal (D2752) | N/AVAIL | | | Pre-treatment X-rays |
| Crown - Full case noble metal (D2792) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Recement Crown (D2920) | 80% | | YES | |
| Cast Post and Core in Addition to Crown (D2952) | 80% | | YES | |
| Crown Repair, by report (D2980) | 80% | | YES | |
| Root Canal Therapy - Anterior (D3310) | 80% | | YES | |
| Root Canal Therapy - Bicuspid (D3320) | 80% | | YES | |
| Root Canal Therapy - Molar (D3330) | 80% | | YES | |
| Osseous Surgery (D4260) | 80% | 1 IN 1 CY | YES | Pre-treat X-rays & Perio Cht. |
| Free Soft Tissue Graft Procedure (including donor site surgery) (D4271) | 80% | | YES | Location, Nature & Extent |
| Periodontal Scaling and Root Planing - Quadrant (D4341) | 80% | 1 IN 1 CY | YES | Pre-treat X-rays & Perio Cht. |
| Periodontal Maintenance (Following Active Therapy) (D4910) | 80% | | YES | Prior Dates of Active Therapy |
| Complete Denture - Maxillary (Upper) (D5110) | 80% | 1 IN 5 CY | YES | |
| Complete Denture - Mandibular (Lower) (D5120) | 80% | 1 IN 5 CY | YES | |
| Maxillary (Upper) Partial Denture (D5213) | 80% | 1 IN 5 CY | YES | |
| Mandibular (Lower) Partial Denture (D5214) | 80% | 1 IN 5 CY | YES | |
| Reline Complete Maxillary Denture (Chairside) (D5730) | 80% | N/AVAIL | YES | |
| Surgical placement of implant: Endosteal implant (D6010) | 80% | | YES | Pre-treatment X-rays |
| Prefabricated abutment, includes placement (D6056) | 80% | | YES | |
| Abutment supported porcelain fused to metal crown (high noble metal) (D6059) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |

**Restorative and Major Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Additional Information Required for Review |
|---|---|---|---|---|
| Pontic - Cast high noble metal (D6210) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Pontic - Porcelain fused to high noble metal (D6240) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Crown - Porcelain fused to high noble metal (D6750) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Crown - Full cast high noble metal (D6790) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Extraction, Erupted Tooth or Exposed Root (D7140) | 80% | | YES | |
| Surgical Removal of Erupted Tooth (D7210) | 80% | | YES | |
| Removal of Impacted Tooth - Completely Bony (D7240) | 80% | | YES | |
| Oroantral Fistula Closure (D7260) | 80% | | YES | |
| Occlusal Orthotic Device, by Report (D7880) | 0% | Not Covered | | |
| Removable Appliance Therapy (D8210) | 80% | | YES | |
| Palliative (Emergency) Treatment of Dental Pain (D9110) | 80% | | YES | |
| Deep Sedation / General Anesthesia (D9220) | 80% | | YES | |
| Consultation (Diagnostic Service Provided by Dentist or Physician Other Than Practitioner Providing Treatment) (D9310) | 80% | 2 IN 1 CY | YES | |
| Occlusal Guards, by report (D9940) | 80% | | YES | |
| External Bleaching - per Arch (D9972) | 0% | Not Covered | | |

**Plan Provisions**

Maximum Age for Non-Orthodontic Services (Up to Age) Child - 26, Student -26
Coordination of Benefits: Birthday Rule Applies
Coordination of Benefits with any other Dental Plan: This plan coordinates benefits based on the above provision.
Missing Tooth Exclusion/Prior Loss Clause: Are plan benefits available for teeth lost prior to effective date? NO
This plan provides the alternate benefit of an amalgam filling for composite fillings performed on molar teeth. NO
This plan provides the alternate benefit of a full cast restoration for porcelain or veneer materials on molar teeth. NO
This plan provides the alternate benefit of a full cast restoration for porcelain or veneer crowns on bicuspid teeth. NO
This plan combines the frequency limitation for cleanings and perio maintenance visits. NO
This plan pays benefits based on the service: Completion Date.
Extractions performed for orthodontic purposes may be subject to Orthodontic benefit levels.
Benefits for Anesthesia are based on medical necessity.

**Orthodontic Services**

Payment Method is: Monthly Repetitive
Percentage Considered at Initial Placement: 20
Orthodontic Benefit Level: 80%
Remaining benefits for the appliance adjustment visits will be paid automatically an a periodic basis provided that the patient is still eligible for coverage, active treatment is still being rendered, and the lifetime orthodontic maximum benefits have not been exceeded.
Maximum age for Orthodontics (Up to Age) Child - 19, Student - 19, Adult - NC

Like most dental benefit plans, MetLife's dental plans contain certain exclusions and limitations. The patient should refer to his/her plan booklet for complete plan details. All claims submitted are subject to MetLife's standard processing guidelines and reviews. In some cases it may be determined that an alternative method of treatment is as appropriate and cost-effective. A pretreatment estimate is recommended before the start of extensive dental treatment such as crowns, veneers, bridgework, implants or treatment related to periodontal services, TMJ or orthodontics.

MetLife Dental - Plan Benefit Summary as of
Calendar Year Benefit Period Start Date: January 01

Participant's Name: Effective Date of Current Coverage:
Patient: Self

| Group Name: | Group Num: | Sub: | Branch: | Plan: | Coverage: |
|---|---|---|---|---|---|
| *THE PORT AUTHORITY OF NEW YORK* | *0302043* | *0006* | *0007* | *99* | |

Eligibility is not a guarantee of coverage as actual benefit payments are determined only when a claim is processed. Please fax claims to 1-859-389-6505 or mail claims to: MetLife Dental, P.O. Box 981282, El Paso, TX 79998-1282. The mailing address for Appeal and Reconsideration claims is MetLife Group Claims Review, P.O. Box 14589, Lexington, KY 40512. Please bring this fax to your dentist. This fax will provide the dentist with a comprehensive understanding of your dental benefits plan and assist with planning your dental care.

**MAXIMUMS - If applicable, please refer to the footnotes below.**

| | Benefit Period Individual | Benefit Period Family | Lifetime Individual | Lifetime Family |
|---|---|---|---|---|
| Basic Plan | NONE | NONE | NONE | NONE |
| Used to Date | Not App. | Not App. | Not App. | Not App. |
| Orthodontics | NONE | NONE | $1035 | NONE |
| Used to Date | Not App. | Not App. | $0 | Not App. |
| Periodontics | NONE | NONE | NONE | NONE |
| Used to Date | Not App. | Not App. | Not App. | Not App. |

The maximums may be combined with other types of procedures, such as TMJ or Perio.

**DEDUCTIBLES - If applicable, please refer to the footnotes below.**

| | Benefit Period Individual | Benefit Period Family | Lifetime Individual | Lifetime Family |
|---|---|---|---|---|
| Basic Plan | $25 | $50 | NONE | NONE |
| Met to Date | $0 | $0 | Not App. | Not App. |
| Orthodontics | NONE | NONE | NONE | NONE |
| Met to Date | Not App. | Not App. | Not App. | Not App. |
| Periodontics | $25 | $50 | NONE | NONE |
| Met to Date | $0 | $0 | Not App. | Not App. |

The deductibles may be combined with other types of procedures, such as TMJ or Perio.

This section provides information on the level of coverage and how often the services are covered. This listing is not an all-inclusive listing of all possible covered procedures under this plan. Benefits are based on the MetLife determined reasonable and customary amounts. Please note the information herein is not a guarantee of coverage. A patient's eligibility and benefits will only be determined at the time a claim is processed by MetLife.

Please note frequency limitations may be combined for like services.

**Diagnostic and Preventive Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Up to Age | Last Date of Service |
|---|---|---|---|---|---|
| Periodic Oral Evaluation (D0120) | 80% | 2 IN 1 CY | NO | | |
| Limited Oral Evaluation - problem focused (D0140) | 80% | 2 IN 1 CY | NO | | |
| Comprehensive Oral Evaluation (D0150) | 80% | 2 IN 1 CY | NO | | |
| Intraoral - Complete Series (D0210) | 80% | 1 IN 3 CY | NO | | |
| Panoramic Film (D0330) | 80% | 1 IN 3 CY | NO | | |
| Bitewing - Single Film (D0270) | 80% | 2 IN 1 CY | NO | | |
| Intraoral Periapical First Film (D0220) | 80% | | NO | | |
| Prophylaxis Adult (D1110) | 80% | 2 IN 1 CY | NO | | |
| Prophylaxis Child (D1120) | 80% | 2 IN 1 CY | NO | 14 | |
| Topical Application of Fluoride - Child (D1203) | 80% | 2 IN 1 CY | NO | 14 | |
| Topical Application of Fluoride - Adult (D1204) | 80% | 2 IN 1 CY | NO | 19 | |
| Space Maintainer - Fixed - Unilateral (D1510) | 80% | | YES | 19 | |
| Sealant - Per Tooth (D1351) | 0% | Not Covered | | | |

**Restorative and Major Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Additional Information Required for Review |
|---|---|---|---|---|
| Amalgam 1 Surface Filling - Adult/Child (D2140) | 80% | | YES | |
| Resin-Based Composite - 1 Surface, Posterior (D2391) | 80% | | YES | |
| Inlay - Metallic - 1 Surface (D2510) | N/AVAIL | | | Pre-treatment X-rays |
| Crown - Porcelain fused to noble metal (D2752) | N/AVAIL | | | Pre-treatment X-rays |
| Crown - Full case noble metal (D2792) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Recement Crown (D2920) | 80% | | YES | |
| Cast Post and Core in Addition to Crown (D2952) | 80% | | YES | |
| Crown Repair, by report (D2980) | 80% | | YES | |
| Root Canal Therapy - Anterior (D3310) | 80% | | YES | |
| Root Canal Therapy - Bicuspid (D3320) | 80% | | YES | |
| Root Canal Therapy - Molar (D3330) | 80% | | YES | |
| Osseous Surgery (D4260) | 80% | 1 IN 1 CY | YES | Pre-treat X-rays & Perio Cht. |
| Free Soft Tissue Graft Procedure (including donor site surgery) (D4271) | 80% | | YES | Location, Nature & Extent |
| Periodontal Scaling and Root Planing - Quadrant (D4341) | 80% | 1 IN 1 CY | YES | Pre-treat X-rays & Perio Cht. |
| Periodontal Maintenance (Following Active Therapy) (D4910) | N/AVAIL | | | Prior Dates of Active Therapy |
| Complete Denture - Maxillary (Upper) (D5110) | 80% | 1 IN 5 CY | YES | |
| Complete Denture - Mandibular (Lower) (D5120) | 80% | 1 IN 5 CY | YES | |
| Maxillary (Upper) Partial Denture (D5213) | 80% | 1 IN 5 CY | YES | |
| Mandibular (Lower) Partial Denture (D5214) | 80% | 1 IN 5 CY | YES | |
| Reline Complete Maxillary Denture (Chairside) (D5730) | 80% | N/AVAIL | YES | |
| Surgical placement of implant: Endosteal implant (D6010) | 0% | Not Covered | | |
| Prefabricated abutment, includes placement (D6056) | 0% | Not Covered | | |
| Abutment supported porcelain fused to metal crown (high noble metal) (D6059) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |

**Restorative and Major Services**

| Description of Services | Benefit Level | Plan Frequency Limit (if applicable) | Deductible Yes/No | Additional Information Required for Review |
|---|---|---|---|---|
| Pontic - Cast high noble metal (D6210) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Pontic - Porcelain fused to high noble metal (D6240) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Crown - Porcelain fused to high noble metal (D6750) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Crown - Full cast high noble metal (D6790) | 80% | 1 IN 5 CY | YES | Pre-treatment X-rays |
| Extraction, Erupted Tooth or Exposed Root (D7140) | 80% | | YES | |
| Surgical Removal of Erupted Tooth (D7210) | 80% | | YES | |
| Removal of Impacted Tooth - Completely Bony (D7240) | 80% | | YES | |
| Oroantral Fistula Closure (D7260) | 80% | | YES | |
| Occlusal Orthotic Device, by Report (D7880) | 0% | Not Covered | | |
| Removable Appliance Therapy (D8210) | 80% | | YES | |
| Palliative (Emergency) Treatment of Dental Pain (D9110) | 80% | | YES | |
| Deep Sedation / General Anesthesia (D9220) | 80% | | YES | |
| Consultation (Diagnostic Service Provided by Dentist or Physician Other Than Practitioner Providing Treatment) (D9310) | 80% | 2 IN 1 CY | YES | |
| Occlusal Guards, by report (D9940) | 80% | | YES | |
| External Bleaching - per Arch (D9972) | 0% | Not Covered | | |

**Plan Provisions**

Maximum Age for Non-Orthodontic Services (Up to Age) Child - 19, Student -26
Coordination of Benefits: Birthday Rule Applies
Coordination of Benefits with any other Dental Plan: This plan coordinates benefits based on the above provision.
Missing Tooth Exclusion/Prior Loss Clause: Are plan benefits available for teeth lost prior to effective date? NO
This plan provides the alternate benefit of an amalgam filling for composite fillings performed on molar teeth. NO
This plan provides the alternate benefit of a full cast restoration for porcelain or veneer materials on molar teeth. NO
This plan provides the alternate benefit of a full cast restoration for porcelain or veneer crowns on bicuspid teeth. NO
This plan combines the frequency limitation for cleanings and perio maintenance visits. NO
This plan pays benefits based on the service: Completion Date.
Extractions performed for orthodontic purposes may be subject to Orthodontic benefit levels.
Benefits for Anesthesia are based on medical necessity.

**Orthodontic Services**

Payment Method is: Monthly Repetitive
Percentage Considered at Initial Placement: 20
Orthodontic Benefit Level: 80%
Remaining benefits for the appliance adjustment visits will be paid automatically an a periodic basis provided that the patient is still eligible for coverage, active treatment is still being rendered, and the lifetime orthodontic maximum benefits have not been exceeded.
Maximum age for Orthodontics (Up to Age) Child - 19, Student - 19, Adult - NC

Like most dental benefit plans, MetLife's dental plans contain certain exclusions and limitations. The patient should refer to his/her plan booklet for complete plan details. All claims submitted are subject to MetLife's standard processing guidelines and reviews. In some cases it may be determined that an alternative method of treatment is as appropriate and cost-effective. A pretreatment estimate is recommended before the start of extensive dental treatment such as crowns, veneers, bridgework, implants or treatment related to periodontal services, TMJ or orthodontics.

## THE PORT AUTHORITY OF NEW YORK AND NEW JERSEY
## GG-030/ GG-030C

### DENTAL CARE PROGRAM

| Diagnostic & Preventive Services | Patient Copayment |
|---|---|
| Oral Examination | No Charge |
| Full Mouth X-ray | No Charge |
| Single Films (periapical or bitewing) | No Charge |
| Bitewing Series | No Charge |
| Cleaning of Teeth (prophylaxis & polishing) | No Charge |
| Fluoride Treatment | No Charge |
| Specialty Consultation | No Charge |
| Treatment in case of dental emergency | No Charge |
| **Restorative Dentistry** | |
| Silver Amalgam, One Surface | No Charge |
| Silver Amalgam, Two Surfaces | No Charge |
| Silver Amalgam, Three Surfaces or more | No Charge |
| Composite Filling, One Surface | No Charge |
| Composite Filling, Two Surfaces | No Charge |
| Composite Filling, Three Surfaces or more | No Charge |
| **Oral Surgery** | |
| Routine Extractions - per tooth | No Charge |
| Surgical Extractions | No Charge |
| Soft Tissue Impactions | No Charge |
| Bony Impactions | No Charge |
| Alveolectomy, per Quadrant | No Charge |
| **Root Canal Therapy** | |
| Pulp Capping, Direct | No Charge |
| Pulpotomy | No Charge |
| Root Therapy - Anterior | No Charge |
| Root Therapy - Bicuspid | No Charge |
| Root Therapy - Molar | No Charge |
| Apicoectomy | No Charge |
| **Periodontics** | |
| Scaling of Teeth, per quad | No Charge |
| Gingivectomy, per quad | No Charge |
| Osseous Surgery, per quad | No Charge |
| **Prosthetics - Crowns** | |
| Acrylic with Metal Crown | No Charge |
| Porcelain Crown | No Charge |
| Porcelain with Metal Crown. | 50.00 |
| Stainless Steel Crown | No Charge |
| Post | No Charge |
| Recementation, per crown | No Charge |
| **Prosthetics - Fixed Bridges** | |
| Acrylic W//Metal Bridge Crown or Pontic | No Charge |
| Porcelain W/Metal Bridge Crown or Pontic | 50.00 |
| Recementation, bridge | No Charge |
| **Prosthetics - Removable** | |
| Full Upper or Lower Denture, W/Adjustments | No Charge |
| Partial Upper or Lower Denture, Cast Base | No Charge |
| Denture Adjustments | No Charge |
| Broken Body of Denture | No Charge |
| Replacement of Broken/Missing Teeth | No Charge |
| **Orthodontia - (Dependent Children Only)*** | |
| Maximum Case Fee – 24 months | No Charge |

his summary contains a general description of your Dental Care Program for your use as a convenient reference. All benefits, exclusions nd limitations are listed in your group's contract.

THE PORT AUTHORITY OF NY & NJ

# The Port Authority of New York & New Jersey and Port Authority Trans-Hudson Corporation

## Medical Plans

PORT AUTHORITY
TRANS-HUDSON CORPORATION

UNITEDhealthcare®

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# Schedule of Benefits

## Effective Date of these Plans

**September 1, 1998**

## Medical Benefits

| Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up To The Dollar Amount And/Or Number Of Days Shown Below. | | |
|---|---|---|
| | **Network** | **Non-Network** |
| Hospital Services<br>In-Patient<br>Hospital's regular semi-private rate (See ***NOTE**)<br><br>Room and Board<br><br>Maximum Payment Period<br>Other Fees (incurred on days that payment is made for Room and Board)<br><br>Other Fees include:<br>- Hospital charges for anesthetics<br>- Hospital charges for giving anesthetics<br>- Charges for transportation to and from the Hospital by professional ambulance<br>- Hospital charges for Other Services and Supplies<br>- Hospital Pre-Admission Tests<br><br>Out-Patient Benefits | Unlimited<br><br>Unlimited | 120 days for Each Cause<br>Full Amount<br><br>Unlimited |
| Emergency Room Care | Full Amount | |
| Ambulatory Surgical Center Services | Full Amount | |
| Physician's Services for Surgery<br>Surgeon's Fees<br>Anesthesiologist's Fees<br>Assistant Surgeon's Fees (See page 19) | 100% | 100% Reasonable Charge |
| Laboratory Tests and X-Rays, including one mammogram and one Pap smear per Calendar Year. | 100% | 100% Reasonable Charge |
| Routine Well Baby Care | 100% | 100% Reasonable Charge |
| Hospice Care up to 210 days lifetime | 100% | 100% Reasonable Charge |
| Surgery for Temporomandibular Joint Dysfunction | None | 100% Reasonable Charge |

***NOTE:**

There is maximum number of 120 days for each Non-Network Hospital confinement.

A new maximum of 120 days of Hospital confinements applies:

- 90 days after your last confinement for the same cause or
- If the cause of the later confinement or surgical procedure is a new disability and is completely different from the disability which caused the first confinement or surgical procedure.

| Covered Expenses Subject To The Deductible/Copayment | | |
|---|---|---|
| **Maximum Benefits** | | |
| | **Network** | **Non-Network** |
| Lifetime Maximum Benefit | Unlimited | |
| Hearing Loss Benefit per Calendar Year | N/A | $200 |
| **Deductibles/Copayments/Out-of-Pocket** | | |
| Individual Deductible per Calendar Year | N/A | $50 |
| Family Deductible per Calendar Year | N/A | $100 |
| Physician Office Visits Copayment | $5 | N/A |
| Individual Out-of-Pocket Maximum per Calendar Year | N/A | $1,000 |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | | |
| Hearing Loss Benefit | None | 80% |
| Temporomandibular Joint Dysfunction services | None | 80% |
| Emergency Room Care for Non-Emergency treatment | 80% | |
| **All Other Covered Expenses for Medical Benefits** | 100% | 80% |
| **Percentage of Covered Expenses Payable after the Out-of-Pocket Maximum is reached** | 100% | 100% |

*Benefits for Organ/Tissue Transplants performed at a Designated Transplant* Facility are payable at 100% of Covered Expenses.

Benefits for Organ/Tissue Transplants performed at a Non-Designated Transplant *Facility are payable at Plan benefits, subject to the deductible.*

## Mental Disorder Treatment and Alcohol or Substance Abuse Treatment

| Mental Disorder Treatment | | |
|---|---|---|
| **Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up To The Maximums Shown Below** | | |
| | **Network** | **Non-Network** |
| **Lifetime Maximum Benefits** | Unlimited | |
| **Calendar Year Maximum Benefits** | | |
| Inpatient | 30 days | |
| Outpatient | None | |
| **Covered Expenses subject to The Deductible/Copayment. Covered Expenses are subject to the same Cash Deductible as Medical Benefits** | | |
| Inpatient | Unlimited | |
| Outpatient | Unlimited | |
| Copayment for Outpatient Treatment | $10 | None |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | 100% | 80% |

| Alcohol or Substance Abuse Treatment | | |
|---|---|---|
| **Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up To The Maximums Shown Below** | | |
| **Lifetime Maximum Benefits** | Two (2) Confinements | |
| **Calendar Year Maximum Benefits** | | |
| Inpatient | | |
| Alcohol or Substance Abuse Treatment | | |
| • Detoxification Treatment | 7 days | |
| • All other Covered Expense | 30 days | |
| Outpatient | None | |
| **Covered Expenses Subject To The Deductible/copayment. Covered Expenses Are Subject To The Same Cash Deductible As Medical Benefits.** | | |
| **Outpatient** | | |
| Alcohol or Substance Abuse Treatment - Lifetime | 120 visits | |
| Alcohol or Substance Abuse Treatment - Calendar Year | 60 visits | |
| **Copayment for outpatient services** | $5 | None |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | 100% | 80% |

**Percentage Of Covered Expenses Payable After The Out-of-Pocket Maximum Is Reached For All Mental Disorder Treatment and Alcohol or Substance Abuse Treatment - 100%**

## Pregnancy Benefits

Pregnancy Benefits are payable in the same manner as Medical Benefits.

## Preventive Health Care Benefits

Preventive Health Care Benefits are payable in the same manner as Medical Benefits. See page 23.

| Percentage of Reasonable Charge Payable After Deductibles/Copayments are Satisfied | | |
|---|---|---|
| | **Network** | **Non-Network** |
| Routine physical exam for covered Employees and Dependent spouses, including diagnostic tests and immunizations | 100% | None |
| Routine pediatric care to age 19, including PKU tests and immunizations | 100% | 100% |

## Family Planning Benefits

Family Planning Benefits are payable in the same manner as Medical Benefits

## End of Schedule of Benefits

# Coverage under the Former Plans

This section applies only to persons covered under the prior Plans of the Employer (called the Former Plans) in effect on the day before the Effective Date of coverage under these Plans. The coverage described in this booklet replaces the coverage under the Former Plans.

Coverage and benefits paid under the Former Plans will be considered as coverage and benefits paid under these Plans for figuring the following under any benefits of these Plans:

- Benefit limits and maximum amounts. Any Covered Expenses applied toward the benefit limits or maximum amounts under the Former Plans are applied to those same benefit limits or maximum amounts under these Plans.
- Coinsurance percentage.

A person may have satisfied or partially satisfied a deductible requirement under the Former Plans. Expenses counted toward the deductible under the Former Plans will be counted toward any annual deductible under these Plans. They will be counted under these Plans the same way they were counted under the Former Plans.

Certain children are included as Eligible Dependents under these Plans regardless of age. The child must have been covered under the Former Plans. The child must meet the following conditions:

- The child is mentally or physically incapacitated.
- The child is not capable of self-support.
- The child depends on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested.

# Eligibility

## Eligible Employees

All full-time and some part-time Employees of the Employer. Employees represented for collective negotiations or bargaining may be eligible under the terms of their agreements.

## Eligible Dependents

A Dependent is a Qualified Dependent of an eligible Employee.

1. Qualified Dependent means, among other things, the spouse of an Employee, *excluding, in any case:*
   - a spouse who is also covered as an Employee under any group medical benefits provided by the Employer,
   - a legally separated or divorced spouse (or one whose marriage has been annulled), unless:
     - the Employee is legally responsible for the support of such legally separated or divorced spouse, and
     - the legally separated or divorced spouse has not remarried, and
     - the Employee has not remarried or, if remarried, has not notified the Employer in writing that such legally separated or divorced spouse should continue to be covered as a Qualified Dependent.

   If the Employee is remarried, a divorced spouse and a current spouse may in no event both be simultaneously covered as a Qualified Dependent.

   The option to cover a legally separated or divorced spouse rather than a current spouse after the Employee remarries may be exercised only once by the Employee.

2. An Eligible Employee's unmarried child from birth through the last day of the Calendar Year in which the child turns age 19.

   An eligible Employee's unmarried child under age 26 through the last day of the Calendar Year in which the child reaches age 26, if the child is a registered student in regular full-time attendance at school. The child must be residing with and mainly dependent on the Employee for care and support. The child cannot be employed on a regular full-time basis by one or more employers for a total of 30 or more hours per week.

   Child includes the following:
   - A stepchild who resides in the eligible Employee's home. The Employee must verify financial support.
   - A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)

## Cost of Coverage

The coverage under these Plans is non-contributory. This means that the Employer pays for the full cost of the coverage for active and retired employees.

## Enrollment Requirements

**Employee Coverage**

An Employee enrolls for Employee coverage by:

- completing an enrollment form, and
- giving the form to the Employer.

An Employee's enrollment is either timely or late.

An Employee is considered a timely enrollee if he or she enrolls during either the Initial Eligibility Period or a Special Enrollment Period.

An Employee is considered a late enrollee when he or she enrolls during the Annual Enrollment Period. See Enrollment Periods below.

**Dependent Coverage**

An Employee must enroll for coverage as an Employee in order to enroll his or her Dependents. If a husband and wife are both eligible Employees, only one may enroll their Dependents for coverage.

*No person can be covered both as an Employee and as a Dependent under any* group medical and dental health Plan of the Employer.

Initial Dependents are those family members who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage.

Subsequent Dependents are family members who become Eligible Dependents after the date the Employee first becomes eligible under one of these Plans. Subsequent Dependents may be added during a Special Enrollment Period.

A Dependent's enrollment is either timely or late.

A Dependent is considered a timely enrollee when he or she is enrolled for coverage during either the Initial Eligibility Period or a Special Enrollment Period.

A Dependent is considered a late enrollee when he or she enrolls during the Annual Enrollment Period.

## Enrollment Periods

The Initial Eligibility Period is the 31-day period which begins on the date the Employee or Dependent is first eligible under these Plans.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Annual Enrollment Period to enroll for coverage.

The Annual Enrollment Period is designated by the Employer each year. It is held before the start of each Plan Year. During this period, all eligible Employees and Dependents can enroll for coverage.

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents.

A Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under one of these Plans was previously offered to the Employee or Dependent.
- The Employee's or Dependent's prior coverage was one of the following:
  - COBRA continuation which was exhausted.
  - Non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated or the contract was cancelled.
- The Employee requests enrollment under one of these Plans not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of Employer contribution.

A Special Enrollment Period is available to Subsequent Dependents. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

**Late Enrollees**

A late enrollee can enroll only during an Annual Enrollment Period.

## Effective Date of Employee Coverage

Employee coverage is effective on the date coincident with or next following the latest of:

- The Effective Date shown in **Schedule of Benefits**.
- The date the Employee enrolls for coverage.
- The date following the day the Employee completes a Waiting Period of 30 days of continuous service with the Employer.

## Effective Date of Dependent Coverage

Coverage for Initial Dependents is effective on the date coincident with or next following the later of:

- The date the Employee becomes covered.
- The date the Employee enrolls the Dependents.

Coverage for a Subsequent Dependent is effective as follows:

- For a spouses, the later of the date the spouse is enrolled and the date of the marriage;
- For a newborn, the date of birth; or
- For an adopted child, the date of adoption or placement for adoption.

### Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for his/her children, these children can be enrolled as timely enrollees as required by OBRA 93.

### Special Provision for Newborn Children

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

The Employee must enroll the child during the 31-day Special Enrollment Period in order for the child to be a timely enrollee and covered beyond the 31 day period.

## Medical Benefits

Medical Benefits are payable for Covered Expenses incurred by the Covered Person while covered under these Plans.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Covered Services and Supplies listed in this Benefit. The Company, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with both of the following:

- The methodologies in the most recent edition of the Current Procedural Terminology.
- The methodologies as reported by generally recognized professionals or publications.

The Covered Expenses must be incurred for the care of an accidental injury or sickness. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

Each Covered Person must satisfy certain Copayments and/or Deductibles in connection with any payment made for certain Covered Services and Supplies. Then these Plans pay the percentage of Covered Expenses shown in the **Schedule of Benefits**.

After coverage under these Plans end, Medical Benefits may be payable as shown in **Extended Benefits**. See page 36.

Covered Services and Supplies for pregnancy are shown in **Pregnancy Benefits**.

Covered Services and Supplies for Mental Disorder Treatment are shown in **Mental Disorder Treatment and Alcohol or Substance Abuse Treatment Benefits**.

Covered Services and Supplies for Family Planning Benefits are shown in **Family Planning Benefits.**

## Copayments and Deductibles

Before Medical Benefits are payable, each Covered Person must satisfy certain Copayments and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Copayments are not counted toward any Deductible. Covered Services and Supplies which require a Copayment are not subject to a Deductible.

A Deductible is the amount of Covered Expenses the Covered Person must pay before Medical Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentage shown in the **Schedule of Benefits**.

The amount of each Copayment/Deductible is shown in the **Schedule of Benefits**. A Covered Expense can only be used to satisfy one copayment or deductible.

### Individual Deductible

The Individual Deductible applies to all Covered Expenses provided by a Non-Network Provider except as shown in **Schedule of Benefits**. It applies each Calendar Year.

Any Covered Expenses a Covered Person incurs during October, November and December of a year which count toward that person's Individual Deductible for that year will also count toward that person's Individual Deductible for the next year.

### Family Deductible

The most a family will have to pay for Individual Deductibles in any Calendar Year is the amount of the Family Deductible. The Family Deductible applies no matter how large a family may be. Only Covered Expenses which count toward a Covered Person's Individual Deductible count toward this Deductible.

### Physician Office Visit Copayment

The Physician Office Visit Copayment applies to Network Physician's Services. It also applies to Network physical therapist's services if the physical therapist bills for his/her services separately from any other charges. It applies to all Covered Services and Supplies given in connection with each office visit.

## Out-of-Pocket Feature

Covered Expenses are payable at the percentage shown in the **Schedule of Benefits** until any Out-of-Pocket Maximum shown in the **Schedule of Benefits** has been reached during a Calendar Year. Then, Covered Expenses are payable at 100% for the rest of that year as shown below.

All Covered Expenses that the Covered Person pays, other than those shown below, count toward the Out-of-Pocket Maximums.

Covered Expenses used to satisfy the following Copayment and/or Deductibles do not count toward any of the Out-of-Pocket Maximums. These Deductibles and Copayments still apply even after the applicable Out-of-Pocket Maximum has been reached:

- Physician Office Visit Copayment.
- Individual Deductible.
- Family Deductible.

### Individual Out-of-Pocket Maximum

When the Individual Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, Covered Expenses, other than those shown in the Out-of-Pocket Feature, are payable at 100% for that same person for the rest of that year.

## Covered Services and Supplies

Covered Services and Supplies must be Medically Necessary and given for the diagnosis or treatment of an accidental injury or sickness.

A Covered Person and his or her Physician decide which services and supplies are given, but these Plans only pay for the following Covered Services and Supplies which are Medically Necessary as determined by the Company.

Covered Services and Supplies also include services and supplies that are part of an Alternate Care Proposal (ACP). An ACP is a voluntary course of treatment developed by the Company and accepted by the Employee and attending Physician as an alternative to the services and supplies that would otherwise have been considered Covered Services and Supplies.

Unless the ACP specifies otherwise, the provisions of these Plans related to benefit amounts, maximum amounts, copayments and deductibles will apply to these services.

### Acupuncture Treatment

Covered Expenses for treatment provided by a Physician.

### Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

### Anesthetics

### Chemotherapy

### Durable Medical Equipment

Durable Medical Equipment means equipment which meets all of the following:

- It is for repeated use and is not a consumable or disposable item.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of Durable Medical Equipment are:

- Appliances which replace a lost body organ or part or help an impaired one to work.
- Orthicon devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

The Company decides whether to cover the purchase or rental of the equipment.

## Enteral Formulas

Written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which is left untreated, cause chronic disability, mental retardation or death.

Benefits are payable for enteral formulas for home use for which a Physician has issued a written order. The order must state that the enteral formula is necessary as a disease-specific treatment regimen for diseases which include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive, disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which is left untreated will cause malnourishment, chronic physical disability, mental retardation or death.

Coverage for certain inherited diseases of amino acid and organic metabolism shall include modified solid food products that are low protein, or which contain modified protein which are medically necessary. Coverage for modified solid food products for any calendar year or any continuous period of twelve months for any covered person shall not exceed $2,500.

## Foot Care

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a Covered Service only if needed due to severe systemic disease.

## Hearing Loss

The following are Covered Services and Supplies:

- Necessary test to prove there is a hearing loss.
- Necessary test to show where the hearing loss is.
- Charges for a permanent hearing aid.

Payment for all Covered Services and Supplies for Hearing Loss is subject to Calendar Year Maximum of $200 for each Covered Person.

## Home Health Care

The following Covered Services must be given by a Home Health Care Agency:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy.
- Occupational therapy.
- Speech Therapy.

Covered Services are limited to 200 combined Network and Non-Network visits each Calendar Year. Each period of home health aide care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit.

## Hospice Care

- Room and Board, up to 210 days.
- Other Services and Supplies.
- Part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Home Health Care Services as shown under Home Health Care. The limit on the number of visits shown under Home Health Care does not apply to Hospice patients.
- Counseling for the patient and Covered Family Members.
- Bereavement counseling for Covered Family Members. Services must be given within six months after the patient's death. Covered Services are limited to a total of 15 visits for each family.

Counseling must be given by a Licensed Counselor.

Services for the patient must be given in an inpatient Hospice facility or in the patient's home.

The Physician must certify that the patient is terminally ill with six months or less to live.

Any counseling services given in connection with a terminal illness will not be considered as Mental Disorder Treatment.

## Hospital Services

- Room and Board.

  Covered Expenses for a private room are limited to the regular daily charge made by the Hospital for a semi-private room.
- Other Services and Supplies.
- Emergency Room.

  Emergency room services are Covered Services payable at 100% only if it is determined that the services are Medically Necessary and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services.

  Emergency Room services for non-emergency care are payable at 80%.

## Infertility Treatment

Diagnosis and treatment of infertility, including surgery and inpatient drug therapy.

## Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment.

## Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Handling charges for blood or blood derivatives only if not donated or replaced.

## Medical Transportation Services

Transportation by professional ambulance, other than air ambulance, to and from a medical facility.

Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico or Canada.

## Nurse-Practitioner Services

Services of a licensed or certified Nurse-Practitioner acting within the scope of that license or certification.

## Oral Surgery and Dental Services

- Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.
- The following services and supplies are covered only if needed because of accidental injury to natural teeth:
  - Oral surgery.
  - Full or partial dentures.
  - Fixed bridge work.
  - Prompt repair to natural teeth.
  - Crowns.

## Organ/Tissue Transplants

Benefits for Organ/Tissue Transplants performed at a Non-Designated Transplant Facility are payable at Plan benefits, subject to the deductible.

Benefits for Organ/Tissue Transplants performed at a Designated Transplant Facility are payable at 100% of Covered Expenses. For benefits performed at a Designated Transplant Facility, Medical Management must be notified. Call the toll-free number shown on the ID card and follow the prompts for medical management.

Medical management must be notified at least ten working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation.
- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

Services and supplies for Medically Necessary organ or tissue transplants are payable under this Plan.

**Donor Charges for Organ/Tissue Transplants**

- In the case of an organ or tissue transplant, donor charges are considered Covered Expenses ONLY if the recipient is a Covered Person under this Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Service UNLESS the search is made in connection with a transplant procedure arranged by a Designated Transplant Facility.

If a Qualified Procedure, listed below, is Medically Necessary and performed at a Designated Transplant Facility, the **Medical Care and Treatment** and **Transportation and Lodging** provisions described below apply.

**Qualified Procedures**

- Heart Transplants.
- Lung transplants.
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Bone Marrow/Stem Cell transplants.
- Other transplant procedures when the Company determines that it is Medically Necessary to perform the procedure at a Designated Transplant Facility.

**Medical Care and Treatment**

The Covered Expenses for services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and physician fees.
- Transplant procedures.
- Follow-up care for a period up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search.

**Transportation and Lodging**

Medical Management will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Transplant Facility.
- *If the patient is a covered dependent minor child, the transportation expenses* of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.
- There is a combined overall lifetime maximum of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

## Orthoptic Training (Eye Muscle Exercise)

Training by a licensed optometrist or an orthoptic technician.

## Outpatient Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

## Outpatient Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

## Physician Services

### Medical Care and Treatment

- Hospital, office and home visits.
- Emergency room services.

### Surgery

Services for surgical procedures.

### Reconstructive Surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:

  - Birth defect.
  - Sickness.
  - Surgery to treat a Sickness or accidental injury.
  - Accidental injury.
- Reconstructive breast surgery following a Medically Necessary mastectomy.
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury.

***Assistant Surgeon Services***

Covered Expenses for assistant surgeon services are limited to 1/5 of the amount of Covered Expenses for the surgeon's Reasonable and Customary Charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not covered.

**Multiple Surgical Procedures**

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered Expenses for any subsequent procedure are limited to 25% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

## Prescribed Drugs and Medicines for inpatient services only.

## Private Duty Nursing Care

Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

## Psychologist Services

## Radiation Therapy

## Rehabilitation Therapy

**Inpatient**

- Services of a Hospital or Rehabilitation Facility for room, board, care and treatment during a confinement.
- Inpatient rehabilitative therapy is a Covered Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

**Outpatient**

- Services of a Hospital or Comprehensive Outpatient Rehabilitative Facility (CORF).

- Covered Services for each day of therapy reduces the number of visits under Covered Services for Outpatient Physical Therapy, Outpatient Occupational Therapy or Speech Therapy. This reduction only applies to days of therapy during which the therapy includes services given by a physical therapist, occupational therapist or speech therapist.

### Skilled Nursing Facility Services

- Room and Board.

  Covered Expenses for Room and Board are limited to the facility's regular daily charge for a semi-private room.
- Other Services and Supplies.

Covered Services are limited to the first 60 combined Network and Non-Network *days of confinement each Calendar Year.*

### Speech Therapy

Services of a licensed speech therapist.

*These services must be given to restore speech lost or impaired due to one of the following:*

- Surgery, radiation therapy or other treatment which affects the vocal chords
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to accidental injury or organic brain lesion (aphasia).
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

### Spinal Manipulations

Services of a Physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

### Temporomandibular Joint Dysfunction

Examination of the jaw and supporting structure, initial installation, and subsequent adjustments to removable appliances and Medically Necessary surgery to correct a condition known as Temporomandibular Joint Dysfunction (TMJ).

**Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.**

## Mental Disorder Treatment and Alcohol or Substance Abuse Treatment Benefits

Benefits are payable for Covered Services and Supplies for Mental Disorder Treatment given to the Covered Person while covered under these Plans. These Covered Services and Supplies are listed in **Medical Benefits**.

Benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment are subject to the copayments, deductibles and percentage of Covered Expenses payable as shown in **Schedule of Benefits**.

Benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment include, but are not limited to:

- Assessment.
- Diagnosis.
- Treatment planning.
- Medication management.
- Individual, family and group psychotherapy.
- Psychological education.
- Psychological testing.

After coverage under these Plans stop, extended benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment are the same as for Sickness.

Additional Covered Services and Supplies specific to Mental Disorder Treatment are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits**.

## Additional Covered Services and Supplies

### Licensed Counselor Services

*Services of a Licensed Counselor for Mental Disorder Treatment.*

### Treatment Center Services

- Room and Board.
- Other Services and Supplies.

**Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.**

# Pregnancy Benefits

Benefits are payable for Covered Services and Supplies given to the Covered Person for pregnancy while covered under these Plans. These Covered Services and Supplies are listed in **Medical Benefits.**

**Benefits for pregnancy are paid in the same way as benefits are paid for Sickness.**

Benefits are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery.

- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

After coverage under these Plans stop, extended benefits for pregnancy are the same as for Sickness.

Additional Covered Services and Supplies specific to pregnancy are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits.**

## Additional Covered Services and Supplies

### Birth Center Services

- Room and Board.
- Other Services and Supplies.
- Anesthetics.

### Nurse-Midwife's Services

Services of a licensed or certified Nurse-Midwife.

### Routine Well Baby Care

The following services and supplies given during a newborn child's initial Hospital confinement:

- Hospital services for nursery care.
- Other Services and Supplies given by the Hospital.
- Services for a circumcision.
- Physician Services.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# Family Planning Benefits

Benefits are payable for Covered Expenses for Family Planning Benefits incurred by the Covered Person while covered under these Plans.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for the Covered Services and Supplies listed in this Benefit. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

These Family Planning Benefits are subject to the same copayments, deductibles and percentage of Covered Expenses payable as benefits that are paid due to Sickness under **Medical Benefits**.

After coverage under these Plans stop, there are no extended benefits.

## Covered Services and Supplies

### Assisted Reproductive Technology

Covered Services and Supplies for Assisted Reproductive Technology (ART) are limited to a Covered Person who has undergone extensive screening and it has been determined that:

- The ART is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the following assisted reproductive technology procedures:
  - In vitro fertilization services.
  - artificial insemination
  - Gamete intrafallopian transfer (GIFT).
  - Zygote intrafallopian transfer (ZIFT).
  - Microinjection techniques.

The Covered Person must have been unable to become pregnant through more conservative means for a minimum of 12 months, unless one partner has already been diagnosed as infertile.

### Not Covered

- More than three attempts at ART.
- ART if infertility is the result of voluntary sterilization.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# Preventive Health Care Benefits

Benefits, as shown below, are payable for Covered Services and Supplies for Preventive Health Care Benefits given to a Covered Person by a Physician while the person is covered under these Plans.

The Office Visit Copayment shown in the **Schedule of Benefits** applies to the Covered Services and Supplies on the same basis as it applies to Sickness under the **Medical Benefits**.

Benefits are payable at 100% of Covered Expenses after the Copayment or Deductible has been paid.

After coverage under these Plans stop, there are no extended benefits.

## Covered Services and Supplies

- Routine physical exam for covered Employees and Dependent spouses, including diagnostic tests and immunizations, only if provided by a Network Provider.
- Child up to age 19, preventive care services given in connection with routine pediatric care, including PKU tests and immunizations. Preventive care services may be provided by either a Network or Non-Network Provider.

- A routine well-woman exam, if provided by a Network Provider, includes the following:
  - Breast examination and/or mammogram.
  - Pelvic examination.
  - Pap smear.
- A routine well-woman exam, if provided by a Non-Network Provider, includes the following:
  - Mammogram.
  - Pap smear.
- Chromosome testing only if provided by a Network Provider.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# General Exclusions and Limitations

These Plans do not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies received before an Employee or his or her Dependent becomes covered under these Plans.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under these Plans.
- Abdominoplastys, unless Medically Necessary.
- Breast reduction surgery, unless Medically Necessary.
- Chelation therapy, except to treat heavy metal poisoning.
- Completion of claim forms, or missed appointments.
- Cosmetic or reconstructive surgery or treatment. (This is surgery or treatment primarily to change appearance.) It does not matter whether or not it is for psychological or emotional reasons. See **Medical Benefits** for limited coverage of reconstructive surgery.
- Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

  Care that meets one of these conditions is custodial care regardless of any of the following:
    - Who recommends, provides or directs the care.
    - Where the care is provided.
    - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.

- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- *Eye glasses, contact lenses, eye refractions, cochlear implants, unless* required due to an accidental injury or sickness.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's immediate family:
  - The Employee's spouse.
  - The child, brother, sister or parent of the Employee.
- Expenses and associated expenses incurred for services and supplies for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for services which are otherwise Experimental, Investigational, or Unproven that are deemed to be, in the Company's judgment, covered transplant services. The fact that an Experimental, Investigational or Unproven Service, treatment, device and pharmacological regimen, is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- *Services and supplies which the Covered Person is not legally required to pay.*
- Liposuction.
- Services or supplies which are not Medically Necessary, including any confinement or treatment given in connection with a service or supply which is not Medically Necessary.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Occupational injury or Sickness. An occupational injury or Sickness is an injury or Sickness which is covered under a workers' compensation act or similar law.

  For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or Sickness includes any injury or Sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Private duty nursing services while confined in a facility, unless Medically Necessary.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.

- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a Covered Person under these Plans and is undergoing a covered transplant.
- Reversal of sterilization.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Charges made by a Hospital for confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below.

  If that type of facility is otherwise covered under these Plans, then benefits for that covered facility which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.

  - Adult or child day care center.
  - Ambulatory Surgical Center.
  - Birth Center.
  - Half-way house.
  - Hospice.
  - Skilled Nursing Facility.
  - Treatment Center.
  - Vocational rehabilitation center.
  - Any other area of a Hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- Drugs given while not confined in a Hospital, nursing home or similar place that has its own drug dispensary.
- Stand-by services required by a Physician.
- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions and implants. See **Medical Benefits** for limited coverage of oral surgery and dental services.
- Telephone consultations.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity).
- Nutritional counseling, special foods, food supplements, liquid diets, diet plans or any related products, except for Enteral Formulas as described in Medical Benefits.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- Services given by volunteers or persons who do not normally charge for their services.

# Claims Information

## How to File a Non-Network Claim

Claim forms for services provided by a Network Provider are not required.

If the provider does not submit electronically, the following steps should be completed when submitting bills for payment:

- From United HealthCare customer service.
- Get a claim form from the Employee's department.
- Complete the Employee portion of the form.
- Have the provider complete the provider portion of the form.
- Send the form and bills to the address shown on the form.

Make sure the bills and the form include the following information:

- The Employee's name and social security number.
- The Employer's name and contract number (197512 for The Port Authority of New York & New Jersey and 197944 for Port Authority Trans-Hudson Corporation).
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

If the Covered Employee asks for a claim form but does not receive it within 15 days, the covered Employee can file a claim without it by sending the bills with a letter, including all of the information listed above.

## When Claims Must be Filed

Claims forms must be submitted within 15 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of loss was given to the Company as soon as was reasonably possible.

## How and When Claims Are Paid

All payments will be paid to the covered Employee as soon as the Company receives satisfactory completed claim forms, except in the following cases:

- If the covered Employee has financial responsibility under a court order for a dependent's medical care, the Company will make payments directly to the provider of care.

- If the Company pays benefits directly to Network Providers, unless it has been documented that the Network Provider has been reimbursed for Covered Expenses.
- If the covered Employee requests in writing that payments be made directly to a provider. A covered Employee does this when completing the claim form.

These payments will satisfy the Company's obligation to the extent of the payment.

The Company will send an Explanation of Benefits (EOB) to the covered Employee. The EOB will explain how the Company considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee will receive a written explanation.

Any benefits continued for Dependents after a covered Employee's death will be paid to one of the following:

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.
- A provider of care who makes charges to the covered Employee's Dependents for Covered Services and Supplies.
- The legal guardian of the covered Employee's Dependent.

## Legal Actions

The covered Employee may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee lives allows for a longer period of time.

## Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to the Company within 90 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and the Company will provide the claimant with a written response within 60 days of the date the Company receives the claimant's request for review. If, because of extenuating circumstances, the Company is unable to complete the review process within 60 days, the Company will notify the claimant of the delay within the 60 day period and will provide a final written response to the request for review within 120 days of the date the Company received the claimant's written request for review.

If the denial is upheld, the Company's written response to the claimant will cite the specific Plan provision(s) upon which the denial is based.

# Coordination of Benefits

Coordination of benefits applies when a covered Employee or a covered Dependent has health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

## Definitions

**"Other Plans"** are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.
- No-Fault motor vehicle laws.

**"Primary Plan"**: A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

**"Secondary Plan"**: Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

**"Allowable Expenses"** means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense.

When this Plan is a secondary plan, the benefit is based on the primary carrier's allowable expense.

For example, if the primary carrier has an indemnity plan and the secondary plan is a network plan, the secondary plan coordinates against the full allowable expense of that indemnity plan.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

If you are retired and Medicare Eligible, see the section on Retired Employees or Their Dependents Who Are Medicare Eligible in the Retired Employee provision.

## How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

## Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
  - Medicare is secondary to the plan covering the person as a dependent.
  - Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

  If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  *If the other plan does not have a birthday rule, but instead has a rule based on* the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the plan of the parent with custody for the child.
  - Second, the plan of the spouse of the parent with the custody of the child.

- Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

If you are a retired employee and not Medicare eligible, see the section on Retired Employees or Their Dependents Who Are Not Yet Medicare Eligible in the Retired Employee provision.

## Right to Exchange Information

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this.

## Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Employer or Plan will not have to pay that amount again.

## Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Company may recover the amount paid from the other plan or organization or person.

Benefits may be paid that are in excess of what should have been paid under this Plan. The Company has the right to recover the excess payment.

# Recovery Provisions

## Refund of Overpayments

If benefits are paid under this Plan for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Plan if:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment made under this Plan exceeded the benefits under this Plan.

The refund equals the amount of benefits paid in excess of the amount that should have been paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Employer get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

## Reimbursement of Benefits Paid

If benefits are paid under this Plan for expenses incurred on account of a Covered Person, the Employee or any other person or organization that was paid must make a refund to the Plan if that person or organization recovers funds from a source other than this Plan as a result of claims against any other party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

## Subrogation

In the event a Covered Person suffers an injury or Sickness as a result of an allegedly negligent or wrongful act or omission of a third party, the Plan has the right to pursue subrogation against any person or insurer.

The Plan will be subrogated and succeed to the Covered Person's right of recovery against any person or insurer. The Plan may use this right to the extent of the benefits under this Plan.

The Covered Person agrees to help the Plan use this right when requested.

# Effect of Medicare and Government Plans

## Medicare

When a Covered Person becomes eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

### When This Plan Pays Primary to Medicare

This Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

### When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan for Covered Persons who are Medicare eligible if:

- The employee is a Retired Employee.
- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See **How this Plan Pays When Medicare is Primary**.

### Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person must enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan.

## How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare eligibles. It does not apply to any Covered Person unless that Covered Person becomes eligible under Medicare and Medicare is the Primary payer.

The amount of charges for Covered Expenses under this Plan is determined first. However, the amount of Covered Expenses is based on the amount of charges allowed under Medicare rules instead of the Reasonable Charges as defined by the Plan. Then the amount payable under Medicare for the same expenses is subtracted from the amount of Covered Expenses. This Plan pays 80% of the difference between the two amounts after the deductible.

This plan is designed to provide payment toward the outstanding balance left on medical expenses after Medicare Part B has paid their share. The plan determines the amount of covered expenses remaining after Medicare has made payment. It applies the $50 plan's deductible to this amount. Any covered expenses above the deductible amount are reimbursed at 80%.

When this plan determines the amount of the covered expense, it takes into consideration the Medicare Approved Amount for the service in question. If a doctor accepts the Medicare Assignment of Benefits, they have agreed to reduce their charge to the Medicare Approved Amount. If the doctor has not agreed to accept the Medicare Assignment of Benefits, they cannot charge more than the Medicare Limiting Amount. The Medicare Limiting Amount is currently set at 115% of the Medicare Approved Amount. Certain individual states have limited the amount a doctor can charge to 110% or 105% of the Medicare Approved Amount.

Here is an example illustrating the calculation of benefits available under this plan. The example assumes that both the Medicare Part B Annual Deductible of $100 and the plan annual deductible of $50 have been met before this claim occurred.

| | **DOCTOR ACCEPTS MEDICARE ASSIGNMENT** | **DOCTOR DOES NOT ACCEPTS MEDICARE ASSIGNMENT** |
|---|---|---|
| **DOCTOR'S CHARGE** | $100 | $100 |
| **MEDICARE APPROVED AMOUNT** | $80 | $80 |
| **DOCTOR'S REVISED CHARGE** | $80 | $92 (limit = 115% of approved amt) |
| **MEDICARE PAYMENT (80% of approved amount)** | $64 | $64 |
| **BALANCE LEFT OVER AFTER MEDICARE PAYMENT** | $16 | $28 |
| **THIS PLAN PAYS 80% OF OUTSTANDING BALANCE** | $12.80 | $22.40 |
| ***PATIENT RESPONSIBILITY*** | ***$3.20*** | ***$6.00*** |

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

### Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

## Termination of Coverage

### Employee Coverage

Employee coverage ends on the earlier of the following:

- The day this Plan ends.
- The end of the month in which the person stops being an eligible Employee.

If you become a Retired Employee while covered under this Plan, please see the provision titled Retired Employee.

#### Disability

Coverage under this Plan is continued during a period of short or long term disability. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

### Leave of Absence or Temporary Layoff

For information regarding leave of absence or temporary layoff, see your Human Resources Manual.

## Dependent Coverage

Coverage for all of an Employee's Dependents ends on the day the Employee's coverage ends.

Coverage for an individual Dependent ends on the earliest of:

- The day the Dependent becomes covered as an Employee under this Plan.
- The day the Dependent stops being an eligible Dependent.
- The last day of the month in which the Dependent Child is no longer a full-time student.

### Continuation of Coverage for Incapacitated Children

*A mentally or physically incapacitated child's coverage will not end due to age.* It will continue as long as Dependents coverage under this Plan continues and as long as the child continues to meet the following conditions:

- *The child is incapacitated.*
- The child is not capable of self-support.
- The child depends mainly on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

# Extended Benefits

There are extended benefits under **Medical Benefits**, **Mental Disorder Treatment and Alcohol or Substance Treatment** and **Pregnancy Benefits**.

Extended benefits are payable for a Totally Disabled Covered Person for up to 12 months. Extended benefits are only payable for Covered Services and Supplies given during the 12-month period after the person's coverage ends.

The person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Covered Services or Supplies are given.

Extended benefits are only payable for Covered Services and Supplies given for the accidental injury, Sickness, or pregnancy causing Total Disability.

# Continuation of Health Coverage (COBRA)

**Under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, current or former employees and their eligible dependents who are covered under a group health plan have the right to elect to temporarily continue health coverage at their own expense if the coverage terminates due to a "Qualifying Event" as defined below. Those eligible to continue coverage become "Qualified Beneficiaries" under the law. CobraServ has been retained as the third party administrator to notify you of your group health care benefits continuation rights when and if the occasion arises. CobraServ can be reached at (800) 877-7994.**

If coverage under these Plans would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the Qualified Beneficiary's health coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.
- If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or work hours being reduced, that Qualified Beneficiary may elect an additional 11 months of coverage under these Plans, subject to the following conditions:
    - The Qualified Beneficiary must provide the Employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
    - The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
    - If the Qualified Beneficiary entitled to the additional 11 months of coverage has nondisabled family members who are entitled to continuation coverage, those nondisabled family members are also entitled to the additional 11 months of continuation coverage.
- 36 months from the date the health coverage would have stopped due to the Qualifying Event other than those described above.
- The date these Plans stops being in force.
- The date the Qualified Beneficiary fails to make the required payment for the coverage.
- The date the Qualified Beneficiary becomes entitled to benefits under Medicare.

- The date the Qualified Beneficiary, after electing this continuation, becomes covered under any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a Qualified Beneficiary's preexisting condition.)

*If the Qualified Beneficiary is already covered under any other group health plan* and elects continuation of health coverage under these Plans, the Qualified Beneficiary can continue coverage under that other group health plan. If the Qualified Beneficiary does not stop coverage under that other plan, coverage under this continuation will stop.

If after the first Qualifying Event another Qualifying Event occurs, coverage can be continued for Dependents for an additional period, for a total of 36 months from the date of the first Qualifying Event.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

## Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the latter of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the date the person receives notice of the right to continue coverage is sent.

Unless otherwise specified, an Employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

## Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

## Notification Requirements

A Qualified Beneficiary must notify the Employer within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage is legally dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible Dependent.

CobraServ will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

## Conversion

At the end of this continuation period, a Qualified Beneficiary may be eligible for a conversion privilege if one is generally available under the plans.

## Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

## Special Terms that Apply to this Continuation Provision

### Qualifying Event

A Qualifying Event is any of the following which results in loss of coverage for a Qualified Beneficiary:

- The Employee's employment ends (except in the case of gross misconduct).
- The Employee's work hours are reduced.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is legally dissolved.
- The Employee becomes legally separated from his/her spouse.
- The Employee's Dependent child stops being an eligible Dependent.

A bankruptcy is a Qualifying Event for certain Retired Employees and their Dependents under certain conditions. If there is a bankruptcy, Retired Employees should contact the Employer or CobraServ for more information.

### Qualified Beneficiary

Any of the following persons who are covered under these Plans on the day before a Qualifying Event:

- The Employee.
- An Employee's spouse.
- An Employee's former spouse (or legally separated spouse).
- A Dependent child, including a child born to or placed for adoption with the Employee during a period of continued coverage.

# Continuation of Health Coverage During Family and Medical Leave (FMLA)

**The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period for certain family and medical reasons. This provision of the Plan is intended to comply with the law and any pertinent regulations. See the Employer (Human Resources Manual) to find out how this continuation may apply to you.**

**Reasons for Taking Leave**

FMLA leave is granted for any of the following reasons:

- Care of a child after birth.
- Care of a child after placement of that child with the Employee for adoption or foster care.
- Care of the Employee's spouse, child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the Employee unable to work.

See the Employer to find out if you are eligible for a leave.

**Continuation of Health Coverage**

For the duration of a FMLA leave, the Employee may continue benefits for himself or herself and his or her Dependents on the same terms as if the Employee had continued to work. The Employee must pay the same contributions toward the cost of the coverage that he or she made while working.

**Reenrollment after a FMLA Leave**

If any or all of an Employee's coverages end while the Employee is on a FMLA leave, the Employee can reenroll for coverage when he or she returns to work from the FMLA leave.

The Employee and any Dependents will be considered timely enrollees if the Employee reenrolls within thirty-one days from the date he or she returns to work. *Any waiting period will be applied as if there had been no break in coverage.*

# Conversion Coverage

If the covered Employee's group health coverage stops under these Plans, the covered Employee may buy individual health insurance (called "Conversion Coverage").

Proof of insurability will not have to be given. However, if the benefits under Conversion Coverage are greater than those under these Plans, the covered Employee and his or her covered Dependents will be asked to give proof of insurability for the greater benefits.

If the covered Employee has Dependents coverage when the group coverage stops, the Conversion Coverage will be for the covered Employee and all Covered Family Members on the day such coverage stops. The covered Employee must apply for Conversion Coverage on the same basis as the coverage he or she has under these Plans. The covered Employee cannot apply for single Conversion Coverage unless he or she is enrolled for Employee Only coverage under these Plans. A Dependent child over age 19 will be issued single Conversion Coverage because only Dependent children under 19 are covered as family members under Conversion Coverage.

An individual policy will be issued if the person converting is eligible and lives in one of the following states:

| | |
|---|---|
| *Georgia* | *Oregon* |
| Maine | Puerto Rico |
| Minnesota | South Dakota |
| New Hampshire | Vermont |
| New Mexico | Virginia |
| New York | |

If the person converting lives in a state or jurisdiction of the United States not listed above and is eligible, Conversion Coverage will be provided through The Group Conversion Trust. The person will receive a Certificate of Insurance instead of an individual policy.

See **Conversion Coverage for Medicare Eligibles** at the end of this provision if the covered Employee or a covered Dependent is Medicare Eligible.

## Conditions for Conversion

### For Covered Employees

- These Plans must be in force, and
- the person is no longer an eligible Employee.

If a covered Employee's group health coverage stops because these Plans end and are replaced by other plans provided by the Employer, the covered Employee will not have the right to buy Conversion Coverage.

The person's Employer may continue coverage under these Plans when the person becomes a Retired Employee. In this case, the person cannot buy Conversion Coverage until the continued coverage stops.

### For Covered Dependents

If the covered Employee dies, the covered Employee's wife or husband or any guardian of the covered Employee's Dependent children may buy Conversion Coverage for the covered Dependents.

If the covered Employee's marriage is dissolved, the covered Employee's former spouse may buy Conversion Coverage. This can happen at either of the following times:

- When the marriage is legally dissolved.
- At the end of any period of continuation of coverage under these Plans, but only if these Plans are in force on that date.

Any of a covered Employee's covered Dependents may buy Conversion Coverage if one of the following is true:

- The Dependent stops being eligible.
- The Dependent is 19 or older when the covered Employee buys Conversion Coverage. (Only Dependent children under 19 are covered under a covered Employee's new family coverage.)

## How to Apply

Application must be made within 31 days after the group coverage stops.

Get an application from the Company.

The first premium must be paid before Conversion Coverage can be put in force.

Conversion Coverage will be effective on the date that the group coverage stops. In some cases a covered Employee can choose to continue group coverage after employment ends. In some cases a covered Employee's Dependents can choose to continue their group coverage after the covered Employee's death. In these cases Conversion Coverage will go into effect when the continued coverage stops but only if these Plans are in force on that date.

If the covered Employee dies within the 31-day conversion period, the covered Employee's wife or husband or any guardian of the covered Employee's Dependents may apply for Conversion Coverage for those covered Dependents.

## Limitations

Conversion Coverage may have greatly reduced benefits at a much higher cost. In most cases, the benefits will be limited to Hospital and surgical benefits only.

The benefit amounts for Conversion Coverage will be governed by the following:

- The rules of the Company.
- The laws of the state or jurisdiction where the person lives when he or she applies.

A copy of the individual policy or Certificate of Insurance is on file with the state insurance authority, where required. A copy may also be obtained from the Company.

The Company might limit the benefits of, or refuse to issue, Conversion Coverage because the covered Employee or a Dependent has other health coverage. Each person will be told the rules when they apply.

## Conversion Coverage for Medicare Eligibles

A Medicare Eligible who lives in one of the following states is not eligible for Conversion Coverage:

| | |
|---|---|
| Georgia | Oregon |
| Maine | Puerto Rico |
| Minnesota | South Dakota |
| New Hampshire | Vermont |
| New Mexico | Virginia |
| New York | |

Conversion Coverage of a Medicare Eligible who lives in any other state or jurisdiction of the United States (except Michigan) will be provided through The Group Conversion Trust. Michigan residents will be covered under an individual policy.

# Retired Employee Coverage

Retired Employees are eligible for the benefits as described below after they stop being an Active Employee.

As a Retired Employee, Plan Benefits are continued. The continued coverage will be the same coverage in effect as for Active Employees at the time of retirement, except continued benefits for Medicare Eligibles are modified as shown in **Medicare and Other Government Plans**.

### Retired Employees or Their Dependents Who Are Not Yet Medicare Eligible

Plan benefits for Retired Employees or their Dependents who are not Medicare eligible are payable in the same manner as Plan benefits for Active Employees and their Dependents, except as shown above.

### Retired Employees or Their Dependents Who Are Medicare Eligible

Unless a change is stated below, all coverage remains the same as the coverage for Active Employees and their Dependents. When Retired Employees or their Dependents become Medicare eligible, Plan benefits are changed. These Plan changes apply to all Covered Expenses incurred on or after the date the person becomes both Medicare eligible and is either a Retired Employee or a Dependent of a Retired Employee.

Plan benefits are changed as follows:

- Preventive Health Benefits will stop.
- The Network Provider provision no longer applies. Plan benefits are no longer paid at the Network or Non-Network level.
- Plan benefits are payable at 80%, except that your Medicare Part A deductible and other Part A expenses will be paid at 100%.
- An Individual Deductible of $50 applies to each Covered Person each Calendar Year. All other deductibles and copayments under the Plans no longer apply.

- A Family Deductible of $100 applies each Calendar Year. The Family Deductible applies no matter how large a family may be. Only Covered Expenses which count toward a Covered Person's Individual Deductible count toward this Deductible. All other deductibles and copayments under the Plans no longer apply.
- Any Covered Expenses incurred in the Calendar Year in which the Covered Person becomes Medicare eligible may be used to satisfy the $50 Individual Deductible for that Calendar Year. This applies even if the expenses are incurred prior to becoming Medicare eligible.
- Any Covered Expenses a Covered Person incurs during October, November and December of a year which count toward that person's Individual Deductible for that year will also count toward that person's Individual Deductible for the next year.

**Plan Changes for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment**

The same $50 Individual Deductible that applies to all other Plan benefits also applies to Mental Disorder Treatment and Alcohol or Substance Abuse Treatment.

**Maximum Benefits**

If you are age 65 or over and you retire on or after September 1, 1998, the Maximum Benefit for all other Plan benefits for each Covered Person is unlimited.

The Maximum Benefit includes any amount paid under the Employer's group plan for Medicare eligible Retired Employees or their Dependents in effect on the day before the effective date of these Plans.

## Medicare Benefits Are Primary to These Plan Benefits

Medicare benefits are primary to this Plan's benefits for Medicare eligible Retired Employees or their Dependents.

Medicare benefits are payable first. Then this Plan pays benefits (with the changes stated above) for Covered Expenses which are more than the amount payable for the same expenses under Medicare.

If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating Physician), this Plan determines the amount of Covered Expenses based on the amount of charges allowed by Medicare.

If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating Physician), this Plan determines the amount of Covered Expenses based on the lesser of the following:

- The Reasonable Charge (See Glossary).
- The amount of the Limiting Charge as defined by Medicare.

This plan is designed to provide payment toward the outstanding balance left on medical expenses after Medicare Part B has paid their share. The plan determines the amount of covered expenses remaining after Medicare has made payment. It applies the $50 plan's deductible to this amount. Any covered expenses above the deductible amount are reimbursed at 80%.

When this plan determines the amount of the covered expense, it takes into consideration the Medicare Approved Amount for the service in question. If a doctor accepts the Medicare Assignment of Benefits, they have agreed to reduce their charge to the Medicare Approved Amount. If the doctor has not agreed to accept the Medicare Assignment of Benefits, they cannot charge more than the Medicare Limiting Amount. The Medicare Limiting Amount is currently set at 115% of the Medicare Approved Amount. Certain individual states have limited the amount a doctor can charge to 110% or 105% of the Medicare Approved Amount.

Here is an example illustrating the calculation of benefits available under this plan. The example assumes that both the Medicare Part B Annual Deductible of $100 and the plan annual deductible of $50 have been met before this claim occurred.

| | **DOCTOR ACCEPTS MEDICARE ASSIGNMENT** | **DOCTOR DOES NOT ACCEPTS MEDICARE ASSIGNMENT** |
|---|---|---|
| **DOCTOR'S CHARGE** | $100 | $100 |
| **MEDICARE APPROVED AMOUNT** | $80 | $80 |
| **DOCTOR'S REVISED CHARGE** | $80 | $92 (limit = 115% of approved amt) |
| **MEDICARE PAYMENT (80% of approved amount)** | $64 | $64 |
| **BALANCE LEFT OVER AFTER MEDICARE PAYMENT** | $16 | $28 |
| **THIS PLAN PAYS 80% OF OUTSTANDING BALANCE** | $12.80 | $22.40 |
| ***PATIENT RESPONSIBILITY*** | ***$3.20*** | ***$6.00*** |

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

## Government Plans (other than Medicare and Medicaid)

*If the Covered Person is also covered under a Government Plan, this Plan does* not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

*This provision does not apply to any Government Plan which by law requires this* Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, *or in which any government participates other than as an employer.*

### Definitions

**Retired Employee**

Retired Employee means an Employee who meets all of the following:

- *The Employee is retired by the Employer, consistent with retirement* arrangements recognized by resolution of the Employer's Board or its Committee on Operations or is separated after the Employee would have met the age and length of service required to be retired under the Employer's pension plan which would have been applicable had the Employee been a member.
- The Employee was covered under this Plan or the Former Plan on the day before the date of retirement.
- Employees not eligible for Medicare are covered with pre age 65 coverage.

***Totally Disabled or Total Disability***

A Retired Employee's inability due to accidental injury or Sickness to perform the normal activities of a person in good health and of like age and sex. A Retired Employee or Retired Employee's Dependent who meets this definition and is *eligible for Medicare will have these Plans as Secondary.*

# Glossary

(These definitions apply when the following terms are used.)

### Ambulatory Surgical Center

A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
  - It provides at least one operating room and at least one post-anesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It has immediate access to a blood bank or blood supplies.
  - It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

An Ambulatory Surgical Center which is part of a Hospital, as defined herein, will be considered an Ambulatory Surgical Center for the purposes of these Plans.

## Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law.
  - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity.
  - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
  - It is operated under the full-time supervision of a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) or registered graduate nurse (R.N.).
  - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.

- It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.
- It is expected to discharge or transfer patients within 24 hours following delivery.

A Birth Center which is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of these Plans.

## Calendar Year

*A period of one year beginning with a January 1.*

## Comprehensive Outpatient Rehabilitation Facility

A facility which is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured or sick persons and which fully meets one of the following two tests:

- It is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility.
- It meets all of the following tests:
  - It provides at least the following comprehensive outpatient rehabilitation services:
    - *Services of Physicians who are available at the facility on a full or part-*time basis.
    - Physical therapy.
    - Social or psychological services.
  - It has policies established by a group of professional personnel (associated with the facility) including one or more Physicians to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full or part-time Physician.
  - *It has a requirement that every patient must be under the care of a Physician.*
  - It is established and operated in accordance with the applicable licensing and other laws.

## Covered Family Members or Covered Person

The Employee and the Employee's wife or husband or former spouse and/or Dependent children who are covered under these Plans.

## Each Cause

A person may be confined in a Hospital more than one time. More than one surgical procedure may be performed on one person. The Company will consider all Hospital confinements and all surgical procedures to occur because of the same cause unless the person recovers completely from the injury or Sickness which caused the first Hospital confinement or surgical procedure before the next confinement or procedure, or in the case of pregnancy, the later Hospital confinement or surgical procedure is caused by a different pregnancy, or

- as to Dependents only, the disability which causes the later Hospital confinement or surgical procedure is completely different from the disability which caused the first Hospital confinement or surgical procedure, or

- the Employee returns to work for one full day before having another Hospital confinement or surgical procedure.

## Employee

A person on the payroll of the Employer and regularly employed by the Employer on a full-time basis of not less than 50% of normal hours in a pay period or as contractually negotiated.

## Experimental, Investigational or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case are determined to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Company, in its judgment, may deem an Experimental, Investigational or Unproven Service covered under these Plans for treating a life threatening sickness or condition if it is determined by the Company that the Experimental, Investigational or Unproven Service at the time of the determination:

- is proved to be safe with promising efficacy; and
- is provided in a clinically controlled research setting, and
- uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

## Home Health Care Agency

An agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare.
- It is established and operated in accordance with the applicable licensing and other laws.

- It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
  - It has a full-time administrator.
  - It maintains written records of services provided to the patient.
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.
  - *Its employees are bonded and it maintains malpractice insurance.*

## Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice.
- It is licensed in accordance with any applicable state laws.
- It meets the following criteria:
  - It provides 24 hour-a-day, 7 day-a-week service.
  - *It is under the direct supervision of a duly qualified Physician.*
  - It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve *caring for terminally ill patients.*
  - The main purpose of the agency is to provide Hospice services.
  - It has a full-time administrator.
  - It maintains written records of services given to the patient.
  - It maintains malpractice insurance coverage.

A Hospice which is part of a Hospital will be considered a Hospice for the purposes of these Plans.

## Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a Hospital.
- *It meets all of the following tests:*
  - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons *by or under the supervision of a staff of duly qualified Physicians.*
  - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
  - It is operated continuously with organized facilities for operative surgery on the premises.

## Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

## Medically Necessary or Medical Necessity

Health care services and supplies which are determined by the Company to be medically appropriate, and

(1) necessary to meet the basic health needs of the Covered Person; and

(2) rendered in the most appropriate manner and type of setting appropriate for the delivery of the service or supply; and

(3) *consistent in type, frequency and duration of treatment with scientifically based* guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and

(4) consistent with the diagnosis of the condition; and

(5) required for reasons other than the convenience of the Covered Person or his or her Physician; and

(6) demonstrated through prevailing peer-reviewed medical literature to be either:

(a) safe and effective for treating or diagnosing the condition or Sickness for *which their use is proposed, or,*

(b) safe with promising efficacy

(i) for treating a life threatening Sickness or condition, and

(ii) in a clinically controlled research setting; and

(iii) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, Sickness, mental illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary used in this booklet relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

## Medicare

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

## Mental Disorder Treatment

*Mental Disorder Treatment is treatment for both of the following:*

- Any Sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/ or physiological dependence or addiction to alcohol or psychiatric drugs or medications, regardless of any underlying physical or organic cause, and
- Any Sickness where the treatment is primarily the use of psychotherapy or other psychotherapist methods.

All inpatient services, including Room and Board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a Sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the Sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

Prescription Drugs unless prescribed while in-patient are not considered Mental Disorder Treatment.

## No-Fault Automobile Insurance Law

The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

## Network Provider

A provider which participates in the network.

## Non-Network Hospital

A hospital (as defined) which does not participate in the network.

## Non-Network Provider

A provider which does not participate in the network.

## Nurse-Midwife

A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Midwives.

## Nurse-Practitioner

A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Practitioners.

## Other Services and Supplies

Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

## Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropody (D.P.M.; D.S.C.).
- Doctor of Chiropractic (D.C.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).
- Doctor of Osteopathy (D.O.).
- Doctor of Podiatry (D.P.M.).

## Plan/Plans

The Employee medical benefits for The Port Authority and PATH are referred to as this Plan or these Plans.

## Pre-Admission Tests

Tests performed on a Covered Person in a Hospital before confinement as a resident inpatient provided they meet all of the following requirements:

- The tests are related to the performance of scheduled surgery.
- The tests have been ordered by a Physician after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital.

## Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

## Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

## Reasonable Charge / Reasonable and Customary

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is *located and other geographic areas having similar medical cost experience.*

## Room and Board

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

## Sickness

The term "Sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

## Skilled Nursing Facility

*If the facility is approved by Medicare as a Skilled Nursing Facility then it is covered* by these Plans.

*If* not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Sickness.
- It maintains a daily medical record of each patient who is under the care of a licensed Physician.
- It is authorized to administer medication to patients on the order of a licensed Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A Skilled Nursing Facility which is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of these Plans.

## Total Disability or Totally Disabled

- An Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation.
- A Dependent's inability to perform the normal activities of a person of like age and sex.

## Treatment Center

A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and Board (if these Plans provides inpatient benefits at a Treatment Center).
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

## End of Summary Plan Description

## Notice to Employees

This booklet describes Employer-sponsored health benefits under the The Port Authority of New York & New Jersey Medical Plan or Port Authority Trans-Hudson Corporation (PATH) Medical Plan (collectively called "these Plans").

All benefits becoming due under these Plans are funded by The Port Authority of New York & New Jersey and Port Authority Trans-Hudson Corporation (collectively called "the Employer").

The Port Authority and PATH have entered into an arrangement with United HealthCare Service Corp. (called "the Company") which provides for the Company to process benefit claims and provide certain other services under these Plans.

This booklet is intended to describe the medical plans being provided to certain employees of The Port Authority of New York and New Jersey and Port Authority Trans-Hudson Corporation by arrangement with United HealthCare Service Corp., as of March, 2001. The medical plans described in this booklet, which first became effective for certain employees as of September 1, 1998, are subject to change from time to time, e.g. through collective bargaining negotiations when required, or as otherwise legally permitted, so employees, retirees and qualified dependents should confirm the benefits described with United HealthCare at (877) 259-1391. This booklet does not in any way constitute a contract between the Port Authority of New York and New Jersey or Port Authority Trans-Hudson Corporation and its or their employees.

The Company has arranged with certain health care providers to participate in a network. These health care providers, called "Network Providers", have agreed to discount their charges for Covered Services and Supplies.

If Network Providers are used, the amount of Covered Expenses for which a Covered Person is responsible will generally be less than the amount owed if Non-Network Providers had been used. However, because the total charges for Covered Expenses may be less when Network Providers are used, the portion that the Covered Person owes will be less. Covered Persons are issued an identification card (ID Card) showing that they are eligible for the network discounts. A Covered Person should show this ID Card every time health care services are given. This is how the provider knows that the patient is covered under a network plan. Otherwise, the person could be billed for the provider's normal charge.

A directory of Network Providers will be made available. A Covered Person can also call Member Services to determine which providers participate in the Network. The telephone number for Member Services is on the ID Card.

United HealthCare Service Corp. does not insure the benefits described in this booklet.

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THE PORT AUTHORITY OF NY & NJ

# he Port Authority of New York & New Jersey and Port Authority Trans-Hudson Corporation

## Medical Plans

PORT AUTHORITY
TRANS-HUDSON CORPORATION

UNITEDhealthcare®

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# Schedule of Benefits

## Effective Date of these Plans

**January 1 20 04**

## Medical Benefits

| Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up To The Dollar Amount And/Or Number Of Days Shown Below. | | |
|---|---|---|
| | **Network** | **Non-Network** |
| Hospital Services<br>In-Patient<br>Hospital's regular semi-private rate (See ***NOTE**)<br><br>Room and Board<br><br>Maximum Payment Period<br>Other Fees (incurred on days that payment is made for Room and Board)<br><br>Other Fees include:<br>- *Hospital charges for anesthetics*<br>- Hospital charges for giving anesthetics<br>- Charges for transportation to and from the Hospital by professional ambulance<br>- Hospital charges for Other Services and Supplies<br>- Hospital Pre-Admission Tests | Unlimited | 120 days for Each Cause Full Amount |
| Out-Patient Benefits | Unlimited | Unlimited |
| Emergency Room Care | Full Amount | |
| Ambulatory Surgical Center Services | Full Amount | |
| Physician's Services for Surgery<br>Surgeon's Fees<br>Anesthesiologist's Fees<br>Assistant Surgeon's Fees (See page 19) | 100% | 100% Reasonable Charge |
| Laboratory Tests and X-Rays, including one mammogram and one Pap smear per Calendar Year. | 100% | 100% Reasonable Charge |
| Routine Well Baby Care | 100% | 100% Reasonable Charge |
| Hospice Care up to 210 days lifetime | 100% | 100% Reasonable Charge |
| Surgery for Temporomandibular Joint Dysfunction | None | 100% Reasonable Charge |

***NOTE:**

There is maximum number of 120 days for each Non-Network Hospital confinement.

A new maximum of 120 days of Hospital confinements applies:

- 90 days after your last confinement for the same cause or
- If the cause of the later confinement or surgical procedure is a new disability and is completely different from the disability which caused the first confinement or surgical procedure.

| Covered Expenses Subject To The Deductible/Copayment | | |
|---|---|---|
| **Maximum Benefits** | | |
| | **Network** | **Non-Network** |
| Lifetime Maximum Benefit | Unlimited | |
| Hearing Loss Benefit per Calendar Year | N/A | $200 |
| **Deductibles/Copayments/Out-of-Pocket** | | |
| *Individual Deductible per Calendar Year* | N/A | $200 |
| Family Deductible per Calendar Year | N/A | $400 |
| Physician Office Visits Copayment | $5 | N/A |
| Individual Out-of-Pocket Maximum per Calendar Year | N/A | $1[illegible] |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | | |
| Hearing Loss Benefit | None | 80% |
| Temporomandibular Joint Dysfunction services | None | 80% |
| Emergency Room Care for Non-Emergency treatment | 80% | |
| **All Other Covered Expenses for Medical Benefits** | 100% | 80% |
| **Percentage of Covered Expenses Payable after the Out-of-Pocket Maximum is reached** | 100% | 100% |

Benefits for Organ/Tissue Transplants performed at a Designated Transplant Facility are payable at 100% of Covered Expenses.

Benefits for Organ/Tissue Transplants performed at a Non-Designated Transplant Facility are payable at Plan benefits, subject to the deductible.

## Mental Disorder Treatment and Alcohol or Substance Abuse Treatment

| Mental Disorder Treatment | | |
|---|---|---|
| **Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up o he Maximums Shown Below** | | |
| | **Network** | **Non-Network** |
| ***Lifetime Maximum Benefits*** | *Unlimited* | |
| **Calendar Year Maximum Benefits** | | |
| Inpatient | 30 days | |
| Outpatient | None | |
| **Covered Expenses subject to he Deductible/Copayment. Covered Expenses are subject to the same Cash Deductible as Medical Benefits** | | |
| Inpatient | Unlimited | |
| Outpatient | Unlimited | |
| Copayment for Outpatient Treatment | $10 | None |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | 100% | 80% |

| Alcohol or Substance Abuse Treatment | | |
|---|---|---|
| **Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up o he Maximums Shown Below** | | |
| **Lifetime Maximum Benefits** | Two (2) Confinements | |
| **Calendar Year Maximum Benefits** | | |
| Inpatient | | |
| Alcohol or Substance Abuse Treatment | | |
| • Detoxification Treatment | 7 days | |
| • All other Covered Expense | 30 days | |
| Outpatient | None | |
| **Covered Expenses Subject o he Deductible/copayment. Covered Expenses Are Subject o he Same Cash Deductible As Medical Benefits.** | | |
| **Outpatient** | | |
| Alcohol or Substance Abuse Treatment - Lifetime | 120 visits | |
| Alcohol or Substance Abuse Treatment - Calendar Year | 60 visits | |
| **Copayment for outpatient services** | $5 | None |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | 100% | 80% |

**Percentage Of Covered Expenses Payable After The Out-of-Pocket Maximum Is Reached For All Mental Disorder Treatment and Alcohol or Substance Abuse Treatment - 100%**

## Pregnancy Benefits

Pregnancy Benefits are payable in the same manner as Medical Benefits.

## Preventive Health Care Benefits

Preventive Health Care Benefits are payable in the same manner as Medical Benefits. See page 23.

| Percentage of Reasonable Charge Payable After Deductibles/Copayments are Satisfied | | |
|---|---|---|
| | **Network** | **Non-Network** |
| Routine physical exam for covered Employees and Dependent spouses, including diagnostic tests and immunizations | 100% | None |
| Routine pediatric care to age 19, including PKU tests and immunizations | 100% | 100% |

## Family Planning Benefits

Family Planning Benefits are payable in the same manner as Medical Benefits

## End of Schedule of Benefits

# Coverage under the Former Plans

This section applies only to persons covered under the prior Plans of the Employer (called the Former Plans) in effect on the day before the Effective Date of coverage under these Plans. The coverage described in this booklet replaces the coverage under the Former Plans.

Coverage and benefits paid under the Former Plans will be considered as coverage and benefits paid under these Plans for figuring the following under any benefits of these Plans:

- Benefit limits and maximum amounts. Any Covered Expenses applied toward the benefit limits or maximum amounts under the Former Plans are applied to those same benefit limits or maximum amounts under these Plans.
- Coinsurance percentage.

A person may have satisfied or partially satisfied a deductible requirement under the Former Plans. Expenses counted toward the deductible under the Former Plans will be counted toward any annual deductible under these Plans. They will be counted under these Plans the same way they were counted under the Former Plans.

Certain children are included as Eligible Dependents under these Plans regardless of age. The child must have been covered under the Former Plans. The child must meet the following conditions:

- The child is mentally or physically incapacitated.
- The child is not capable of self-support.
- The child depends on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested.

# Eligibility

## Eligible Employees

All full-time and some part-time Employees of the Employer. Employees represented for collective negotiations or bargaining may be eligible under the terms of their agreements.

## Eligible Dependents

A Dependent is a Qualified Dependent of an eligible Employee.

1. Qualified Dependent means, among other things, the spouse of an Employee, excluding, in any case:
   - a spouse who is also covered as an Employee under any group medical benefits provided by the Employer,
   - a legally separated or divorced spouse (or one whose marriage has been annulled), unless:
     - the Employee is legally responsible for the support of such legally separated or divorced spouse, and
     - the legally separated or divorced spouse has not remarried, and
     - the Employee has not remarried or, if remarried, has not notified the Employer in writing that such legally separated or divorced spouse should continue to be covered as a Qualified Dependent.

   If the Employee is remarried, a divorced spouse and a current spouse may in no event both be simultaneously covered as a Qualified Dependent.

   The option to cover a legally separated or divorced spouse rather than a current spouse after the Employee remarries may be exercised only once by the Employee.

2. An Eligible Employee's unmarried child from birth through the last day of the Calendar Year in which the child turns age 19.

   An eligible Employee's unmarried child under age 26 through the last day of the Calendar Year in which the child reaches age 26, if the child is a registered student in regular full-time attendance at school. The child must be residing with and mainly dependent on the Employee for care and support. The child cannot be employed on a regular full-time basis by one or more employers for a total of 30 or more hours per week.

   Child includes the following:
   - A stepchild who resides in the eligible Employee's home. The Employee must verify financial support.
   - A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)

## Cost of Coverage

The coverage under these Plans is non-contributory. This means that the Employer pays for the full cost of the coverage for active and retired employees.

## Enrollment Requirements

**Employee Coverage**

An Employee enrolls for Employee coverage by:

- completing an enrollment form, and
- giving the form to the Employer.

An Employee's enrollment is either timely or late.

An Employee is considered a timely enrollee if he or she enrolls during either the Initial Eligibility Period or a Special Enrollment Period.

An Employee is considered a late enrollee when he or she enrolls during the Annual Enrollment Period. See Enrollment Periods below.

**Dependent Coverage**

An Employee must enroll for coverage as an Employee in order to enroll his or her Dependents. If a husband and wife are both eligible Employees, only one may enroll their Dependents for coverage.

No person can be covered both as an Employee and as a Dependent under any group medical and dental health Plan of the Employer.

Initial Dependents are those family members who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage.

Subsequent Dependents are family members who become Eligible Dependents after the date the Employee first becomes eligible under one of these Plans. Subsequent Dependents may be added during a Special Enrollment Period.

A Dependent's enrollment is either timely or late.

A Dependent is considered a timely enrollee when he or she is enrolled for coverage during either the Initial Eligibility Period or a Special Enrollment Period.

A Dependent is considered a late enrollee when he or she enrolls during the Annual Enrollment Period.

## Enrollment Periods

The Initial Eligibility Period is the 31-day period which begins on the date the Employee or Dependent is first eligible under these Plans.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Annual Enrollment Period to enroll for coverage.

The Annual Enrollment Period is designated by the Employer each year. It is held before the start of each Plan Year. During this period, all eligible Employees and Dependents can enroll for coverage.

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents.

A Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under one of these Plans was previously offered to the Employee or Dependent.
- The Employee's or Dependent's prior coverage was one of the following:
  - COBRA continuation which was exhausted.
  - Non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated or the contract was cancelled.
- The Employee requests enrollment under one of these Plans not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of Employer contribution.

A Special Enrollment Period is available to Subsequent Dependents. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment *requirements.*

**Late Enrollees**

A late enrollee can enroll only during an Annual Enrollment Period.

## Effective Date of Employee Coverage

Employee coverage is effective on the date coincident with or next following the latest of:

- The Effective Date shown in **Schedule of Benefits.**
- The date the Employee enrolls for coverage.
- The date following the day the Employee completes a Waiting Period of 30 days of continuous service with the Employer.

## Effective Date of Dependent Coverage

Coverage for Initial Dependents is effective on the date coincident with or next following the later of:

- The date the Employee becomes covered.
- The date the Employee enrolls the Dependents.

Coverage for a Subsequent Dependent is effective as follows:

- For a spouses, the later of the date the spouse is enrolled and the date of the marriage;
- For a newborn, the date of birth; or
- For an adopted child, the date of adoption or placement for adoption.

### Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for his/her children, these children can be enrolled as timely enrollees as required by OBRA 93.

### Special Provision for Newborn Children

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

The Employee must enroll the child during the 31-day Special Enrollment Period in order for the child to be a timely enrollee and covered beyond the 31 day period.

## Medical Benefits

Medical Benefits are payable for Covered Expenses incurred by the Covered Person while covered under these Plans.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Covered Services and Supplies listed in this Benefit. The Company, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with both of the following:

- The methodologies in the most recent edition of the Current Procedural Terminology.
- The methodologies as reported by generally recognized professionals or publications.

The Covered Expenses must be incurred for the care of an accidental injury or sickness. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

Each Covered Person must satisfy certain Copayments and/or Deductibles in connection with any payment made for certain Covered Services and Supplies. Then these Plans pay the percentage of Covered Expenses shown in the **Schedule of Benefits**.

*After coverage under these Plans end, Medical Benefits may be payable as shown* in **Extended Benefits**. See page 36.

Covered Services and Supplies for pregnancy are shown in **Pregnancy Benefits**.

Covered Services and Supplies for Mental Disorder Treatment are shown in **Mental Disorder reatment and Alcohol or Substance Abuse reatment Benefits**.

Covered Services and Supplies for Family Planning Benefits are shown in **Family Planning Benefits.**

## Copayments and Deductibles

Before Medical Benefits are payable, each Covered Person must satisfy certain Copayments and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Copayments are not counted toward any Deductible. Covered Services and Supplies which require a *Copayment are not subject to a Deductible.*

A Deductible is the amount of Covered Expenses the Covered Person must pay before Medical Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentage shown in the **Schedule of Benefits.**

The amount of each Copayment/Deductible is shown in the **Schedule of Benefits**. A Covered Expense can only be used to satisfy one copayment or deductible.

### Individual Deductible

The Individual Deductible applies to all Covered Expenses provided by a Non-Network Provider except as shown in **Schedule of Benefits**. It applies each Calendar Year.

Any Covered Expenses a Covered Person incurs during October, November and December of a year which count toward that person's Individual Deductible for that year will also count toward that person's Individual Deductible for the next year.

### Family Deductible

The most a family will have to pay for Individual Deductibles in any Calendar Year is the amount of the Family Deductible. The Family Deductible applies no matter how large a family may be. Only Covered Expenses which count toward a Covered Person's Individual Deductible count toward this Deductible.

### Physician Office Visit Copayment

The Physician Office Visit Copayment applies to Network Physician's Services. It also applies to Network physical therapist's services if the physical therapist bills for his/her services separately from any other charges. It applies to all Covered *Services and Supplies given in connection with each office visit.*

## Out-of-Pocket Feature

Covered Expenses are payable at the percentage shown in the **Schedule of Benefits** until any Out-of-Pocket Maximum shown in the **Schedule of Benefits** has been reached during a Calendar Year. Then, Covered Expenses are payable at 100% for the rest of that year as shown below.

All Covered Expenses that the Covered Person pays, other than those shown below, count toward the Out-of-Pocket Maximums.

*Covered Expenses used to satisfy the following Copayment and/or Deductibles do not* count toward any of the Out-of-Pocket Maximums. These Deductibles and Copayments still apply even after the applicable Out-of-Pocket Maximum has been reached:

- Physician Office Visit Copayment.
- Individual Deductible.
- Family Deductible.

### Individual Out-of-Pocket Maximum

When the Individual Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, Covered Expenses, other than those shown in the Out-of-Pocket Feature, are payable at 100% for that same person for the rest of that year.

## Covered Services and Supplies

Covered Services and Supplies must be Medically Necessary and given for the diagnosis or treatment of an accidental injury or sickness.

A Covered Person and his or her Physician decide which services and supplies are given, but these Plans only pay for the following Covered Services and Supplies which are Medically Necessary as determined by the Company.

Covered Services and Supplies also include services and supplies that are part of an Alternate Care Proposal (ACP). An ACP is a voluntary course of treatment developed by the Company and accepted by the Employee and attending Physician as an *alternative to the services and supplies that would otherwise have been considered* Covered Services and Supplies.

Unless the ACP specifies otherwise, the provisions of these Plans related to benefit amounts, maximum amounts, copayments and deductibles will apply to these services.

### Acupuncture Treatment

*Covered Expenses for treatment provided by a Physician.*

### Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

### Anesthetics

### Chemotherapy

### Durable Medical Equipment

Durable Medical Equipment means equipment which meets all of the following:

- It is for repeated use and is not a consumable or disposable item.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of Durable Medical Equipment are:

- Appliances which replace a lost body organ or part or help an impaired one to work.
- Orthicon devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

The Company decides whether to cover the purchase or rental of the equipment.

## Enteral Formulas

Written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which is left untreated, cause chronic disability, mental retardation or death.

Benefits are payable for enteral formulas for home use for which a Physician has issued a written order. The order must state that the enteral formula is necessary as a disease-specific treatment regimen for diseases which include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive, disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which is left untreated will cause malnourishment, chronic physical disability, mental retardation or death.

Coverage for certain inherited diseases of amino acid and organic metabolism shall include modified solid food products that are low protein, or which contain modified protein which are medically necessary. Coverage for modified solid food products for any calendar year or any continuous period of twelve months for any covered person shall not exceed $2,500.

## Foot Care

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a Covered Service only if needed due to severe systemic disease.

## Hearing Loss

The following are Covered Services and Supplies:

- Necessary test to prove there is a hearing loss.
- Necessary test to show where the hearing loss is.
- Charges for a permanent hearing aid.

*Payment for all Covered Services and Supplies for Hearing Loss is subject to* Calendar Year Maximum of $200 for each Covered Person.

## Home Health Care

*The following Covered Services must be given by a Home Health Care Agency:*

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy.
- Occupational therapy.
- Speech Therapy.

Covered Services are limited to 200 combined Network and Non-Network visits each Calendar Year. Each period of home health aide care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit.

## Hospice Care

- Room and Board, up to 210 days.
- Other Services and Supplies.
- Part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Home Health Care Services as shown under Home Health Care. The limit on the number of visits shown under Home Health Care does not apply to Hospice patients.
- Counseling for the patient and Covered Family Members.
- Bereavement counseling for Covered Family Members. Services must be given within six months after the patient's death. Covered Services are limited to a total of 15 visits for each family.

Counseling must be given by a Licensed Counselor.

Services for the patient must be given in an inpatient Hospice facility or in the patient's home.

The Physician must certify that the patient is terminally ill with six months or less to live.

Any counseling services given in connection with a terminal illness will not be considered as Mental Disorder Treatment.

## Hospital Services

- Room and Board.

  Covered Expenses for a private room are limited to the regular daily charge made by the Hospital for a semi-private room.
- Other Services and Supplies.
- Emergency Room.

  Emergency room services are Covered Services payable at 100% only if it is determined that the services are Medically Necessary and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services.

  Emergency Room services for non-emergency care are payable at 80%.

## Infertility Treatment

Diagnosis and treatment of infertility, including surgery and inpatient drug therapy.

## Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment.

## Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Handling charges for blood or blood derivatives only if not donated or replaced.

## Medical Transportation Services

Transportation by professional ambulance, other than air ambulance, to and from a medical facility.

Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico or Canada.

## Nurse-Practitioner Services

Services of a licensed or certified Nurse-Practitioner acting within the scope of that license or certification.

## *Oral Surgery and Dental Services*

- Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.
- The following services and supplies are covered only if needed because of accidental injury to natural teeth:
  - Oral surgery.
  - Full or partial dentures.
  - Fixed bridge work.
  - Prompt repair to natural teeth.
  - Crowns.

## Organ/Tissue Transplants

Benefits for Organ/Tissue Transplants performed at a Non-Designated Transplant Facility are payable at Plan benefits, subject to the deductible.

Benefits for Organ/Tissue Transplants performed at a Designated Transplant Facility are payable at 100% of Covered Expenses. For benefits performed at a Designated Transplant Facility, Medical Management must be notified. Call the toll-free number shown on the ID card and follow the prompts for medical management.

Medical management must be notified at least ten working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation.
- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

Services and supplies for Medically Necessary organ or tissue transplants are payable under this Plan.

**Donor Charges for Organ/Tissue Transplants**

- In the case of an organ or tissue transplant, donor charges are considered Covered Expenses ONLY if the recipient is a Covered Person under this Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Service UNLESS the search is made in connection with a transplant procedure arranged by a Designated Transplant Facility.

If a Qualified Procedure, listed below, is Medically Necessary and performed at a Designated Transplant Facility, the **Medical Care and reatment** and **Transportation and Lodging** provisions described below apply.

**Qualified Procedures**

- Heart Transplants.
- Lung transplants.
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Bone Marrow/Stem Cell transplants.
- Other transplant procedures when the Company determines that it is Medically Necessary to perform the procedure at a Designated Transplant Facility.

**Medical Care and Treatment**

The Covered Expenses for services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and physician fees.
- Transplant procedures.
- Follow-up care for a period up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search.

**Transportation and Lodging**

Medical Management will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Transplant Facility.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.
- There is a combined overall lifetime maximum of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

## Orthoptic Training (Eye Muscle Exercise)

Training by a licensed optometrist or an orthoptic technician.

## Outpatient Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

## Outpatient Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

## Physician Services

### Medical Care and Treatment

- Hospital, office and home visits.
- Emergency room services.

### Surgery

Services for surgical procedures.

### Reconstructive Surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:

    - Birth defect.
    - Sickness.
    - Surgery to treat a Sickness or accidental injury.
    - Accidental injury.
- Reconstructive breast surgery following a Medically Necessary mastectomy.
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury.

**Assistant Surgeon Services**

Covered Expenses for assistant surgeon services are limited to 1/5 of the amount of Covered Expenses for the surgeon's Reasonable and Customary Charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not covered.

**Multiple Surgical Procedures**

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered Expenses for any subsequent procedure are limited to 25% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

## Prescribed Drugs and Medicines for inpatient services only.

## Private Duty Nursing Care

Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

## Psychologist Services

## Radiation Therapy

## Rehabilitation herapy

**Inpatient**

- Services of a Hospital or Rehabilitation Facility for room, board, care and treatment during a confinement.
- Inpatient rehabilitative therapy is a Covered Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

**Outpatient**

- Services of a Hospital or Comprehensive Outpatient Rehabilitative Facility (CORF).

- Covered Services for each day of therapy reduces the number of visits under Covered Services for Outpatient Physical Therapy, Outpatient Occupational Therapy or Speech Therapy. This reduction only applies to days of therapy *during which the therapy includes services given by a physical therapist*, occupational therapist or speech therapist.

### Skilled Nursing Facility Services

- Room and Board.

  *Covered Expenses for Room and Board are limited to the facility's regular daily* charge for a semi-private room.

- Other Services and Supplies.

Covered Services are limited to the first 60 combined Network and Non-Network days of confinement each Calendar Year.

### Speech Therapy

Services of a licensed speech therapist.

These services must be given to restore speech lost or impaired due to one of the following:

- Surgery, radiation therapy or other treatment which affects the vocal chords
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to accidental injury or organic brain lesion (aphasia).
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

### Spinal Manipulations

Services of a Physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

### Temporomandibular Joint Dysfunction

Examination of the jaw and supporting structure, initial installation, and subsequent adjustments to removable appliances and Medically Necessary surgery to correct a condition known as Temporomandibular Joint Dysfunction (TMJ).

**Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.**

## Mental Disorder Treatment and Alcohol or Substance Abuse Treatment Benefits

Benefits are payable for Covered Services and Supplies for Mental Disorder Treatment given to the Covered Person while covered under these Plans. These Covered Services and Supplies are listed in **Medical Benefits**.

Benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment are subject to the copayments, deductibles and percentage of Covered Expenses payable as shown in **Schedule of Benefits**.

Benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment include, but are not limited to:

- Assessment.
- Diagnosis.
- Treatment planning.
- Medication management.
- Individual, family and group psychotherapy.
- Psychological education.
- Psychological testing.

After coverage under these Plans stop, extended benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment are the same as for Sickness.

Additional Covered Services and Supplies specific to Mental Disorder Treatment are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits**.

## Additional Covered Services and Supplies

### Licensed Counselor Services

Services of a Licensed Counselor for Mental Disorder Treatment.

### Treatment Center Services

- Room and Board.
- Other Services and Supplies.

**Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.**

# Pregnancy Benefits

Benefits are payable for Covered Services and Supplies given to the Covered Person for pregnancy while covered under these Plans. These Covered Services and Supplies are listed in **Medical Benefits.**

**Benefits for pregnancy are paid in the same way as benefits are paid for Sickness.**

Benefits are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery.

- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

After coverage under these Plans stop, extended benefits for pregnancy are the same as for Sickness.

Additional Covered Services and Supplies specific to pregnancy are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits.**

## Additional Covered Services and Supplies

### Birth Center Services

- Room and Board.
- Other Services and Supplies.
- Anesthetics.

### Nurse-Midwife's Services

Services of a licensed or certified Nurse-Midwife.

### Routine Well Baby Care

The following services and supplies given during a newborn child's initial Hospital confinement:

- Hospital services for nursery care.
- Other Services and Supplies given by the Hospital.
- Services for a circumcision.
- Physician Services.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# Family Planning Benefits

Benefits are payable for Covered Expenses for Family Planning Benefits incurred by the Covered Person while covered under these Plans.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for the Covered Services and Supplies listed in this Benefit. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

These Family Planning Benefits are subject to the same copayments, deductibles and percentage of Covered Expenses payable as benefits that are paid due to Sickness under **Medical Benefits**.

After coverage under these Plans stop, there are no extended benefits.

**Covered Services and Supplies**

### Assisted Reproductive Technology

Covered Services and Supplies for Assisted Reproductive Technology (ART) are limited to a Covered Person who has undergone extensive screening and it has been determined that:

- The ART is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the following assisted reproductive technology procedures:
  - In vitro fertilization services.
  - artificial insemination
  - Gamete intrafallopian transfer (GIFT).
  - Zygote intrafallopian transfer (ZIFT).
  - *Microinjection techniques.*

The Covered Person must have been unable to become pregnant through more conservative means for a minimum of 12 months, unless one partner has already been diagnosed as infertile.

### Not Covered

- More than three attempts at ART.
- ART if infertility is the result of voluntary sterilization.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# Preventive Health Care Benefits

Benefits, as shown below, are payable for Covered Services and Supplies for Preventive Health Care Benefits given to a Covered Person by a Physician while the person is covered under these Plans.

The Office Visit Copayment shown in the **Schedule of Benefits** applies to the Covered Services and Supplies on the same basis as it applies to Sickness under the **Medical Benefits**.

Benefits are payable at 100% of Covered Expenses after the Copayment or Deductible has been paid.

After coverage under these Plans stop, there are no extended benefits.

**Covered Services and Supplies**

- Routine physical exam for covered Employees and Dependent spouses, including diagnostic tests and immunizations, only if provided by a Network Provider.
- Child up to age 19, preventive care services given in connection with routine pediatric care, including PKU tests and immunizations. Preventive care services may be provided by either a Network or Non-Network Provider.

- A routine well-woman exam, if provided by a Network Provider, includes the following:
  - Breast examination and/or mammogram.
  - Pelvic examination.
  - Pap smear.
- A routine well-woman exam, if provided by a Non-Network Provider, includes the following:
  - Mammogram.
  - Pap smear.
- Chromosome testing only if provided by a Network Provider.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# General Exclusions and Limitations

These Plans do not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies received before an Employee or his or her Dependent becomes covered under these Plans.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under these Plans.
- Abdominoplastys, unless Medically Necessary.
- Breast reduction surgery, unless Medically Necessary.
- Chelation therapy, except to treat heavy metal poisoning.
- Completion of claim forms, or missed appointments.
- Cosmetic or reconstructive surgery or treatment. (This is surgery or treatment primarily to change appearance.) It does not matter whether or not it is for psychological or emotional reasons. See **Medical Benefits** for limited coverage of reconstructive surgery.
- Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

  Care that meets one of these conditions is custodial care regardless of any of the following:
    - Who recommends, provides or directs the care.
    - Where the care is provided.
    - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.

- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Eye glasses, contact lenses, eye refractions, cochlear implants, unless required due to an accidental injury or sickness.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's immediate family:
  - The Employee's spouse.
  - The child, brother, sister or parent of the Employee.
- Expenses and associated expenses incurred for services and supplies for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for services which are otherwise Experimental, Investigational, or Unproven that are deemed to be, in the Company's judgment, covered transplant services. The fact that an Experimental, Investigational or Unproven Service, treatment, device and pharmacological regimen, is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- Services and supplies which the Covered Person is not legally required to pay.
- Liposuction.
- Services or supplies which are not Medically Necessary, including any confinement or treatment given in connection with a service or supply which is not Medically Necessary.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Occupational injury or Sickness. An occupational injury or Sickness is an injury or Sickness which is covered under a workers' compensation act or similar law.

  For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or Sickness includes any injury or Sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Private duty nursing services while confined in a facility, unless Medically Necessary.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.

- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a Covered Person under these Plans and is undergoing a covered transplant.
- Reversal of sterilization.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Charges made by a Hospital for confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below.

  If that type of facility is otherwise covered under these Plans, then benefits for that covered facility which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.

  - Adult or child day care center.
  - Ambulatory Surgical Center.
  - Birth Center.
  - Half-way house.
  - *Hospice.*
  - Skilled Nursing Facility.
  - Treatment Center.
  - Vocational rehabilitation center.
  - Any other area of a Hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- Drugs given while not confined in a Hospital, nursing home or similar place that has its own drug dispensary.
- Stand-by services required by a Physician.
- Care of or treatment to the teeth, gums *r* supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions and implants. See **Medical Benefits** for limited coverage of oral surgery and dental services.
- Telephone consultations.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity).
- Nutritional counseling, special foods, food supplements, liquid diets, diet plans or any related products, except for Enteral Formulas as described in Medical Benefits.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- Services given by volunteers or persons who do not normally charge for their services.

# Claims Information

## How to File a Non-Network Claim

Claim forms for services provided by a Network Provider are not required.

If the provider does not submit electronically, the following steps should be completed when submitting bills for payment:

- From United HealthCare customer service.
- Get a claim form from the Employee's department.
- Complete the Employee portion of the form.
- Have the provider complete the provider portion of the form.
- Send the form and bills to the address shown on the form.

Make sure the bills and the form include the following information:

- The Employee's name and social security number.
- The Employer's name and contract number (197512 for The Port Authority of New York & New Jersey and 197944 for Port Authority Trans-Hudson Corporation).
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

If the Covered Employee asks for a claim form but does not receive it within 15 days, the covered Employee can file a claim without it by sending the bills with a letter, including all of the information listed above.

## When Claims Must be Filed

Claims forms must be submitted within 15 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of loss was given to the Company as soon as was reasonably possible.

## How and When Claims Are Paid

All payments will be paid to the covered Employee as soon as the Company receives satisfactory completed claim forms, except in the following cases:

- If the covered Employee has financial responsibility under a court order for a dependent's medical care, the Company will make payments directly to the provider of care.

- If the Company pays benefits directly to Network Providers, unless it has been documented that the Network Provider has been reimbursed for Covered Expenses.
- If the covered Employee requests in writing that payments be made directly to a provider. A covered Employee does this when completing the claim form.

These payments will satisfy the Company's obligation to the extent of the payment.

The Company will send an Explanation of Benefits (EOB) to the covered Employee. The EOB will explain how the Company considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee will receive a written explanation.

Any benefits continued for Dependents after a covered Employee's death will be paid to one of the following:

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.
- A provider of care who makes charges to the covered Employee's Dependents for Covered Services and Supplies.
- The legal guardian of the covered Employee's Dependent.

## Legal Actions

The covered Employee may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee lives allows for a longer period of time.

## Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to the Company within 90 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and the Company will provide the claimant with a written response within 60 days of the date the Company receives the claimant's request for review. If, because of extenuating circumstances, the Company is unable to complete the review process within 60 days, the Company will notify the claimant of the delay within the 60 day period and will provide a final written response to the request for review within 120 days of the date the Company received the claimant's written request for review.

If the denial is upheld, the Company's written response to the claimant will cite the specific Plan provision(s) upon which the denial is based.

# Coordination of Benefits

Coordination of benefits applies when a covered Employee or a covered Dependent has health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

## Definitions

**"Other Plans"** are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.
- No-Fault motor vehicle laws.

**"Primary Plan"**: A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

**"Secondary Plan"**: Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

**"Allowable Expenses"** means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense.

When this Plan is a secondary plan, the benefit is based on the primary carrier's allowable expense.

For example, if the primary carrier has an indemnity plan and the secondary plan is a network plan, the secondary plan coordinates against the full allowable expense of that indemnity plan.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

If you are retired and Medicare Eligible, see the section on Retired Employees or Their Dependents Who Are Medicare Eligible in the Retired Employee provision.

## How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

## Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
  - Medicare is secondary to the plan covering the person as a dependent.
  - Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

  If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the plan of the parent with custody for the child.
  - Second, the plan of the spouse of the parent with the custody of the child.

- Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

If you are a retired employee and not Medicare eligible, see the section on Retired Employees or Their Dependents Who Are Not Yet Medicare Eligible in the Retired Employee provision.

## Right to Exchange Information

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this.

## Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Employer or Plan will not have to pay that amount again.

## Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Company may recover the amount paid from the other plan or organization or person.

Benefits may be paid that are in excess of what should have been paid under this Plan. The Company has the right to recover the excess payment.

# Recovery Provisions

## Refund of Overpayments

If benefits are paid under this Plan for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Plan if:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment made under this Plan exceeded the benefits under this Plan.

The refund equals the amount of benefits paid in excess of the amount that should have been paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Employer get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

## Reimbursement of Benefits Paid

If benefits are paid under this Plan for expenses incurred on account of a Covered Person, the Employee or any other person or organization that was paid must make a refund to the Plan if that person or organization recovers funds from a source other than this Plan as a result of claims against any other party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

## Subrogation

In the event a Covered Person suffers an injury or Sickness as a result of an allegedly negligent or wrongful act or omission of a third party, the Plan has the right to pursue subrogation against any person or insurer.

The Plan will be subrogated and succeed to the Covered Person's right of recovery against any person or insurer. The Plan may use this right to the extent of the benefits under this Plan.

The Covered Person agrees to help the Plan use this right when requested.

# Effect of Medicare and Government Plans

## Medicare

When a Covered Person becomes eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

### When This Plan Pays Primary to Medicare

This Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

### When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan for Covered Persons who are Medicare eligible if:

- The employee is a Retired Employee.
- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See **How this Plan Pays When Medicare is Primary**.

### Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person must enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan.

## How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare eligibles. It does not apply to any Covered Person unless that Covered Person becomes eligible under Medicare and Medicare is the Primary payer.

The amount of charges for Covered Expenses under this Plan is determined first. However, the amount of Covered Expenses is based on the amount of charges allowed under Medicare rules instead of the Reasonable Charges as defined by the Plan. Then the amount payable under Medicare for the same expenses is subtracted from the amount of Covered Expenses. This Plan pays 80% of the difference between the two amounts after the deductible.

This plan is designed to provide payment toward the outstanding balance left on medical expenses after Medicare Part B has paid their share. The plan determines the amount of covered expenses remaining after Medicare has made payment. It applies the $50 plan's deductible to this amount. Any covered expenses above the deductible amount are reimbursed at 80%.

When this plan determines the amount of the covered expense, it takes into consideration the Medicare Approved Amount for the service in question. If a doctor accepts the Medicare Assignment of Benefits, they have agreed to reduce their charge to the Medicare Approved Amount. If the doctor has not agreed to accept the Medicare Assignment of Benefits, they cannot charge more than the Medicare Limiting Amount. The Medicare Limiting Amount is currently set at 115% of the Medicare Approved Amount. Certain individual states have limited the amount a doctor can charge to 110% or 105% of the Medicare Approved Amount.

Here is an example illustrating the calculation of benefits available under this plan. The example assumes that both the Medicare Part B Annual Deductible of $100 and the plan annual deductible of $50 have been met before this claim occurred.

| | **DOCTOR ACCEPTS MEDICARE ASSIGNMEN** | **DOCTOR DOES NO ACCEPTS MEDICARE ASSIGNMEN** |
|---|---|---|
| **DOCTOR'S CHARGE** | $100 | $100 |
| **MEDICARE APPROVED AMOUN** | $80 | $80 |
| **DOC OR'S REVISED CHARGE** | $80 | $92 (limit = 115% of approved amt) |
| **MEDICARE PAYMEN (80% of approved amount)** | $64 | $64 |
| **BALANCE LEF OVER AF ER MEDICARE PAYMEN** | $16 | $28 |
| **HIS PLAN PAYS 80% OF OUTS ANDING BALANCE** | $12.80 | $22.40 |
| ***PATIENT RESPONSIBILITY*** | ***$3.20*** | ***$6.00*** |

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

### Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

## Termination of Coverage

### Employee Coverage

Employee coverage ends on the earlier of the following:

- The day this Plan ends.
- The end of the month in which the person stops being an eligible Employee.

If you become a Retired Employee while covered under this Plan, please see the provision titled Retired Employee.

#### Disability

Coverage under this Plan is continued during a period of short or long term disability. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

### Leave of Absence or Temporary Layoff

For information regarding leave of absence or temporary layoff, see your Human Resources Manual.

## Dependent Coverage

Coverage for all of an Employee's Dependents ends on the day the Employee's coverage ends.

Coverage for an individual Dependent ends on the earliest of:

- The day the Dependent becomes covered as an Employee under this Plan.
- *The day the Dependent stops being an eligible Dependent.*
- The last day of the month in which the Dependent Child is no longer a full-time student.

### Continuation of Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as Dependents coverage under this Plan continues and as long as the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

# Extended Benefits

There are extended benefits under **Medical Benefits**, **Mental Disorder Treatment and Alcohol or Substance Treatment** and **Pregnancy Benefits**.

Extended benefits are payable for a Totally Disabled Covered Person for up to 12 months. Extended benefits are only payable for Covered Services and Supplies given during the 12-month period after the person's coverage ends.

The person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Covered Services or Supplies are given.

Extended benefits are only payable for Covered Services and Supplies given for the accidental injury, Sickness, or pregnancy causing Total Disability.

# Continuation of Health Coverage (COBRA)

**Under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended current or former employees and their eligible dependents who are covered under a group health plan have the right to elect to temporarily continue health coverage at their own expense if the coverage terminates due to a "Qualifying Event" as defined below. Those eligible to continue coverage become "Qualified Beneficiaries" under the law. CobraServ has been retained as the third party administrator to notify you of your group health care benefits continuation rights when and if the occasion arises. CobraServ can be reached at (800) 877-7994.**

If coverage under these Plans would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the Qualified Beneficiary's health coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.
- If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or work hours being reduced, that Qualified *Beneficiary may elect an additional 11 months of coverage under these Plans,* subject to the following conditions:
    - The Qualified Beneficiary must provide the Employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
    - The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
    - If the Qualified Beneficiary entitled to the additional 11 months of coverage has nondisabled family members who are entitled to continuation coverage, those nondisabled family members are also entitled to the additional 11 months of continuation coverage.
- 36 months from the date the health coverage would have stopped due to the *Qualifying Event other than those described above.*
- The date these Plans stops being in force.
- The date the Qualified Beneficiary fails to make the required payment for the coverage.
- The date the Qualified Beneficiary becomes entitled to benefits under Medicare.

- The date the Qualified Beneficiary, after electing this continuation, becomes covered under any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a Qualified Beneficiary's preexisting condition.)

If the Qualified Beneficiary is already covered under any other group health plan and elects continuation of health coverage under these Plans, the Qualified Beneficiary can continue coverage under that other group health plan. If the Qualified Beneficiary does not stop coverage under that other plan, coverage under this continuation will stop.

*If after the first Qualifying Event another Qualifying Event occurs, coverage can be* continued for Dependents for an additional period, for a total of 36 months from the date of the first Qualifying Event.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

## Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the latter of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the date the person receives notice of the right to continue coverage is sent.

Unless otherwise specified, an Employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

## Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

## Notification Requirements

A Qualified Beneficiary must notify the Employer within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage is legally dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible Dependent.

CobraServ will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

## Conversion

At the end of this continuation period, a Qualified Beneficiary may be eligible for a conversion privilege if one is generally available under the plans.

## Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

## Special Terms that Apply to this Continuation Provision

### Qualifying Event

A Qualifying Event is any of the following which results in loss of coverage for a Qualified Beneficiary:

- The Employee's employment ends (except in the case of gross misconduct).
- The Employee's work hours are reduced.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is legally dissolved.
- The Employee becomes legally separated from his/her spouse.
- The Employee's Dependent child stops being an eligible Dependent.

A bankruptcy is a Qualifying Event for certain Retired Employees and their Dependents under certain conditions. If there is a bankruptcy, Retired Employees should contact the Employer or CobraServ for more information.

### Qualified Beneficiary

Any of the following persons who are covered under these Plans on the day before a Qualifying Event:

- The Employee.
- An Employee's spouse.
- An Employee's former spouse (or legally separated spouse).
- A Dependent child, including a child born to or placed for adoption with the Employee during a period of continued coverage.

# Continuation of Health Coverage During Family and Medical Leave (FMLA)

**The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 weeks of unpaid job-p rotected leave during any 12-month period for certain family and medical reasons. This provision of the Plan is intended to comply with the law and any pertinent regulations. See the Employer (Human Resources Manual) to find out how this continuation may apply to you.**

***Reasons for Taking Leave***

FMLA leave is granted for any of the following reasons:

- Care of a child after birth.
- Care of a child after placement of that child with the Employee for adoption or foster care.
- Care of the Employee's spouse, child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the Employee unable to work.

See the Employer to find out if you are eligible for a leave.

**Continuation of Health Coverage**

For the duration of a FMLA leave, the Employee may continue benefits for himself or herself and his or her Dependents on the same terms as if the Employee had continued to work. The Employee must pay the same contributions toward the cost of the coverage that he or she made while working.

**Reenrollment after a FMLA Leave**

If any or all of an Employee's coverages end while the Employee is on a FMLA leave, the Employee can reenroll for coverage when he or she returns to work from the FMLA leave.

The Employee and any Dependents will be considered timely enrollees if the Employee reenrolls within thirty-one days from the date he or she returns to work. Any waiting period will be applied as if there had been no break in coverage.

# Conversion Coverage

If the covered Employee's group health coverage stops under these Plans, the covered Employee may buy individual health insurance (called "Conversion Coverage").

Proof of insurability will not have to be given. However, if the benefits under Conversion Coverage are greater than those under these Plans, the covered Employee and his or her covered Dependents will be asked to give proof of insurability for the greater benefits.

If the covered Employee has Dependents coverage when the group coverage stops, the Conversion Coverage will be for the covered Employee and all Covered Family Members on the day such coverage stops. The covered Employee must apply for Conversion Coverage on the same basis as the coverage he or she has under these Plans. The covered Employee cannot apply for single Conversion Coverage unless he or she is enrolled for Employee Only coverage under these Plans. A Dependent child over age 19 will be issued single Conversion Coverage because only Dependent children under 19 are covered as family members under Conversion Coverage.

An individual policy will be issued if the person converting is eligible and lives in one of the following states:

| | |
|---|---|
| Georgia | Oregon |
| Maine | Puerto Rico |
| Minnesota | South Dakota |
| New Hampshire | Vermont |
| New Mexico | Virginia |
| New York | |

If the person converting lives in a state or jurisdiction of the United States not listed above and is eligible, Conversion Coverage will be provided through The Group Conversion Trust. The person will receive a Certificate of Insurance instead of an individual policy.

See **Conversion Coverage for Medicare Eligibles** at the end of this provision if the covered Employee or a covered Dependent is Medicare Eligible.

## Conditions for Conversion

### For Covered Employees

- These Plans must be in force, and
- the person is no longer an eligible Employee.

If a covered Employee's group health coverage stops because these Plans end and are replaced by other plans provided by the Employer, the covered Employee will not have the right to buy Conversion Coverage.

The person's Employer may continue coverage under these Plans when the person becomes a Retired Employee. In this case, the person cannot buy Conversion Coverage until the continued coverage stops.

### For Covered Dependents

If the covered Employee dies, the covered Employee's wife or husband or any guardian of the covered Employee's Dependent children may buy Conversion Coverage for the covered Dependents.

If the covered Employee's marriage is dissolved, the covered Employee's former spouse may buy Conversion Coverage. This can happen at either of the following times:

- When the marriage is legally dissolved.
- At the end of any period of continuation of coverage under these Plans, but *only if these Plans are in force on that date.*

Any of a covered Employee's covered Dependents may buy Conversion Coverage if one of the following is true:

- The Dependent stops being eligible.
- The Dependent is 19 or older when the covered Employee buys Conversion Coverage. (Only Dependent children under 19 are covered under a covered Employee's new family coverage.)

## How to Apply

Application must be made within 31 days after the group coverage stops.

Get an application from the Company.

The first premium must be paid before Conversion Coverage can be put in force.

Conversion Coverage will be effective on the date that the group coverage stops. In some cases a covered Employee can choose to continue group coverage after employment ends. In some cases a covered Employee's Dependents can choose to continue their group coverage after the covered Employee's death. In these cases Conversion Coverage will go into effect when the continued coverage stops but only if these Plans are in force on that date.

If the covered Employee dies within the 31-day conversion period, the covered Employee's wife or husband or any guardian of the covered Employee's Dependents may apply for Conversion Coverage for those covered Dependents.

## Limitations

Conversion Coverage may have greatly reduced benefits at a much higher cost. In most cases, the benefits will be limited to Hospital and surgical benefits only.

The benefit amounts for Conversion Coverage will be governed by the following:

- The rules of the Company.
- The laws of the state or jurisdiction where the person lives when he or she applies.

A copy of the individual policy or Certificate of Insurance is on file with the state insurance authority, where required. A copy may also be obtained from the Company.

The Company might limit the benefits of, or refuse to issue, Conversion Coverage because the covered Employee or a Dependent has other health coverage. Each person will be told the rules when they apply.

## Conversion Coverage for Medicare Eligibles

A Medicare Eligible who lives in one of the following states is not eligible for Conversion Coverage:

| | |
|---|---|
| Georgia | Oregon |
| Maine | Puerto Rico |
| Minnesota | South Dakota |
| New Hampshire | Vermont |
| New Mexico | Virginia |
| New York | |

Conversion Coverage of a Medicare Eligible who lives in any other state or jurisdiction of the United States (except Michigan) will be provided through The Group Conversion Trust. Michigan residents will be covered under an individual policy.

# Retired Employee Coverage

Retired Employees are eligible for the benefits as described below after they stop being an Active Employee.

As a Retired Employee, Plan Benefits are continued. The continued coverage will be the same coverage in effect as for Active Employees at the time of retirement, except continued benefits for Medicare Eligibles are modified as shown in **Medicare and Other Government Plans**.

### Retired Employees or Their Dependents Who Are Not Yet Medicare Eligible

Plan benefits for Retired Employees or their Dependents who are not Medicare eligible are payable in the same manner as Plan benefits for Active Employees and their Dependents, except as shown above.

### Retired Employees or Their Dependents Who Are Medicare Eligible

Unless a change is stated below, all coverage remains the same as the coverage for Active Employees and their Dependents. When Retired Employees or their Dependents become Medicare eligible, Plan benefits are changed. These Plan changes apply to all Covered Expenses incurred on or after the date the person becomes both Medicare eligible and is either a Retired Employee or a Dependent of a Retired Employee.

Plan benefits are changed as follows:

- Preventive Health Benefits will stop.
- The Network Provider provision no longer applies. Plan benefits are no longer paid at the Network or Non-Network level.
- Plan benefits are payable at 80%, except that your Medicare Part A deductible and other Part A expenses will be paid at 100%.
- An Individual Deductible of $50 applies to each Covered Person each Calendar Year. All other deductibles and copayments under the Plans no longer apply.

- A Family Deductible of $100 applies each Calendar Year. The Family Deductible applies no matter how large a family may be. Only Covered Expenses which count toward a Covered Person's Individual Deductible count toward this Deductible. All other deductibles and copayments under the Plans no longer apply.
- Any Covered Expenses incurred in the Calendar Year in which the Covered Person becomes Medicare eligible may be used to satisfy the $50 Individual Deductible for that Calendar Year. This applies even if the expenses are incurred prior to becoming Medicare eligible.
- Any Covered Expenses a Covered Person incurs during October, November and December of a year which count toward that person's Individual Deductible for that year will also count toward that person's Individual Deductible for the next year.

**Plan Changes for Mental Disorder reatment and Alcohol or Substance Abuse reatment**

The same $50 Individual Deductible that applies to all other Plan benefits also applies to Mental Disorder Treatment and Alcohol or Substance Abuse Treatment.

**Maximum Benefits**

If you are age 65 or over and you retire on or after January 1, 2004, the Maximum Benefit for all other Plan benefits for each Covered Person is unlimited.

The Maximum Benefit includes any amount paid under the Employer's group plan for Medicare eligible Retired Employees or their Dependents in effect on the day before the effective date of these Plans.

## Medicare Benefits Are Primary to These Plan Benefits

Medicare benefits are primary to this Plan's benefits for Medicare eligible Retired Employees or their Dependents.

Medicare benefits are payable first. Then this Plan pays benefits (with the changes stated above) for Covered Expenses which are more than the amount payable for the same expenses under Medicare.

If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating Physician), this Plan determines the amount of Covered Expenses based on the amount of charges allowed by Medicare.

If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating Physician), this Plan determines the amount of Covered Expenses based on the lesser of the following:

- The Reasonable Charge (See Glossary).
- The amount of the Limiting Charge as defined by Medicare.

This plan is designed to provide payment toward the outstanding balance left on medical expenses after Medicare Part B has paid their share. The plan determines the amount of covered expenses remaining after Medicare has made payment. It applies the $50 plan's deductible to this amount. Any covered expenses above the deductible amount are reimbursed at 80%.

When this plan determines the amount of the covered expense, it takes into consideration the Medicare Approved Amount for the service in question. If a doctor accepts the Medicare Assignment of Benefits, they have agreed to reduce their charge to the Medicare Approved Amount. If the doctor has not agreed to accept the Medicare Assignment of Benefits, they cannot charge more than the Medicare Limiting Amount. The Medicare Limiting Amount is currently set at 115% of the Medicare Approved Amount. Certain individual states have limited the amount a doctor can charge to 110% or 105% of the Medicare Approved Amount.

Here is an example illustrating the calculation of benefits available under this plan. The example assumes that both the Medicare Part B Annual Deductible of $100 and the plan annual deductible of $50 have been met before this claim occurred.

| | **DOCTOR ACCEPTS MEDICARE ASSIGNMEN** | **DOCTOR DOES NO ACCEPTS MEDICARE ASSIGNMEN** |
|---|---|---|
| **DOCTOR'S CHARGE** | $100 | $100 |
| **MEDICARE APPROVED AMOUN** | $80 | $80 |
| **DOC OR'S REVISED CHARGE** | $80 | $92 (limit = 115% of approved amt) |
| **MEDICARE PAYMEN (80% of approved amount)** | $64 | $64 |
| **BALANCE LEF OVER AF ER MEDICARE PAYMEN** | $16 | $28 |
| **HIS PLAN PAYS 80% OF OUTS ANDING BALANCE** | $12.80 | $22.40 |
| ***PATIENT RESPONSIBILITY*** | ***$3.20*** | ***$6.00*** |

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

## Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

### Definitions

#### Retired Employee

Retired Employee means an Employee who meets all of the following:

- The Employee is retired by the Employer, consistent with retirement arrangements recognized by resolution of the Employer's Board or its Committee on Operations or is separated after the Employee would have met the age and length of service required to be retired under the Employer's pension plan which would have been applicable had the Employee been a member.
- The Employee was covered under this Plan or the Former Plan on the day before the date of retirement.
- Employees not eligible for Medicare are covered with pre age 65 coverage.

#### Totally Disabled or Total Disability

A Retired Employee's inability due to accidental injury or Sickness to perform the normal activities of a person in good health and of like age and sex. A Retired Employee or Retired Employee's Dependent who meets this definition and is eligible for Medicare will have these Plans as Secondary.

# Glossary

(These definitions apply when the following terms are used.)

### Ambulatory Surgical Center

A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
  - It provides at least one operating room and at least one post-anesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It has immediate access to a blood bank or blood supplies.
  - It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

An Ambulatory Surgical Center which is part of a Hospital, as defined herein, will be considered an Ambulatory Surgical Center for the purposes of these Plans.

## Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law.
  - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity.
  - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
  - It is operated under the full-time supervision of a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) or registered graduate nurse (R.N.).
  - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.

- It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.
- It is expected to discharge or transfer patients within 24 hours following delivery.

A Birth Center which is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of these Plans.

## Calendar Year

A period of one year beginning with a January 1.

## Comprehensive Outpatient Rehabilitation Facility

A facility which is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured or sick persons and which fully meets one of the following two tests:

- It is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility.
- It meets all of the following tests:
  - It provides at least the following comprehensive outpatient rehabilitation services:
    - Services of Physicians who are available at the facility on a full or part-time basis.
    - Physical therapy.
    - Social or psychological services.
  - It has policies established by a group of professional personnel (associated with the facility) including one or more Physicians to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full or part-time Physician.
  - It has a requirement that every patient must be under the care of a Physician.
  - It is established and operated in accordance with the applicable licensing and other laws.

## Covered Family Members or Covered Person

The Employee and the Employee's wife or husband or former spouse and/or Dependent children who are covered under these Plans.

## Each Cause

A person may be confined in a Hospital more than one time. More than one surgical procedure may be performed on one person. The Company will consider all Hospital confinements and all surgical procedures to occur because of the same cause unless the person recovers completely from the injury or Sickness which caused the first Hospital confinement or surgical procedure before the next confinement or procedure, or in the case of pregnancy, the later Hospital confinement or surgical procedure is caused by a different pregnancy, or

- as to Dependents only, the disability which causes the later Hospital confinement or surgical procedure is completely different from the disability which caused the first Hospital confinement or surgical procedure, or

- the Employee returns to work for one full day before having another Hospital confinement or surgical procedure.

## Employee

A person on the payroll of the Employer and regularly employed by the Employer on a full-time basis of not less than 50% of normal hours in a pay period or as contractually negotiated.

## Experimental Investiga tional or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care *services, technologies, supplies, treatments, procedures, drug therapies or* devices that, at the time the Company makes a determination regarding coverage in a particular case are determined to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Company, in its judgment, may deem an Experimental, Investigational or Unproven Service covered under these Plans for treating a life threatening sickness or condition if it is determined by the Company that the Experimental, Investigational or Unproven Service at the time of the determination:

- is proved to be safe with promising efficacy; and
- is provided in a clinically controlled research setting, and
- uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

## Home Health Care Agency

An agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare.
- It is established and operated in accordance with the applicable licensing and other laws.

- It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
  - It has a full-time administrator.
  - It maintains written records of services provided to the patient.
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.
  - Its employees are bonded and it maintains malpractice insurance.

## Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice.
- It is licensed in accordance with any applicable state laws.
- It meets the following criteria:
  - It provides 24 hour-a-day, 7 day-a-week service.
  - It is under the direct supervision of a duly qualified Physician.
  - It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
  - The main purpose of the agency is to provide Hospice services.
  - It has a full-time administrator.
  - It maintains written records of services given to the patient.
  - It maintains malpractice insurance coverage.

A Hospice which is part of a Hospital will be considered a Hospice for the purposes of these Plans.

## Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a Hospital.
- It meets all of the following tests:
  - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
  - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
  - It is operated continuously with organized facilities for operative surgery on the premises.

## Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

## Medically Necessary or Medical Necessity

Health care services and supplies which are determined by the Company to be medically appropriate, and

(1) necessary to meet the basic health needs of the Covered Person; and

(2) rendered in the most appropriate manner and type of setting appropriate for the delivery of the service or supply; and

(3) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and

(4) consistent with the diagnosis of the condition; and

(5) required for reasons other than the convenience of the Covered Person or his or her Physician; and

(6) demonstrated through prevailing peer-reviewed medical literature to be either:

   (a) safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,

   (b) safe with promising efficacy

      (i) for treating a life threatening Sickness or condition, and

      (ii) in a clinically controlled research setting; and

      (iii) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

   (For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, Sickness, mental illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary used in this booklet relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

## Medicare

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

## Mental Disorder Treatment

Mental Disorder Treatment is treatment for both of the following:

- Any Sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/ or physiological dependence or addiction to alcohol or psychiatric drugs or medications, regardless of any underlying physical or organic cause, and
- Any Sickness where the treatment is primarily the use of psychotherapy or other psychotherapist methods.

All inpatient services, including Room and Board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a Sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the Sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

*Prescription Drugs unless prescribed while in-patient are not considered Mental* Disorder Treatment.

## No-Fault Automobile Insurance Law

The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

## Network Provider

A provider which participates in the network.

## Non-Network Hospital

A hospital (as defined) which does not participate in the network.

## Non-Network Provider

A provider which does not participate in the network.

## Nurse-Midwife

*A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both* of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- *A person who has completed a program approved by the state for the* preparation of Nurse-Midwives.

## Nurse-Practitioner

A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Practitioners.

## Other Services and Supplies

Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

## Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropody (D.P.M.; D.S.C.).
- Doctor of Chiropractic (D.C.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).
- Doctor of Osteopathy (D.O.).
- Doctor of Podiatry (D.P.M.).

## Plan/Plans

The Employee medical benefits for The Port Authority and PATH are referred to as this Plan or these Plans.

## Pre-Admission Tests

Tests performed on a Covered Person in a Hospital before confinement as a resident inpatient provided they meet all of the following requirements:

- The tests are related to the performance of scheduled surgery.
- The tests have been ordered by a Physician after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital.

## Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

## Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

## Reasonable Charge / Reasonable and Customary

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

## Room and Board

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

## Sickness

The term "Sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

## Skilled Nursing Facility

If the facility is approved by Medicare as a Skilled Nursing Facility then it is covered by these Plans.

If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Sickness.
- It maintains a daily medical record of each patient who is under the care of a licensed Physician.
- It is authorized to administer medication to patients on the order of a licensed Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A Skilled Nursing Facility which is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of these Plans.

## Total Disability or Totally Disabled

- An Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation.
- A Dependent's inability to perform the normal activities of a person of like age and sex.

## Treatment Center

A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and Board (if these Plans provides inpatient benefits at a Treatment Center).
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

## End of Summary Plan Description

## Notice to Employees

This booklet describes Employer-sponsored health benefits under the The Port Authority of New York & New Jersey Medical Plan or Port Authority Trans-Hudson Corporation (PATH) Medical Plan (collectively called "these Plans").

*All benefits becoming due under these Plans are funded by The Port Authority of* New York & New Jersey and Port Authority Trans-Hudson Corporation (collectively called "the Employer").

The Port Authority and PATH have entered into an arrangement with United HealthCare Service LLC (called "the Company") which provides for the Company to process benefit claims and provide certain other services under these Plans.

This booklet is intended to describe the medical plans being provided to certain employees of The Port Authority of New York and New Jersey and Port Authority Trans-Hudson Corporation by arrangement with United HealthCare Service LLC, as of March, 2001. The medical plans described in this booklet, which first became effective for certain employees as of January 1, 2004, are subject to change from time to time, e.g. through collective bargaining negotiations when required, or as otherwise legally permitted, so employees, retirees and qualified dependents should confirm the benefits described with United HealthCare at (877) 259-1391. *This booklet does not in any way constitute a contract between the Port Authority* of New York and New Jersey or Port Authority Trans-Hudson Corporation and its or their employees.

The Company has arranged with certain health care providers to participate in a network. These health care providers, called "Network Providers", have agreed to discount their charges for Covered Services and Supplies.

If Network Providers are used, the amount of Covered Expenses for which a Covered Person is responsible will generally be less than the amount owed if Non-Network Providers had been used. However, because the total charges for Covered Expenses may be less when Network Providers are used, the portion that the Covered Person owes will be less. Covered Persons are issued an identification card (ID Card) showing that they are eligible for the network discounts. A Covered Person should show this ID Card every time health care services are given. This is how the provider knows that the patient is covered under *a network plan. Otherwise, the person could be billed for the provider's normal* charge.

A directory of Network Providers will be made available. A Covered Person can also call Member Services to determine which providers participate in the Network. The telephone number for Member Services is on the ID Card.

*United HealthCare Service LLC does not insure the benefits described in this* booklet.

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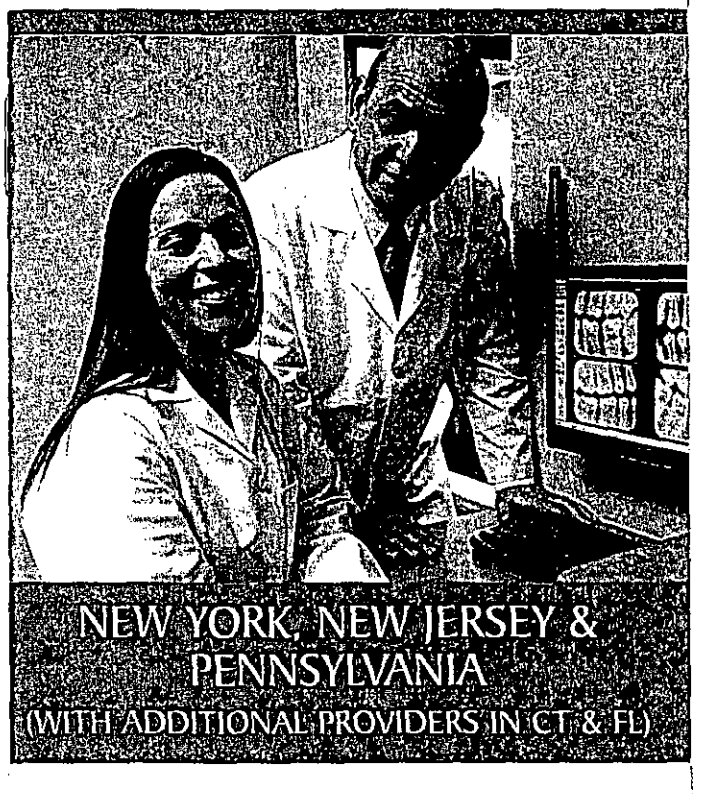
# PARTICIPATING PROVIDERS
# COMPREHENSIVE PLANS




**DENTCARE**

DELIVERY SYSTEMS, INC.

Administered by:

Healthplex®
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333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608

Customer Service: 1-800-468-0600
Press Option 1
Fax: 516-227-1143

The Providers listed in this brochure are under contract with various licensed or certified dental benefit organizations, including Dentcare Delivery Systems, Inc., and International Healthcare Services, Inc.

The directory is constantly changing, so please check the participating status of your dentist before you start treatment.

We request you wait until you receive your eligibility card (except of course in case of emergency) before making an appointment.

***Visit our website at www.healthplex.com.***

***Our website is available to help you easily access online, up-to-date information about our dental provider panel and your dental coverage. Should you have any questions you can call Internet Support at 1-888-468-5171.***

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# NEW YORK

## ALBANY

★C2381 ♿
**Albany Upstate Dental**
540 Broadway
Suite 100
Albany, NY 12207
(518) 465-0808
Dr. Tariq Malik

C2350 ♿
**American Dental Practice**
2258 Western Avenue
Guilderland, NY 12084
(518) 218-2292
Dr. Inderpal Garcha

## BRONX

C1329 ♿
**Dr. Sameh Aknouk**
1473 West Avenue
Bronx, NY 10462
(718) 824-5444
Dr. Sameh Aknouk
Dr. Claudia Lawrence
Dr. Olia Tricot

C1685 ♿
**Arthur Park Dental Center**
563-B East Tremont Avenue
Bronx, NY 10457
(718) 466-4600
Dr. Nelly Kamel

★C1406 ♿
**B & B Dental PC**
910 Grand Concourse
Bronx, NY 10451
(718) 538-2410
Dr. Jeffrey Goldstein
Dr. Yuriy Murdakhayev
Dr. Tad Picker
Dr. Michael Smalline

C-173 ♿
**Bruckner Plaza Dental Services**
1967 Turnbull Avenue
Suite 21 A
Bronx, NY 10473
(718) 823-3393
Dr. Richard Beatus

C-300 ♿
**Citident Concourse Plaza**
230 E 161st Street
Suite 90
Bronx, NY 10451
(718) 992-8200
Dr. Jeffrey Grant
Dr. Steven Kantor
Dr. Naresh Rastogi

C-258 ♿
**City Family Dental**
140 Alcott Place
Bronx, NY 10475
(718) 671-0071
Dr. A. Sulcov

C1286 ♿
**Concourse West Dental**
880 River Avenue
Bronx, NY 10452
(718) 992-0410
Dr. David Magid
Dr. David Sarner

★C1407 ♿
**Executive Associates, LLC**
327 East Fordham Road
2nd Floor
Bronx, NY 10458
*(718) 933-8400*
Dr. Ilia Abramov
Dr. Edward Cronin
Dr. Jeffrey Goldstein
Dr. Hee Koh

C2533 ♿
**Dr. Jay Fensterstock**
55 East Mosholu Parkway North
Bronx, NY 10467
(718) 652-7370
Dr. Jay Fensterstock
Dr. Janet Keane
Dr. Caroline Kim
Dr. Emil Labib
Dr. Ben Mallman

C-240 ♿
**Dr. Gregory Gang**
140-1 Casals Place
Co-Op City
Bronx, NY 10475
(718) 671-6000
Dr. Gregory Gang

C1012 ♿
**Dr. Aptin Ghods Djurabchi**
2505 University Avenue
Bronx, NY 10468
(718) 733-6600
Dr. Aptin Ghods
Dr. Rebecca Kim

C-159 ♿
**Drs. Grant and Kantor**
2202 Grand Concourse
Bronx, NY 10457
(718) 365-6389
Dr. Jeffrey Grant
Dr. Steven Kantor
Dr. Albert Rabizadeh

C-195 ♿
**Dr. Peter Gross**
2967 Morgan Avenue
Bronx, NY 10469
(718) 655-1972
Dr. Peter Gross
Dr. Maral Siegel

C3313
**Gun Hill Dental Assoc**
1425 East Gunhill Road
Bronx, NY 10469
(718) 671-0480
Dr. Gary Nadler
Dr. Richard Rosen



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C-537 ♿
**Drs. Kirshenbaum, Peruso, Dillon**
2169 White Plains Road
Bronx, NY 10462
(718) 597-6314
Dr. Christopher Dillon
Dr. David Kirshenbaum
Dr. William Peruso

C2423 ♿
**Morris Avenue Children & Adult Dentistry PC**
1037 Morris Avenue
Bronx, NY 10456
(718) 293-8005
Dr. Carol Poveda
Dr. Shahroukh Yaghoubian

C2984
**New Horizon Dental, PC**
961 E 174th Street
New Horizons Shopping Center
Bronx, NY 10460
(718) 861-8060
Dr. Mehrdad Haghighi
Dr. Alexander Mikhailov
Dr. Sipra Parmar
Dr. Umme Rashid

C-518
**Dr. Aaron Polinsky**
2532 University Avenue
Suite A A
Bronx, NY 10468
(718) 295-0203
Dr. Aaron Polinsky

C3343
**Dr. Vaibhavi Pradhan**
3950 White Plains Road
Bronx, NY 10466
(718) 652-6622
Dr. Vaibhavi Pradhan

C-125 ♿
**Riverdale Family Dental**
3725 Henry Hudson Parkway
Bronx, NY 10463
(718) 601-0100
Dr. Salvatore Albanese
Dr. Neille Ricks

C-741 ♿
**Dr. Clifford Saloshin**
2277 Westchester Avenue
Bronx, NY 10462
(718) 829-4646
Dr. Clifford Saloshin

C1487
**Dr. Sergey Sandler**
3366 Boston Road
Bronx, NY 10469
(718) 547-5280
Dr. Sergey Sandler

C1722 ♿
**The Townsend Dental Practice**
1606 Townsend Avenue
1st Floor
Bronx, NY 10452
(718) 299-1724
Dr. Gunanand Persaud

## BROOKLYN

C2251 ♿
**4th Avenue Dentist, PC**
5404 4th Avenue
Brooklyn, NY 11220
(718) 439-2876
Dr. Mark Arbetman
Dr. Eugene Milford
Dr. Steven Mitgang
Dr. Richard Silverman
Dr. Zanta Tobe

C1882 ♿
**All Smiles Dental, PC**
2016 Avenue M
Brooklyn, NY 11210
(718) 253-2300
Dr. Ronald Deutsch

C3837
**Arden Dental Services, PC**
2610 Ocean Parkway
Suite 1L
Brooklyn, NY 11235
(718) 769-1001
Dr. Arkady Pavlov

C2268 ♿
**Atlantic Terminal Mall**
139 Flatbush Avenue
Brooklyn, NY 11217
(718) 622-6100
Dr. Ross Krasnov
Dr. Vlada Matytsin
Dr. Anton Moskalenko
Dr. Thomas Rafferty

C-017
**Drs. Bernfeld & Korngold**
1801 Avenue M
Brooklyn, NY 11230
(718) 252-8989
Dr. Mark Arbetman
Dr. Barry Hecht
Dr. Michael Korngold
Dr. Anna Shnayderman

C-201
**Dr. Lawrence J. Bruckner**
1218 Remsen Avenue
Brooklyn, NY 11236
(718) 241-8050
Dr. Lawrence Bruckner

C3254
**Canarsie Family and Cosmetic**
1761 Rockaway Parkway
Brooklyn, NY 11236
(718) 531-9100
Dr. Jason Broth
Dr. Lawrence Weiss

C2963
**Carroll Gardens Dental Assocs**
402 Court Street
Brooklyn, NY 11231
(718) 834-1446
Dr. Gary Nadler
Dr. Richard Rosen
Dr. Irina Sinensky



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C1587
**Dr. Murray Fryd**
592 5th Avenue
Brooklyn, NY 11215
(718) 788-3290
Dr. Murray Fryd

C-394 ♿
**Dr. Ira E. Gronowitz**
8502 Bay Parkway
Brooklyn, NY 11214
(718) 373-5000
Dr. Ira Gronowitz
Dr. Agneta Iachmanovski
Dr. Besa Marisenoj
Dr. Rony Mashihi
Dr. Benjamin Schoenberg
Dr. Benjamin Selzer
Dr. Lisa Uglialoro

C-016 ♿
**Hanson Place Dental Assoc.**
4 Metro Tech Ctr.
Lobby
Brooklyn, NY 11201
(718) 403-0700
Dr. George Jordan
Dr. George Sears
Dr. Lester Toporovsky

C2010
**Dr. Gary Herskovits**
7 Bay 28th Street
Brooklyn, NY 11214
(718) 372-5246
Dr. Gary Herskovits

C-767 ♿
**Kings Plaza Dental**
5412 Kings Plaza Mall
Brooklyn, NY 11234
(718) 258-0011
Dr. Ella Dekhtyar
Dr. Tatyana Fridman
Dr. Marina Klpnis
Dr. Alexander Mikhailov
Dr. Sergey Molton
Dr. Bella Pinkatz
Dr. Engin Sangiray
Dr. Vitaliy Valyuk

C-090 ♿
**Dr. Rodney Leibowitz**
2017 East 68th Street
Brooklyn, NY 11234
(718) 531-8500
Dr. Rodney Leibowitz
Dr. Georgios Mavroglannis

C1814
**Dr. Joseph Lichter**
1122 Avenue P
Brooklyn, NY 11229
(718) 339-7878
Dr. Joseph Lichter

C-157
**Dr. Ronald Malen**
142 Joralemon Street
Suite 6E
Brooklyn, NY 11201
(718) 624-1970
Dr. Ronald Malen

C3234
**Manhattan Avenue Family Dental**
947 Manhattan Avenue
Brooklyn, NY 11222
(718) 389-4266
Dr. Terry Liebman
Dr. Nadeem Naseem

C-543
**Metropolitan Dental Associates**
327 Pennsylvania Avenue
Brooklyn, NY 11207
(718) 342-0009
Dr. Paul Cohen
Dr. Humaira Tayab
Dr. Gloria Williams

**C-541**
**Metropolitan Dental Associates**
447 Fulton Street
Brooklyn, NY 11201
(718) 875-3200
Dr. Stephen Brenner
Dr. Paul Cohen
Dr. Jeffrey Korenman
Dr. Jennifer Noto

C-350 ♿
**Dr. Dev Mishra**
1388 Saint Johns Place
Brooklyn, NY 11213
(718) 467-6336
Dr. Dev Mishra

C-028
**Dr. Gary S. Rafal**
9915 Seaview Avenue
Brooklyn, NY 11236
(718) 763-7799
Dr. Evan Homburger
Dr. Gary Rafal

C-504
**Dr. Patrick J. Sciortino**
459 Bay Ridge Parkway
Brooklyn, NY 11209
(718) 748-1123
Dr. Patrick Sciortino

**C-503**
**Dr. Patrick J. Sciortino**
79 Prospect Park Southwest
Brooklyn, NY 11218
(718) 768-4774
Dr. Vera Kuznetsova
Dr. Patrick Sciortino

C-138 ♿
**Dr. Moeen Sheikh**
5702 6th Avenue
Brooklyn, NY 11220
(718) 745-8295
Dr. Moeen Sheikh

C-287 ♿
**Dr. Jeffrey Tenenbaum**
53 Church Avenue
Brooklyn, NY 11218
(718) 871-4440
Dr. Jeffrey Tenenbaum



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C1980 ♿
**Dr. Gary L. Thomas**
237 Dekalb Avenue
Brooklyn, NY 11205
(718) 230-0203
Dr. Gary Thomas

★C1812
**Vatrenko Gitlin Dental Offices, PC**
178 Brighton 11th St
1st Floor
Brooklyn, NY 11235
(718) 769-4116
Dr. Michael Gitlin
Dr. Irina Vatrenko

C1055 ♿
**Valerie Venterina, DDS, PC**
8510 Bay 16th Street
Brooklyn, NY 11214
(718) 232-8289
Dr. Valerie Venterina

C-369 ♿
**Dr. Lawrence J. Weiss**
5520 Glenwood Road
Brooklyn, NY 11234
(718) 763-0505
Dr. Jason Broth
Dr. Lawrence Weiss

## DUTCHESS

C1186 ♿
**East Fishkill Dental**
1989 Route 52
Suite A
Hopewell Junction, NY 12533
(845) 896-5070
Dr. Steven Kaufman
Dr. David Kirshenbaum
Dr. Arthur Saltzman

## ERIE

C1810 ♿
**Choice 1 Dental, PC**
2878 Niagara Falls Boulevard
Amherst, NY 14228
(716) 693-2861
Dr. Vasuki Thevanayagam

C2300
**Dr. Vincent Florella**
393 Porter Avenue
Buffalo, NY 14201
(716) 882-4137
Dr. Vincent Florella

## JEFFERSON

C2292 ♿
**Sunshine Dental**
140 Eastern Blvd Northland Pza
Watertown, NY 13601
(315) 779-8080
Dr. Aeklavya Panjali

## NASSAU

C-509 ♿
**Drs. Ginsburg & Yurchenko**
2280 Grand Avenue
Suite 209
Baldwin, NY 11510
(516) 867-8466
Dr. Renata Ginsburg
Dr. Yelena Yurchenko

C1183 ♿
**Dr. Aviram Shmuely**
1000 Atlantic Avenue
Baldwin, NY 11510
(516) 771-7777
Dr. Aviram Shmuely

C-513 ♿
**Dr. Alan Kazlow**
407 East Jericho Turnpike
Carle Place, NY 11514
(516) 747-8150
Dr. Alan Kazlow

★C1711 ♿
**East Meadow Dental Associates**
258 East Meadow Avenue
East Meadow, NY 11554
(516) 745-8084
Dr. Ralph Berardi
Dr. James Mastrodomenico

C1790 ♿
**Smile Center**
918-1 Main Street
Farmingdale, NY 11735
(516) 420-1177
Dr. Sherif Desouky

★C1405 ♿
**Floral Park Dental Care**
25 South Tyson Avenue
Floral Park, NY 11001
(516) 437-5566
Dr. Jeffrey Goldstein
Dr. Michael Lang
Dr. Aleta Rosen-Winick

C-351 ♿
**Dr. Edward Maurer**
415 West Merrick Road
Freeport, NY 11520
(516) 378-1415
Dr. Edward Maurer

★C1122 ♿
**Nassau Family Dental, PLLC**
441 North Main Street
Freeport, NY 11520
(516) 379-5500
Dr. Michelle Gershbaum
Dr. Rachel Martz Klein
Dr. Allan Roffe

C2117 ♿
**South Ocean Care, LLC**
101 South Bergen Place
Freeport, NY 11520
(516) 623-3600
Dr. Alicia Andreula
Dr. Richard Butensky
Dr. Anna Shabtai-Bina



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C2417 ♿
**Roosevelt Field Mall Dental, PC**
630 Old Country Road
Suite 1D
Garden City, NY 11530
(516) 294-1919
Dr. Alexander Mikhailov
Dr. Alexander Musheyev
Dr. Bella Pinkatz

C2489 ♿
**Dr. Richard Kaufman**
15 Glen Street
Suite 205
Glen Cove, NY 11542
(516) 671-3755
Dr. Richard Kaufman

C-887
**Quezada & Vieyra Dental**
32-B Glen Street
Glen Cove, NY 11542
(516) 671-2265
Dr. Jorge Quezada
Dr. Rita Vieyra

★C-500
**Alexander Linsky, DMD, PC**
15 Bond Street
Suite 204
Great Neck, NY 11021
(516) 482-6677
Dr. Elizabeth Gharemani
Dr. Alexander Linsky

C-156
**Dr. Ronald Malen**
11 Wooleys Lane
Great Neck, NY 11023
(516) 482-1978
Dr. Ronald Malen

C2392 ♿
**Kane Dental PLLC**
72 Fulton Avenue
Hempstead, NY 11550
(516) 483-2220
Dr. Rebekah Kane
Dr. Dawer Nadi
Dr. Karam Nashed
Dr. Boris Vorob

C-375
**Schecter Dentistry, LLC**
391 Jerusalem Avenue
Hempstead, NY 11550
(516) 485-1144
Dr. Raja Aghabi
Dr. Robert Schecter

C-708 ♿
**Dr. Ron Kaminer**
1315A Broadway
Hewlett, NY 11557
(516) 239-6204
Dr. Eugene Avrashkov
Dr. Ronald Kaminer
Dr. Howard Kotz

C-122
**Dental Health Services**
146 Newbridge Road
Hicksville, NY 11801
(516) 931-4500
Dr. Ira Rosenberg
Dr. Michael Verini

C-095 ♿
**Dental World**
2920 Hempstead Turnpike
Levittown, NY 11756
(516) 796-8300
Dr. Paul Cassis
Dr. Annie Keung
Dr. Ezat Morcos
Dr. Allison Napoli

C-288
**Steven M. Goldberg, DDS, PC**
3601 Hempstead Tpke
Suite 110
Levittown, NY 11756
(516) 579-7577
Dr. Martin Blaustein
Dr. Steven Goldberg
Dr. Gerard Stoessel

C-291 ♿
**Dr. Robert Defeo**
5454 Merrick Road
Massapequa, NY 11758
(516) 798-3300
Dr. Martin Blaustein
Dr. Robert Defeo
Dr. Angela Pitre

C-133
**Sunrise Dental Associates**
25 Carmens Road
Massapequa, NY 11758
(516) 799-5577
Dr. Stephen Genna
Dr. Michael Giuliani
Dr. Monica Giuliani
Dr. Roger Giuliani

C1415
**Dr. Gary Nadler**
129 Davison Avenue
Oceanside, NY 11572
(516) 763-5683
Dr. Gary Nadler

C-372 ♿
**Oceanside Family Dental**
3377 Long Beach Road
Oceanside, NY 11572
(516) 766-0732
Dr. Ronald Kaminer
Dr. Howard Kotz

C-380
**Dr. Jerry Ebstein**
137 Driscoll Avenue
Rockville Centre, NY 11570
(516) 766-0517
Dr. Jerry Ebstein



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★C-168 ♿
**Dr. Robert Silon**
71 Lincoln Avenue
Rockville Centre, NY 11570
(516) 764-7222
Dr. Robert Silon

C1094 ♿
**Dr. Kirk Soodoo**
1270 Front Street
Uniondale, NY 11553
(516) 485-6150
Dr. Kirk Soodoo

C1944 ♿
**Goldberg Dental of Valley Stream**
417 West Merrick Road
Valley Stream, NY 11580
(516) 568-0448
Dr. Steven Goldberg
Dr. Harold Stern

C-002 ♿
**Valley Stream Dental Associates**
**Drs. Berman & Nastasi**
453 Rockaway Avenue
Valley Stream, NY 11581
(516) 825-3884
Dr. Martin Berman
Dr. Brian Carr
Dr. Michael Nastasi

C3280 ♿
**Dental World**
900 Merchants Concourse
Westbury, NY 11590
(516) 683-9100
Dr. Paul Cassis
Dr. Daniel Gambella
Dr. Ezat Morcos

C-377 ♿
**Dr. Kenneth Cohen**
999 Central Avenue
Suite 309
Woodmere, NY 11598
(516) 295-4770
Dr. Kenneth Cohen

## NEW YORK

C2146 ♿
**42nd Street Dental Associates, PC**
330 West 42nd Street
Ground Floor
New York, NY 10036
(212) 631-0222
Dr. Alex Azbel
Dr. Ross Krasnov

C-649 ♿
**86th Street Dental Office**
115 West 86th Street
New York, NY 10024
(212) 579-0213
Dr. Jacob Kirsch

C3062 ♿
**Ahmed Dentist PC**
356 Broadway
New York, NY 10013
(212) 966-5551
Dr. Faten Ahmed

C-549 ♿
**Amsterdam West Side Dental Assocs**
657 Amsterdam Avenue
New York, NY 10025
(212) 749-2400
Dr. Joel Bryk
Dr. Minsoo Cho
Dr. Pedro Vincenty

C1535
**Dr. Van M. Brown**
20 East 35th Street
New York, NY 10016
(212) 685-4217
Dr. Van Brown
Dr. Albert Fuzailof

C2422 ♿
**Columbus Avenue Dental Associates**
902 Columbus Avenue
New York, NY 10025
(212) 749-5000
Dr. Carol Poveda
Dr. Shahroukh Yaghoubian

C-191
**Dr. Terencia Conejero**
159 1st Avenue
New York, NY 10003
(212) 982-1129
Dr. Terencia Conejero

★C1076
**East Village Dental Associates**
645 East 11th Street
New York, NY 10009
(212) 979-6300
Dr. Jeffrey Krantz

C-079 ♿
**Dr. Jay Fensterstock**
30 East 40th Street
Room 207
New York, NY 10016
(212) 696-4979
Dr. Jay Fensterstock
Dr. Liana Gedz
Dr. Lee Gold
Dr. Kenneth Rubin

C-534
**Gramercy Park Dental**
344 3rd Avenue
New York, NY 10010
(212) 889-0999
Dr. Sarven Hacikian
Dr. Glen Holloway

C-359 ♿
**Manhattan Mall Dental**
**Herald Square Dental Associates**
901 Ave of the Americas, #156
New York, NY 10001
(212) 239-0800
Dr. Tatyana Fridman
Dr. Alexander Mikhailov
Dr. Prolay Paul
Dr. Engin Sangiray



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C-007
**Dr. Michael Herman**
128 Central Park South
Suite 1A
New York, NY 10019
(212) 582-3322
Dr. Michael Herman

C-026 ♿
**Dr. Morton Julius**
2253 2nd Avenue
New York, NY 10029
(212) 831-0924
Dr. Morton Julius

C1243 ♿
**Dr. Nelly Kamel**
4175 Broadway
New York, NY 10033
(212) 781-7272
Dr. Nelly Kamel

C-330
**Dr. Garry Levingart**
25 Central Park West
Suite 1T
New York, NY 10023
(212) 581-0707
Dr. Garry Levingart

C-674 ♿
**Metropolitan Dental Associates**
225 Broadway
Mezzanine Level
New York, NY 10007
(212) 732-7400
Dr. Paul Cohen
Dr. Woodley Desir
Dr. Dennis Palladino
Dr. Alexander Rock

C9097
**NYC Dental Associates, PC**
155 Spring Street
New York, NY 10012
(212) 226-1899
Dr. Gary Nadler

C2498 ♿
**Sherman Dental Associates**
19 Vermilyea Avenue
Suite 3
New York, NY 10034
(212) 942-0699
Dr. Eric Bernstein
Dr. Gary Nadler

★C-512 ♿
**Advanced Dentistry Associates**
41 West 72nd Street
Apt 1 D
New York, NY 10023
(212) 721-8373
Dr. Chana Weller

## ONEIDA

C9024
**Dr. Daniel Cerio**
1519 Genesee Street
Utica, NY 13501
(315) 735-0131
Dr. Daniel Cerio

## ONONDAGA

C3079
**Panna Howil, DDS, PC**
313 South Main Street
North Syracuse, NY 13212
(315) 458-1370
Dr. Panna Howil

## ORANGE

C2351 ♿
**Galleria Mall Dental @ Crystal Run**
1 North Galleria Dr
Suite 141
Middletown, NY 10941
(845) 692-9212
Dr. Michael Feldstein
Dr. Evelyn Ghadimian
Dr. Ross Krasnov

C-357 ♿
**Drs. Goldstein & Freud**
1401 Route 300
Newburgh, NY 12550
(845) 564-9300
Dr. Gary Freedman
Dr. George Freud
Dr. Benjy Goldstein
Dr. Yoel Megadesh

★C3014 ♿
**Kenneth Lee, DDS, PC**
50 Route 17K
Suite 104
Newburgh, NY 12550
(845) 561-8880
Dr. Kenneth Lee

C-992 ♿
**Nagpal Dental Associates**
16 Front Street
Port Jervis Professional Plaza
Port Jervis, NY 12771
(845) 856-3700
Dr. Kunwar Nagpal
Dr. Ram Phull

## PUTNAM

C-523 ♿
**Millbrook Office Center**
20 Milltown Road
Suite 205
Brewster, NY 10509
(845) 279-4404
Dr. Ursula Potkay

## QUEENS

C2534 ♿
**Harry L. Aristidou, DDS, PC**
38-03 31st Avenue
Astoria, NY 11103
(718) 278-8183
Dr. Harry Aristidou



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C2573 ♿
**Dr. Gene F. Calafa, Jr.**
29-14 Ditmars Boulevard
Astoria, NY 11105
(718) 274-1515
Dr. Gene Calafa
Dr. Meysam Madani
Dr. Wayne Seid

C2515
**Implant & Family Dentstry**
30-12 30th Avenue
Suite 230
Astoria, NY 11102
(718) 956-7800
Dr. Omid Termechi

C-245
**Dr. Bruce Bieber**
217-10 73rd Avenue
Bayside, NY 11364
(718) 464-7556
Dr. Bruce Bieber

C-262
**Dr. Lawrence Bruckner**
213-08 73rd Avenue
Suite 1N
Bayside, NY 11364
(718) 423-5363
Dr. Lawrence Bruckner

C-386 ♿
**Drs. Shmuely/Schevon**
214-04 18th Avenue
Bayside, NY 11360
(718) 423-1999
Dr. Michael Schevon
Dr. Avlram Shmuely

C-344 ♿
**Dr. Lawrence Kurzweil**
251-04 80th Avenue
Bellerose, NY 11426
(718) 347-1348
Dr. Lawrence Kurzweil

C-381
**Dr. Keven Jackson**
225-16 Linden Boulevard
Cambria Heights, NY 11411
(718) 978-0228
Dr. Keven Jackson

C2544 ♿
**Dr. David A. Jahn**
40-30 75th Street
Suite 1A
Elmhurst, NY 11373
(718) 457-9286
Dr. David Jahn

C-830 ♿
**Queens Dental Associates**
90-15 Queens Boulevard
Elmhurst, NY 11373
(718) 760-1616
Dr. Alexander Mikhailov
Dr. Alexander Musheyev
Dr. Bella Pinkatz
Dr. Engin Sangiray

C-506
**Dr. Mark Zharnitsky**
40-10 82nd Street
Elmhurst, NY 11373
(718) 426-3333
Dr. Mark Zharnitsky

C-828
**Dr. Naushir I.Lalani Dentist**
218 Beach 20th Street
Far Rockaway, NY 11691
(718) 327-8435
Dr. Naushir Lalani

C-307
**Dr. Atul R. Parikh**
20-50 Seagirt Boulevard
Far Rockaway, NY 11691
(718) 327-2147
Dr. Atul Parikh

C3276 ♿
**Jay D. Eisenstadt, DDS PLLC**
142-10 Roosevelt Avenue
Suite 110
Flushing, NY 11354
(718) 886-1171
Dr. Jay Eisenstadt

C1609
**Lawrence Lehman, DDS, LLP**
73-03 197th Street
Flushing, NY 11366
(718) 464-1300
Dr. Lawrence Lehman

C2196
**Twins Dental Care, PC**
157-05 72nd Avenue
Flushing, NY 11367
(718) 591-5450
Dr. Samson Solomon
Dr. Simkha Solomon

★C1404 ♿
**Horizon Dental Center, LLC**
107-50 Queens Boulevard
Forest Hills, NY 11375
(718) 793-1777
Dr. Joybelle Menzies
Dr. Filippo Sperandio

C-385 ♿
**Queens Comprehensive Dental**
**Drs. Molinsky & Arbetman**
67-66 108th Street
Forest Hills, NY 11375
(718) 830-0200
Dr. Mark Molinsky

C2197
**Twins Dental Care, P.C.**
114-06 Queens Boulevard
Forest Hills, NY 11375
(718) 544-5414
Dr. Samson Solomon
Dr. Simkha Solomon

★C-370
**Dr. Debora Zivari**
69-10 Yellowstone Boulevard
Forest Hills, NY 11375
(718) 520-9106
Dr. Debora Zivari



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C1608 ♿
**Dr. Arnold Dornberg**
61-34 188th Street
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Fresh Meadows, NY 11365
(718) 454-8666
Dr. Arnold Dornberg

C2436 ♿
**Flawless Dental, PC**
68-35 Myrtle Avenue
Glendale, NY 11385
(718) 821-0170
Dr. David Jakubowitz

C1044 ♿
**Santa Locascio, DDS, PC**
70-16 Fresh Pond Road
Glendale, NY 11385
(718) 628-6566
Dr. Santa Locascio

★C-071
**Dr. Larry Rosenthal**
71-43 66th Place
Glendale, NY 11385
(718) 497-1728
Dr. Larry Rosenthal

C3270 ♿
**Hollis Advanced Dental Care, PC**
190-02 Jamaica Avenue
2nd Fl
Hollis, NY 11423
(718) 454-7418
Dr. Benjamin Katayev

C1303 ♿
**Howard Beach Dental Associates**
156-36 A Crossbay Boulevard
Howard Beach, NY 11414
(718) 323-5132
Dr. Yakov Kurilenko
Dr. M.H. Reshad

C2456 ♿
**Emmet Dental, PC**
89-02 165th Street
Ste MW29
Jamaica, NY 11432
(718) 657-4838
Dr. Emil Korori

C-554 ♿
**Albee Dental Care**
168-14 Jamaica Ave
Jamaica, NY 11432
(718) 658-0123
Dr. Paul Bernheim
Dr. Douglas Garczynski
Dr. Arkadiy Khaitov
Dr. Preetha Kuruvilla
Dr. Merik Niyazov
Dr. Edward Zhuo

C-520
**Dr. Mohammad Iqbal**
160-33 Highland Avenue
Jamaica, NY 11432
(718) 291-0616
Dr. Mamoon Iqbal
Dr. Mohammad Iqbal

C3255
**Rochdale Dental Associates, PC**
137-04 Guy R Brewer Blvd
Jamaica, NY 11434
(718) 723-5630
Dr. Eric Bernstein
Dr. Gary Nadler

C-542
**Metropolitan Dental Associates**
88-01 Parsons Boulevard
Jamaica Estates, NY 11432
(718) 526-3400
Dr. Geetha Balamurugan
Dr. Paul Cohen
Dr. Stephen Seidner

C1697 ♿
**Dr. Irina Pinsky**
115-25 Metropolitan Avenue
Kew Gardens, NY 11418
(718) 441-2660
Dr. Irina Pinsky

C-238
**Dr. Gerald Leifer**
65-31 52nd Avenue
Maspeth, NY 11378
(718) 457-5444
Dr. Gerald Leifer

C2485 ♿
**Middle Village Dental Associates**
66-26 Metropolitan Avenue
Middle Village, NY 11379
(718) 821-6464
Dr. Anatoliy Barak
Dr. Nandor Halpert
Dr. Susanna Isaacs

★C-521
**Alexander Linsky, DMD, PC**
94-28 Springfield Boulevard
Queens Village, NY 11428
(718) 465-1664
Dr. Alexander Linsky

C-063
**Quality Health Center, Inc.**
220-05 94th Drive
Queens Village, NY 11428
(718) 465-3265
Dr. Norman Klein

C-086 ♿
**Drs. Rogers & Blumenthal**
220 24 Hillside Avenue
Queens Village, NY 11427
(718) 479-7100
Dr. Marc Blumenthal
Dr. Thomas Gorman
Dr. Cliff Rogers

C-127 ♿
**Dr. Larry H. Hirsch**
85-04 63rd Drive
Rego Park, NY 11374
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Dr. Lawrence Hirsch



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C-239
**Dr. Jay Fensterstock**
119-01 Liberty Avenue
Richmond Hill, NY 11419
(718) 843-1616
Dr. Jay Fensterstock
Dr. Ben Mallman
Dr. Kenneth Rubin

C1461 ♿
**Richmond Hill Dental Group**
124-19 101st Avenue
Richmond Hill, NY 11419
(718) 847-3800
Dr. Gene Calafa
Dr. Meysam Madani
Dr. Wayne Seid

C-089
**Dr. Kenneth Rubin**
133-40 131st Street
S. Ozone Park, NY 11420
(718) 529-3800
Dr. Jay Fensterstock
Dr. Ben Mallman
Dr. Celia Palaganas
Dr. Salvatore Pavone
Dr. Kenneth Rubin

## RENSSELAER

C-948 ♿
**Hudson Valley Dental Care**
658 Columbia Turnpike East
Story Place, Suite 3
East Greenbush, NY 12061
(518) 477-2682
Dr. Cristi Freinberg-Trufas

C-332 ♿
**Dr. Shambhu Mehta**
500 Federal Street
Suite 300
Troy, NY 12180
(518) 273-8931
Dr. Shambhu Mehta

## ROCKLAND

C2414 ♿
**Nanuet Mall Dental, PC**
75 West Route 59
Suite 1009A
Nanuet, NY 10954
(845) 624-7500
Dr. Yelena Khrapko
Dr. Ross Krasnov
Dr. Alexander Mikhailov
Dr. Edward Shalomov
Dr. Eduart Shkurti

★C1202 ♿
**Dr. Andrew Kass**
345 North Main Street
New City, NY 10956
(845) 634-4314
Dr. Andrew Kass

C-342
**Dr. Lloyd Kranes**
77 Main Street
Nyack, NY 10960
(845) 358-1280
Dr. Lloyd Kranes

C-989 ♿
**West Nyack Dental, PC**
719 West Nyack Road
Suite 26
West Nyack, NY 10994
(845) 358-6888
Dr. Paul Eliazo
Dr. Jeffrey Goldstein

## STATEN ISLAND

C1408 ♿
**Advanced Hylan Dental Care, PC**
2691 Hylan Boulevard
Staten Island, NY 10306
(718) 987-3365
Dr. Jeffrey Goldstein
Dr. Swapan Nag-Chaudhuri

C1961 ♿
**Arden Dental, PC**
337 Hampton Green
Staten Island, NY 10312
(718) 948-0870
Dr. Valery Dubovikov

★C1481 ♿
**Dr. Maria Lucy Duff**
1121 Forest Avenue
Staten Island, NY 10310
(718) 524-0380
Dr. Maria Duff

★C1139
**Hylan Dentists, PC**
1146 Hylan Blvd
*Staten Island, NY 10305*
(718) 273-5558
Dr. Stanley Becker
Dr. Steven Glassman

★C1502
**Dr. Allan Kaye**
3595 Richmond Avenue
Staten Island, NY 10312
(718) 356-1450
Dr. Allan Kaye

C-141 ♿
**Dr. Alan Kratenstein**
4076 Hylan Boulevard
Staten Island, NY 10308
(718) 966-6200
Dr. Alan Kratenstein

★C1188
**Dr. Ronald S. Leader**
4236 Richmond Avenue
Staten Island, NY 10312
(718) 227-6222
Dr. Ronald Leader



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C2211 ♿
**Staten Island Mall Dental**
2655 Richmond Avenue
Suite 2220
Staten Island, NY 10314
(718) 982-5500
Dr. Sergey Basin
Dr. Ross Krasnov

C-169
**Dr. Harry Weisenfeld**
310 Richmond Hill Road
Staten Island, NY 10314
(718) 494-0100
Dr. Nelson Diamondstein
Dr. Barry Noskow
Dr. Harry Weisenfeld

★C-343
**Dr.Cheryl F. Worrell**
35 Willowbrook Road
Staten Island, NY 10302
(718) 448-0266
Dr. Cheryl Worrell

## SUFFOLK

C1158
**Amityville Dental Care**
71 Ireland Place
Amityville, NY 11701
(631) 691-6161
Dr. Kashmira Demetreles

C-289 ♿
**Steven Goldberg DDS of Babylon**
400 West Main Street
Suite 211
Babylon, NY 11702
(631) 422-6066
Dr. Carl Dropkin
Dr. Renata Ginsburg

★C1459 ♿
**Bayshore Family Dental**
3 Fourth Avenue
Bay Shore, NY 11706
(631) 968-5995
Dr. Kamran Sanandaji
Dr. Kourosh Yaghoubian

C-384
**Carleton Avenue Family Dental**
**Kirshenbaum Peruso & Kaufman**
109 Carleton Avenue
Central Islip, NY 11722
(631) 348-2500
Dr. Hope Arnoldt
Dr. Anthony Demarco
Dr. Channa Jayatilake
Dr. Steven Kaufman
Dr. William Peruso
Dr. Jerome Stein

★C1706
**Dr. Ralph Berardi**
160 Commack Road
Suite M4
Commack, NY 11725
(631) 499-6999
Dr. Ralph Berardi

C-621 ♿
**Commack Dental Services**
**Dent-Wise Consultants**
777 Larkfield Road
Commack, NY 11725
(631) 462-5780
Dr. Marshall Diamond

C1422
**Park Hills Dental Center**
1644 Deer Park Avenue
Deer Park, NY 11729
(631) 586-7100
Dr. Parag Mathur

C-311 ♿
**Dr. Barbara Slonecki**
67 West Main Street
East Islip, NY 11730
(631) 224-1381
Dr. Robert Bodd
Dr. Barbara Slonecki

C2551 ♿
**Dr. Craig Hoffman**
761 Pulaski Road
Greenlawn, NY 11740
(631) 261-1555
Dr. Craig Hoffman

C-293
**Dr. Harvey Caplin**
111 Smithtown Bypass
Suite 217
Hauppauge, NY 11788
(631) 724-0900
Dr. Harvey Caplin
Dr. Yen-Chiu Chen
Dr. Jacqueline Fries
Dr. Ana Ramirez-Walker

★C1271 ♿
**Dr. Mauro Dibenedetto**
800 Broadway Avenue
Holbrook, NY 11741
(631) 244-5724
Dr. Mauro Dibenedetto

C-340
**Sachem Dental Group**
470 Patchogue Holbrook Road
Holbrook, NY 11741
(631) 589-8485
Dr. Robert Cella
Dr. Simon Cheung
Dr. Paul Seltzer

C2516
**Dr. Bharati J. Bedi**
280 Greenbelt Parkway
Holtsville, NY 11742
(631) 472-1832
Dr. Bharati Bedi

C1636 ♿
**Dr. Adam Maslow**
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(631) 673-5784
Dr. Adam Maslow



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**Dr. Kirk Soodoo**
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Huntington, NY 11743
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Dr. Kirk Soodoo

C1361
**Dr. Glenn Goldfarb**
73 Rumford Road
Kings Park, NY 11754
(631) 265-5444
Dr. Glenn Goldfarb

C-339
**Sachem Dental Group**
469 Hawkins Avenue
Lake Ronkonkoma, NY 11779
(631) 588-8280
Dr. Anthony Gentile
Dr. Andrew Georgakopoulos
Dr. Carlton Sumner

C1200
**Emad E. Ibrahim, DDS, PC**
826 Buffalo Avenue
Lindenhurst, NY 11757
(631) 957-8200
Dr. Emad Ibrahim
Dr. Maged Karam

C-880 ♿
**Dr. Darren M. Schnapp**
150 Broadhollow Road
Route 110
Melville, NY 11747
(631) 271-9384
Dr. Darren Schnapp

C-338
**Sachem Dental Group**
110 Smithtown Blvd
Suite 1
Nesconset, NY 11767
(631) 382-8585
Dr. Paul Seitzer

C-677 ♿
**Dr. Richard Freedman**
1251 Deer Park Avenue
North Babylon, NY 11703
(631) 242-7711
Dr. Richard Freedman
Dr. Fabiola Milord
Dr. Calvin Zhao

C-399
**Dr. Eyal Waldman**
168 North Ocean Avenue
Patchogue, NY 11772
(631) 289-7179
Dr. Eyal Waldman

C-361 ♿
**Eastern Suffolk Dental**
1149 Old Country Road
Suite A3
Riverhead, NY 11901
(631) 369-7400
Dr. Steven Goldberg
Dr. Angela Pitre

C-004 ♿
**Coram-Selden Dental Group**
280K Middle Country Road
Selden, NY 11784
(631) 732-9000
Dr. Simmy Arora
Dr. Lazarus Camesas
Dr. Jerrold Hollander
Dr. George Kane
Dr. Inayat Mamoor
Dr. Nahid Sheikh

C1943
**Dr. Lloyd Simonsen**
14 Bank Avenue
Smithtown, NY 11787
(631) 265-1066
Dr. Lloyd Simonsen

★C-545
**Dr. Robert Kroepel**
2360 Oaklawn Avenue
Southold, NY 11971
(631) 765-2860
Dr. Robert Kroepel

## SULLIVAN

C-993
**Nagpal Dental Associates**
Bridge Street
Narrowsburg, NY 12764
(845) 252-3951
Dr. Kunwar Nagpal
Dr. Ram Phull

C2236 ♿
**South Fallsburg Dental**
5203 Main Street
PO Box 708
South Fallsburg, NY 12779
(845) 434-1202
Dr. Peter Genco

## ULSTER

C2301 ♿
**C & S Toprani Dentists, PC**
3524 Route 9 West
Highland, NY 12528
(845) 691-9478
Dr. Chandrakant Toprani
Dr. Subhadra Toprani

## WESTCHESTER

★C-336 ♿
**Dr. Richard Minoff**
2200 Boston Post Road
Larchmont, NY 10538
(914) 834-0407
Dr. Richard Minoff

C-368
**Dr. William Jacobs**
2 Gramatan Avenue
Suite 208
Mount Vernon, NY 10550
(914) 664-2102
Dr. William Jacobs



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C-508 ♿
**Atlantis Dental Health, PC**
505 Central Avenue
Suite 107
White Plains, NY 10606
(914) 949-0648
Dr. Mark Bornstein

C1165 ♿
**Galleria Mall Dental, PC**
100 Main Street
White Plains, NY 10601
(914) 997-9000
Dr. Alex Azbel
Dr. Ross Krasnov
Dr. Karina Krom
Dr. Alexander Mikhailov
Dr. Eduart Shkurti

C9021 ♿
**Concerned Dental Care**
35 East Grassy Sprain Road
Yonkers, NY 10710
(914) 337-5252
Dr. Jay Fensterstock
Dr. George Kane
Dr. Inayat Mamoor
Dr. Antoinette Siciliano

C2313
**Yorktown Dental Group**
206 Veterans Road
Yorktown Heights, NY 10598
(914) 962-5566
Dr. Jennifer Chan
Dr. Steven Greene
Dr. Adam Hislger
Dr. Joseph Indriolo
Dr. Sayeh Naem
Dr. Amanda Wiechert



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## NEW JERSEY

### ATLANTIC

J-64D ♿
***Eastern Dental® of Northfield***
1634 New Road, Route 9
Northfield, NJ 08225
(609) 677-1589
Dr. Elliot Brooks
Dr. Pier Cipriani
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Bassam Massabny
Dr. John Metrinko
Dr. Bennett Sideman

### BERGEN

J-66T
**Skyview Dental Group**
880 River Road
*Suite 2*
Edgewater, NJ 07020
(201) 313-4700
Dr. Behshad Ahkami

J-65B
**Montrose Center**
301 Bridge Plaza North
Fort Lee, NJ 07024
(201) 346-4660
Dr. Larisa Ilyutovich

J-67V
**Dental Care, LLC**
331 Ridge Road
Lyndhurst, NJ 07071
(201) 438-4774
Dr. Juan Alvarez
Dr. Ritesh Shah

J-65W
**Lyndhurst Dental Medicine**
464 Valley Brook Avenue
Lyndhurst, NJ 07071
(201) 933-9092
Dr. Ross Lesser

★J-519
***Dr. Norton L. Smith***
61 North Maple Avenue
*Ridgewood, NJ 07450*
(201) 445-0961
Dr. Norton Smith

J-599
**Dr. Roy E. Ziff**
185 Center Avenue
Westwood, NJ 07675
*(201) 266-9100*
Dr. Roy Ziff

### BURLINGTON

J-59J ♿
**Eastern Dental® of Burlington**
202 Route 130 North
*PEP Boys Plaza*
Cinnaminson, NJ 08077
(856) 303-0600
Dr. Pier Cipriani
Dr. Michael Hoffmaster
Dr. Joseph Iavarone
Dr. Ann Jeffers
Dr. Michael Kovall
Dr. Jaime Magsino
Dr. George Marino
Dr. Bassam Massabny

J-64R
**Eastern Dental® of Marlton**
8001 Lincoln Drive West
Suite A
Marlton, NJ 08053
(856) 983-5400
Dr. Pier Cipriani
Dr. Joseph Iavarone
Dr. Ann Jeffers
Dr. Michael Kovall
Dr. Bassam Massabny
Dr. Alla Podokshik
Dr. Mooni Shah

### CAMDEN

J-64P
**Eastern Dental® of Laurel Springs**
3 Kelly Drivers Road
Laurel Springs, NJ 08021
(856) 784-5100
Dr. Pier Cipriani
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Mydung Lu
Dr. Bassam Massabny
Dr. Nguyet Vu-Nguyen

### CUMBERLAND

J-64U
**Eastern Dental® of Vineland**
1145 East Chestnut Avenue
Vineland, NJ 08360
(856) 692-5400
Dr. Pier Cipriani
Dr. Shweta Gandhi
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Cyril Labega
Dr. Bassam Massabny

### ESSEX

★J-59U
**Dr. Peter Liloia**
392 1/2 Washington Avenue
Belleville, NJ 07109
(973) 759-4115
Dr. Peter Liloia



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J-66U ♿
**Maria Cuesta, PC**
90 Washington Ave.
Suite 209
East Orange, NJ 07017
*(973) 414-9015*
Dr. Maria Cuesta

J-66D
**Center For Family Dentistry**
*1187 Clinton Avenue*
Irvington, NJ 07111
(973) 375-0400
Dr. Gurpreet Kaur
*Dr. Fariba Sharifan*

J-67Y ♿
**Dr. Morris Silver**
860 Grove Street
*Irvington, NJ 07111*
(973) 373-0499
Dr. Morris Silver

J-64H ♿
**Smile Dental Office**
1152 Clinton Avenue
Irvington, NJ 07111
(973) 372-5640
Dr. Usha Polavarapu

J-64M ♿
**Livingston Mall Dental**
112 Eisenhower Parkway
*Livingston, NJ 07039*
(973) 422-9399
Dr. Mai Fares
Dr. Kurosh Haghighi
Dr. Ross Krasnov
Dr. Sofia Martirosov
Dr. Alexander Mikhailov
Dr. Prolay Paul
Dr. Shreyas Shah
Dr. Alyona Sverdlova
Dr. Vitaliy Valyuk

J-67A ♿
**Empire Dental Care, PC**
119-137 Clifford Street
Newark, NJ 07105
(973) 465-7737
*Dr. Saad Touleimat*

J-67C ♿
**Family Dentistry**
603 Clinton Avenue
Newark, NJ 07108
(973) 824-7409
Dr. Colden Raines

J-67E ♿
**SN Family Dental Center**
433 Mount Prospect Avenue
Newark, NJ 07104
(973) 482-3866
Dr. Navneet Rai

J-57U
**Dr. Glenwood Harper**
*514 Scotland Road*
*Orange, NJ 07050*
(973) 672-2276
Dr. Glenwood Harper

## HUDSON

J-57B
**Drs. Davis, Saltzberg, & Wenger**
142 Palisade Avenue
*Suite 200*
Jersey City, NJ 07306
(201) 798-5551
Dr. Theodore Davis
Dr. David Saltzberg
Dr. Joerg Sladky
Dr. Abraham Wenger

*J-68F*
**Diamond Dental Group**
2778 John F Kennedy
Boulevard
Jersey City, NJ 07306
(201) 659-7000
Dr. Ogonna Orjiekwe

J-62K ♿
**Newport Centre Dental**
*30-71A Mall Drive West*
Jersey City, NJ 07310
(201) 626-2500
Dr. Mai Fares
Dr. Ross Krasnov
Dr. David Lac
Dr. Sofia Martirosov
Dr. Huma Mirza
Dr. Emil Nasimov
Dr. Prolay Paul
Dr. Alla Pavlushkin
Dr. Robert Rueda
*Dr. Shreyas Shah*
Dr. Alyona Sverdlova

J-67M
***SS Dental***
Jersey City Dental
162 Newark Avenue
Jersey City, NJ 07302
(201) 434-0919
Dr. Blair Schachtel

J-65Y
**Dr. Michael Valerio**
524 42nd Street
*Union City, NJ 07087*
(201) 863-9090
Dr. Michael Valerio

J-62D ♿
**Hudson Dental**
5300 Bergenline Avenue
West New York, NJ 07093
(201) 865-7750
Dr. William Halklas
Dr. Michael Nourbakhsh

## HUNTERDON

J-67T
**Eastern Dental® of Flemington, LLC**
433 Us Highway 202
Flemington, NJ 08822
(908) 237-2100
Dr. Michael Kovall
Dr. Sumner Schwarz



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J-56G
**Dr. Robert Barchi**
27 Cedar Road
Whitehouse Station, NJ 08889
(908) 439-2342
Dr. Robert Barchi

## MERCER

J-52D ♿
**Eastern Dental® of Ewing**
*1330 Parkway Avenue*
Ewing, NJ 08628
(609) 883-0801
Dr. Pier Cipriani
Dr. Hal Fruchtman
Dr. Gary Gagliardi
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. George Marino
Dr. Bassam Massabny
Dr. Bill Pallouras
Dr. Patrick Quaranta
Dr. Elan Schwarz
Dr. Michael Slomovitz
Dr. Mohab Tanious

J-65P
**Eastern Dental® of Lawrenceville**
520 Lawrence Square Blvd South
Lawrenceville, NJ 08648
(609) 587-6300
Dr. Pier Cipriani
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Bassam Massabny
Dr. Manish Mistry
Dr. James Rodriguez
Dr. Farah Shariff

## MIDDLESEX

J-52C ♿
**Eastern Dental® of Woodbridge**
*1030 Saint Georges Avenue*
Avenel, NJ 07001
(732) 750-3600
Dr. Daya Bale
Dr. Mark Brabston
Dr. Pier Cipriani
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Bassam Massabny
Dr. Robert Weinflash

J-67H ♿
**Summerhill Family & Cosmetic Dentist**
281 Summerhill Road
*Suite 204*
East Brunswick, NJ 08816
(732) 698-1070
Dr. Iman Girgis

J-68D ♿
**Amazing Smiles, LLC**
1907 Oak Tree Road
Suite 204
Edison, NJ 08820
(732) 662-9313
Dr. Richard Kosofsky

J-56C ♿
**Dr. David S. Moss**
98 Market Street
Perth Amboy, NJ 08861
(732) 442-3233
Dr. David Moss

J-52E ♿
**Eastern Dental® of Old Bridge**
960 Route 9 South
Sayreville Plaza
South Amboy, NJ 08879
(732) 727-3399
Dr. Daya Bale
Dr. Joseph Buchalski
Dr. Pier Cipriani
Dr. Joseph Iavarone
Dr. Bassam Massabny
Dr. Alan Morgenstern
Dr. Nicole Niebudek
Dr. Robert Restaino

J-66E ♿
***Woodbridge Center Dental***
294 Woodbridge Center Drive
Woodbridge, NJ 07095
(732) 750-3080
Dr. Ross Krasnov
Dr. John Mamoun
Dr. Alexander Mikhailov
Dr. Emil Nasimov
Dr. Samir Patel
Dr. Prolay Paul
Dr. Robert Rueda
Dr. Shreyas Shah
Dr. Vitaliy Valyuk

## MONMOUTH

J-68C
**All Smiles Dental Center PA**
24 Plaza 9
Englishtown, NJ 07726
(732) 431-2622
Dr. Vishali Nandiwada

J-68E
**Eastern Dental® of Howell, LLC**
2346 Route 9 South
Howell, NJ 07731
(732) 683-1130
Dr. Aaron Feller
Dr. James Rodriguez

J-65K ♿
**Matawan Oral Surgery Associates**
125 Main Street
Matawan, NJ 07747
(732) 583-1144
Dr. Ralph Famiglietti



♿ Office is wheelchair accessible
★ Not accepting new members
Participation of any single provider is subject to change and can not be guaranteed. Please visit our website for an updated provider listing at www.healthplex.com

J-66A ♿
**Neptune Family Dental**
2300 Route 33 Oliver Bros Bldg
Neptune, NJ 07753
(732) 774-0077
Dr. Maria Jimenez
Dr. Michael O'Donnell

J-66F ♿
**Eastern Dental® of Eatontown, LLC**
1802 Route 35 South
Oakhurst, NJ 07755
(732) 660-0500
Dr. Elizabeth Archer
Dr. Pier Cipriani
Dr. Aaron Feiler
Dr. Steven Feinstein
Dr. Joseph Iavarone
Dr. Bassam Massabny

## MORRIS

J-67X ♿
**Eastern Dental® of Parsippany, LLC**
2936 Route 10 West
Morris Plains, NJ 07950
(973) 292-2550
Dr. Aaron Feiler
Dr. Joseph Iavarone
Dr. Martin Kartush
Dr. Mark Szlerer

J-63C ♿
**Morris Plains Dental**
559 Speedwell Avenue
Morris Plains, NJ 07950
(973) 455-1033
Dr. Hamlet Garabedian
Dr. Michael Nourbakhsh

J-67L
**Rockaway Family Dental**
200 E. Main Street
Suites A and B
Rockaway, NJ 07866
(973) 784-4749
Dr. Weimin Jin

## OCEAN

J-56T ♿
**Eastern Dental® of Ocean/ Monmouth**
2770 Hooper Avenue
Kennedy Plaza - Unit 4
Brick, NJ 08723
(732) 477-9200
Dr. Pier Cipriani
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Bassam Massabny
Dr. Mitchell Rubenstein
Dr. John Shavel
Dr. Ewa Tracz

J-65D ♿
**Eastern Dental® of Lacey, LLC**
131 South Main Street (Rte 9)
Forked River, NJ 08731
(609) 693-6066
Dr. Pier Cipriani
Dr. Joy Davis
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Bassam Massabny
Dr. Ewa Tracz

J-66V
**Yafa Walkin, DDS, LLC**
139 Ocean Avenue
Lakewood, NJ 08701
(732) 370-7771
Dr. Yafa Walkin

J-62J ♿
**Eastern Dental® of Toms River**
1228 Route 37 West
Toms River, NJ 08755
(732) 286-7020
Dr. Pier Cipriani
Dr. Joy Davis
Dr. Steven Feinstein
Dr. Paul Gottdenker
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Bassam Massabny
Dr. James Rodriguez

## PASSAIC

J-58K
***Eastern Dental® of Passaic/Essex***
251 Clifton Avenue
Clifton, NJ 07011
(973) 478-9300
Dr. Benedict Antonecchia
Dr. Pier Cipriani
Dr. Joseph Iavarone
Dr. Bassam Massabny
Dr. Anand Patel

J-57T
**Village Dental Associates**
213 Dayton Avenue
Clifton, NJ 07011
(973) 478-1807
Dr. Alexander Tolstunov

★J-58B ♿
**Park Dental PA**
21 Mill Street
Suite 3
Paterson, NJ 07501
(973) 742-7275
Dr. David Gamache

J-59B ♿
**Paterson Dental Group**
295 Broadway
Paterson, NJ 07501
(973) 742-4366
Dr. Steven Savino



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J-64K
**West Broadway Dental, PA**
West Broadway Dental, Pa
1 West Broadway
Paterson, NJ 07505
(973) 684-3803
Dr. John Pogoda
Dr. Mahir Saleh

J-64N ♿
***Willowbrook Mall Dental***
1445 Willowbrook Boulevard
Wayne, NJ 07470
(973) 812-4426
*Dr. Mal Fares*
Dr. Kurosh Haghighi
Dr. Ross Krasnov
Dr. Sofia Martirosov
Dr. Alexander Mikhailov
Dr. Vitaliy Valyuk

## SOMERSET

J-66W ♿
**Somerset St. Family Dental Ctr**
Mahavir Padmavti Corp
42 Somerset Street
Plainfield, NJ 07060
(908) 412-0891
Dr. Alpana Kaluskar
*Dr. Sunitha Murthy*

J-66P
**All-Star Dental, LLC**
1543 Route 27
Suite 202
Somerset, NJ 08873
(732) 418-5000
Dr. Syed Hussain

★J-56K
**Dr. Kevin Massarelli**
178 Mount Bethel Road
Warren, NJ 07059
(908) 647-8577
Dr. Kevin Massarelli

## UNION

J-65R
**Jersey Garden Dental, P.A.**
651 Kapkowski Road
Jersey Garden Mall
Elizabeth, NJ 07201
(908) 351-6996
Dr. Ross Krasnov
Dr. John Mamoun
Dr. Sofia Martirosov
Dr. Samir Patel
Dr. Prolay Paul
Dr. Shreyas Shah
Dr. Vitaliy Valyuk

J-67N ♿
**North Jersey Dental Center**
15 Prince Street
Elizabeth, NJ 07208
(908) 352-5205
Dr. Mira Peyyeti

J-52G ♿
**Eastern Dental® of Union**
2115 U. S. Highway 22 West
Union, NJ 07083
(908) 964-5406
Dr. Pier Ciprianl
Dr. Stephen Grober
Dr. Joseph Iavarone
Dr. Michael Kovall
Dr. Bassam Massabny
Dr. Faranak Yaghoubinejad

## WARREN

J-67W
**Star Dentistry PA**
423 Coventry Drive
Phillipsburg, NJ 08865
(908) 859-5111
Dr. Shirley Botchway-Manu



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# CONNECTICUT

## FAIRFIELD

C1744 ♿
**Town Center Dental**
100 Greyrock Place
Stamford, CT 06901
(203) 348-0300
Dr. Ross Krasnov
Dr. Sofia Martirosov
Dr. Alexander Mikhailov

## HARTFORD

C3307
**Westfarms Mall Dental, LLP**
213 West Farms Mall
Farmington, CT 06032
(860) 561-4400
Dr. Cristian Blejan
Dr. Alexander Mikhailov

## NEW HAVEN

C3306 ♿
***Brass Mill Mall Dental PC***
495 Union Street
Waterbury, CT 06706
(203) 574-2121
Dr. Serioja Constantin
Dr. Ross Krasnov
Dr. Rupin Malhotra
Dr. Michael Rakmanov



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# FLORIDA

## BROWARD

C3205
**Broward Mall Dental PA**
8000 West Broward Blvd
Plantation FL,33388
(954) 476-0802
Dr. John Nelson
Dr. Vadim Valdman

C3337
**Broward Family Dental Care**
6260 West Oakland Park Blvd
Sunrise FL,33313
(954) 742-7995
Dr. Sayed Fadavi

C9046
**Sawgrass Mills Mall Dental, P.A.**
12801 W. Sunrise Boulevard
Sunrise FL,33323
(954) 846-7171
Dr. John Nelson
Dr. Vadim Valdman

## DADE

C3204
**Miami International Mall Dental**
1455 NW 107th Avenue
Miami FL,33172
(305) 597-8787
Dr. Vadim Valdman

C1217
**Norman I. Abolsky, DDS**
12534 North Kendall Drive
Miami FL,33186
(305) 595-2335
Dr. Norman Abolsky

## MIAMI-DADE

C9045
***Westland Mall Dental, P.A.***
1665 W. 49th Street
Hialeah FL,33012
(305) 828-7779
Dr. Vadim Valdman



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# PENNSYLVANIA

## BUCKS

J-53R ♿
**Dr. Solomon Lehrhaupt**
229 Plaza Boulevard
Yardley, PA 19067
(215) 295-1348
Dr. Lehrhaupt Solomon

## NORTHAMPTON

JJ57G
**Dr. Lisa Jean Todes**
118 Cattell Street
Easton, PA 18042
(610) 258-2824
Dr. Lisa Jean Todes

## PHILADELPHIA

J-68A
**Franklin Mills Dental, LLP**
1120 Franklin Mills
Circle 456
Philadelphia, PA 19154
(215) 632-7700
Dr. Prolay Paul
Dr. Shreyas Shah

J-67P ♿
**Gallery Mall Dental**
9th and Markets Streets
Philadelphia, PA 19107
(215) 627-4290
Dr. Prolay Paul
Dr. Shreyas Shah



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2010 Retirement Incentive: Vision Benefits
(Civilian Represented & Non Represented)

# THE PORT AUTHORITY

OF NY & NJ

# VISION CARE BROCHURE

Administered by:

NVA®

National Vision Administrators

Effective: 01/01/98

The Port Authority of New York and New Jersey has selected NATIONAL VISION ADMINISTRATORS (NVA) as administrators of the Vision Benefit Program effective January 1, 1998. We have designed this Benefit Program along with NVA, an innovative leader in the field with your convenience in mind. NVA's highly qualified staff will assist you when needed.

Please read this brochure completely and keep it for future reference.

## HOW TO OBTAIN YOUR BENEFITS

NVA has a network of participating Ophthalmologists, Optometrists, and Opticians to serve you. A directory of local participating providers will be supplied to each eligible employee.

When making your appointment with an NVA Participating Provider, please notify them that your coverage is administered by NVA and sponsored by The Port Authority of New York and New Jersey. When you arrive for your vision care appointment, simply present your NVA Vision Care identification card. You do not need to obtain a vision claim form. The provider will telephone NVA to verify your vision care eligibility and inform you of your eligibility status prior to rendering services. To verify benefit eligibility yourself prior to scheduling your eye care appointment, you may contact NVA's Customer Service Department at the following toll free number **1-800-672-7723**.

## PARTICIPATING PROVIDERS

If you use a Participating Provider your eye exam will be covered in full. If corrective eyewear is necessary, you will be covered up to the plan allowance for lenses, frames or contact lenses after meeting a $25.00 materials deductable. Any costs exceeding the plan allowance are the responsibility of the patient.

## ELIGIBILITY

**EMPLOYEES:** Eligibility for and termination of benefits under this vision care plan is determined

by the same rules that apply to your other health care benefits. Benefits become effective on the 31st day after starting employment.

**DEPENDENTS** are defined as the spouse, unmarried dependent children through the end of the year in which they turn 19; unmarried dependent children who are full-time students through the end of the year in which they turn 26.

**HOW OFTEN BENEFITS ARE PROVIDED**
**EXAMINATION:** Once every calendar year
**LENSES:** Once every calendar year
***FRAMES:*** *Once every 2 calendar years*
**CONTACT LENSES:** Once every calendar year
This benefit includes disposables and is available in lieu of the lenses and frames benefit. (When contact lenses are selected the frame benefit is depleted for the following 2 calendar years).

***COVERED BENEFITS***
**VISION EXAMINATION:** A complete analysis of eyes and related structures; prescribing corrective lenses as needed.
**LENSES:** To correct vision problems - lenses may be plastic or impact resistant glass.
**FRAMES:** The plan offers a wide selection of frames, at no cost to you after the materials deductable is met.
**CONTACT LENSES:** The plan will contribute an allowance towards the purchase of contacts. (In lieu of lenses and frames.)
Medically Necessary Contacts: This enhanced allowance (within the plan limits) will be considered for payment by NVA when an NVA Participating Provider secures prior authorization for the following conditions: a) Following cataract surgery, b) To correct extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, c) Anisometropia, d) Keratoconus.

**VISION SERVICES AND MATERIALS THAT ADD EXTRA COSTS**
This plan is designed to cover your basic visual needs rather than cosmetic materials. Extra

materials that are not covered by the Plan may be purchased through the NVA participating doctor at a controlled cost.
Lenses - The wholesale cost plus 25%.
Example: Gradient Tint wholesale cost $10.00 plus 25% ($2.50) = $12.50
Frames - the difference between the wholesale cost of the frame and the maximum allowance plus 20% of the difference.
Example: $60.00 wholesale cost - $40.00 plan allowance = $20.00 difference. $20.00 difference + (20%) $4.00 = $24.00.

Photochromatic (gray and brown) light or dark; Tinted (other than Pink #1 or #2),gradient or fashion colors; Progressive or no-line multifocals; A frame costing more than the plan allowance; Coatings: Mirror, Anti-reflective, Super A.R., Color, Edge, Ultra Violet; Polish edges;Smart Segment; Scratch resistant (lab or manufacturer applied); Rimless; Polycarbonate; Prescription Sunglasses.

NON-COVERED ITEMS
There are no benefits for professional services or materials connected with:
Medical or surgical treatments (These may, however, be covered under your Medical Benefit Plan); Drugs or medications (These may, however, be covered by your Prescription Drug Plan);Non-prescription lenses including sunglasses; Examinations or materials not listed as a covered service; Replacement of lost, stolen, broken, or damaged lenses; Services or materials provided by Federal, State, Local Government or Worker's Compensation; Examination, procedures training or materials not listed; Industrial 3(mm) safety lenses and safety frames with side shields; Parts or repair of frame.

**NON-PARTICIPATING PROVIDERS**

If you select a non-participating provider you must pay the provider's full fee and obtain an itemized receipt which must contain the following information:

a) Cardmember's Identification Number
b) Patient's name
c) Date service began
d) The services and materials you received.
e) Signature of employee or spouse

Mail to:

**NVA**
**P.O. Box 2187**
**Clifton, NJ 07013**

**NON-PARTICIPATING REIMBURSEMENT SCHEDULE**

| | |
|---|---|
| Vision Examination with Tonometry | $35.00 |
| MATERIALS (pair) | |
| Single Vision Lenses, up to | $15.00 |
| Bifocal Lenses, up to | $25.00 |
| Trifocal Lenses, up to | $35.00 |
| Lenticular Lenses, up to | $60.00 |
| Frames, up to | $40.00 |
| **CONTACT LENSES** | |
| Contact Lenses, with exam up to Including Disposables | $75.00 |

Medically Necessary Contacts, up to the enhanced plan allowance.

THERE IS NO ASSURANCE THE NON-PARTICIPATING REIMBURSEMENT SCHEDULE WILL COVER THE ENTIRE COST OF THE EXAMINATION, LENSES, FRAMES OR CONTACTS.

This brochure is written in layman's language for your convenience. It is not intended to interpret, extend, or change the rules and regulations of the plan. Should any differences arise in

interpretation between the plan and this brochure, the plan shall govern.
Any and all questions or requests for information should be directed to:

**National Vision Administrators**
**P.O. Box 2187**
**Clifton, NJ 07013**
**Toll Free Line 800-672-7723**

**Contact Fill:** NVA provides you with the convenience and savings of Contact Fill, our mail order contact lens replacement service. You may access Contact Fill's services online at www.contactfill.com or by calling them toll-free at 866.234.1393. Contact Fill provides contact lens wearers with significant savings packaged with the convenience of home delivery. Plan discounts applicable at participating retail locations do not apply to purchases made through Contact Fill due to the already low prices.

**Plan Specific Details Online:** The NVA website is easy to use and provides the most up to date information for program participants:

- *Locate a nearby participating provider by name, zip code, or City/State*
- *Verify eligibility for you or a dependent*
- *View benefit program and specific details*
- *Review claims*
- *Print ID cards (when allowable)*
- *Nominate a non-participating provider to join the NVA network*

**THE PORT AUTHORITY OF NY & NJ**

ONE WORLD TRADE CENTER
NEW YORK, NY 10048

(212) 435-7000
(973) 961-6600

October 18, 1999

Dear Port Authority Employee:

The Port Authority of New York & New Jersey is conducting the annual health and dental benefits Open Enrollment now through November 19, 1999 for all employees. The options you choose in this Open Enrollment are *effective January 1, 2000*. Attached are a brief overview of the health (Attachments I, II, III) and dental (Attachment IV) plans available to you, and 'Typical Questions and Answers' (Attachment V). I am pleased to announce the following benefit plan enhancement:

**United HealthCare PPO Plan**

- Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

After reading the attached material:

If you wish to REMAIN in your present coverage, DO NOTHING.

If you are CHANGING health or dental coverage, please COMPLETE THE ATTACHED *BENEFIT SELECTION FORM*.

Please help us to get you enrolled properly by completing the *Benefit Selection Form* and returning it to Employee Benefits, 1WTC-61S no later than November 19, 1999. To avoid confusion and to ensure that the form is received by the due date, you can request that it be signed for upon receipt if sent through the internal PA mail. For outside delivery, you may want to request a return receipt.

If you have questions regarding a specific plan, please call the carrier directly (see Attachment VI). Employees with *general* questions can call Employee Benefits at (212) 435-6163. All coverage changes are *effective January 1, 2000* and remain in effect until the next open enrollment unless a change in family status occurs.

Sincerely,

Rosetta A. Jannotto
Manager, Employee Benefits
Human Resources Department

Attachments (represented employees)

Attachment I

## UNITED HEALTHCARE PLAN (PPO)
## OVERVIEW

The United HealthCare Preferred Provider Organization Plan (PPO) offers members complete freedom to use either a network provider or an out-of-network provider for medical and hospital care. Members who wish to use a network provider have a $5 co-payment, and can also see specialists or other physicians (for additional opinions) without a referral from a primary care physician. If the member uses an out-of-network provider, health care delivery resembles that of a traditional indemnity plan, subject to deductibles, co-insurance, and reimbursement at reasonable and customary rates. The PPO, in effect, is an indemnity plan with an in-network feature that can save you money.

A *Summary of Coverage* under the PPO plan is attached. Highlights include:

- Unlimited Lifetime Major Medical Maximum.
- No requirement to choose a primary care physician.
- No pre-certification required for hospital stays and emergency room services in- or out-of-network.
- Freedom to use a specialist (or any doctor) without having to obtain a referral.
- Full range of medical services including specialist care and outpatient surgery.
- Hospital coverage includes care in a semi-private room.
- Lab, x-ray and anesthesia costs reimbursed at 100% of reasonable and customary charges.
- Single carrier that pays for full hospital and surgical/major medical services.
- An annual physical exam ($5 co-pay) if you use a United HealthCare network physician.
- Routine pediatric care reimbursed at 100% in network and 100% of reasonable & customary charges out-of-network.
- A $5 co-payment if you use a United HealthCare network physician.
- If you utilize an out-of-network provider:
  - Reimbursement at 80% of reasonable and customary charges.
  - Annual deductibles of $50/100 for individual/family.
  - Out-of-pocket annual maximum of $1,000 (in addition to the deductible).

In addition, the United HealthCare PPO includes the following health promotion benefits through its OPTUM program:

- A 24-hour nurse advice line staffed with registered nurses and Masters level counselors who are able to answer your medical questions;
- A toll-free medical tape library with information on over 350 health topics;
- Six bi-monthly issues of *Taking Care*, an informative health care newsletter;
- A free copy of *Taking Care*, a self-help guide to your family's health care.

For additional information on the PPO plan, call United HealthCare directly (1-888-441-9815).

## COST OF PLAN

Contributions for this plan are not required at this time.

Attachment Ia

**United HealthCare**
**Summary of Coverage**
**Port Authority of NY & NJ**

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK * ** |
|---|---|---|
| Deductible – Single | None | $50 |
| Family | None | $100 |
| Coinsurance | None | 20% |
| Maximum Out-of-Pocket per person | Not Applicable | $1,000 (excluding deductible) |
| **PREVENTIVE CARE** | | |
| Physical Examination | $5 copay per visit | No coverage |
| Routine Pediatric Care | 100% coverage | 100% of Reasonable & Customary |
| **OUTPATIENT CARE** | | |
| Physician Office Visits | $5 copay per visit | Subject to Deductible & Coinsurance |
| Surgery | 100% coverage | 100% of Reasonable & Customary |
| Laboratory Services | 100% coverage | 100% of Reasonable & Customary |
| **HOSPITAL CARE** | | |
| Semi-private room & board | 100% coverage | 120 days at 100% balance paid at 80% |
| **EMERGENCY CARE** | | |
| Ambulance Services when medically necessary | No charge | No charge |
| **AT HOSPITAL EMERGENCY ROOM** | | |
| Accident Care, Serious Illness | 100% coverage | 100% coverage |
| **MATERNITY CARE** | | |
| Prenatal & Post-natal care | $5 copay per visit | 100% of Reasonable & Customary |
| Hospital services for mother & child | 100% coverage | 100% - 120 day maximum balance at 80% per stay |
| **SHORT TERM REHABILITATION** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOME HEALTH CARE** | | |
| 60 visits in and out-of- network combined | $5 copay per visit | Subject to Deductible & Coinsurance |
| **SKILLED NURSING FACILITY** | | |
| 60 days per year combined in and out-of-network | 100% coverage | Subject to Deductible & Coinsurance |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Inpatient - 7 days detoxification, 30 days per Year, 2 confinements per lifetime | 100% coverage | 100% coverage |
| **ALCOHOL/SUBSTANCE ABUSE** | | |
| Outpatient – 60 visits per year, 120 visits Per lifetime combined in and out-of- network | $5 copay per visit | Subject to Deductible & Coinsurance |
| **MENTAL HEALTH CARE** | | |
| Inpatient | 100% coverage | 100% 30 days per year balance paid at 80% |
| Outpatient | $10 copay per visit | Subject to Deductible & Coinsurance |
| **CHIROPRACTIC CARE** | $5 copay per visit | Subject to Deductible & Coinsurance |
| **HOSPICE CARE** | | |
| 210 days maximum | 100% coverage | 100% coverage |
| **INFERTILITY TREATMENT** | | |
| 3 Attempt Combined Limit | $5 copay per visit | Subject to Deductible & Coinsurance |
| **OTHER COVERAGE** | | |
| Durable Medical Equipment | 100% coverage | Subject to Deductible & Coinsurance |

* All Benefits are subject to Reasonable & Customary.
** All benefits must meet medical necessity.

# BTU/IBEW
# PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
# OVERVIEW

**THIS OPTION IS NOT AVAILABLE TO EMPLOYEES HIRED ON OR AFTER JANUARY 1, 1999.**

The Prudential/Blue Cross Traditional Indemnity Plan is designed to provide broad financial protection against hospital, doctor and related medical expenses. This plan offers members complete freedom in choosing their health care providers and facilities. Hospitalization is provided through Empire Blue Cross and Surgical/Major Medical coverage is provided by Prudential Insurance Company of America. Members of this plan are subject to an annual deductible of $50 for individual and $100 for family coverage. Eligible Major Medical expenses are reimbursed through Prudential Insurance Company at 80% of Reasonable and Customary Charges up to a $1,000,000 lifetime maximum per covered individual.

A more detailed explanation of this plan follows. For specific claim information, please contact the insurance carrier directly (see attached telephone directory).

## COST OF PLAN

Employees enrolled in this option will have a biweekly payroll deduction of $20 for individual and $40 for family coverage.

Employees may elect to have these deductions taken on a pre-tax basis by completing the Compensation Reduction Agreement section on the attached *Benefit Selection Form* and returning it to the Employee Benefits Division by November 19, 1999. Deductions on a pre-tax basis result in a lower taxable income so you pay less federal income tax and less state income tax (except in New Jersey). Also, depending on your salary level, you may pay less Social Security (FICA) tax as well.

If you prefer to have these deductions made on a post-tax basis, do not complete the Compensation Reduction Agreement section on the attached *Benefit Selection Form*.

## HOW TO ENROLL

To enroll in the Prudential/Blue Cross Traditional Indemnity Plan, complete the attached *Benefit Selection Form* and return it to the Employee Benefits Division, One WTC, 61 South, November 19, 1999.

## PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
(Continued)

**Employees who enroll in this plan will have a biweekly payroll deduction of $20 for individual and $40 for family coverage. Deductions will be effective January 1, 2000 and be reflected in your payroll check dated January 22, 2000.**

I. Plan provides basic coverage through Empire Blue Cross of Greater New York for:

A. Hospitalization
- 120 days paid at a semiprivate room rate for each period of confinement in a participating Blue Cross of Greater NY hospital.

B. Emergency Room Treatment (rendered in a participating Blue Cross of Greater N.Y. hospital by a salaried hospital staff member).
- Accidental Injury: within 72 hours of the injury
- Sudden and Serious: within 12 hours of the illness

II. Plan provides surgical/major medical coverage through The Prudential Insurance Company of America:

A. Surgical Procedures
- 100% reimbursement rate based on the reasonable and customary fee.

B. Major Medical Expenses
- 80% reimbursement rate based on the reasonable and customary fee for doctor visits, lab fees, and x-rays.
- The following primary and preventive care services are covered in full, for dependents from birth to age 19. That is, they are not subject to coinsurance or annual deductibles.
  - Initial hospital check-up for newborns.
  - Scheduled well-child visits.
  - Certain services at each well-child visit, such as physical examinations, developmental assessment and laboratory tests.
  - Appropriate immunizations including diphtheria, haemophilus, influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, and tetanus.
  - One preventive care visit every two years for children ages six up to their nineteenth birthday.
- Routine physical exams not covered.
- Vision and eye exams not covered.

## PRUDENTIAL/BLUE CROSS TRADITIONAL INDEMNITY PLAN
(Continued)

C. Mental and Nervous Coverage

- Inpatient hospital benefits are reimbursed at 100% up to 30 days in any 12-month period in a participating accredited non-governmental hospital. Confinements in excess of 30 days are reimbursed at 80%. Confinements in a non-participating hospital are reimbursed at 80%. All confinements in a non-participating hospital and/or those reimbursed at 80% are subject to the plan maximum as stated above and must be deemed medically necessary.
- Outpatient services will be reimbursed at 50% of reasonable and customary charges to a maximum of $45 per visit, with a fifty (50) visit annual limit.

D. Alcohol and Substance Abuse

| | |
|---|---|
| 1. Inpatient Alcohol: | 7 days detoxification reimbursed at 100%. 30 days inpatient rehabilitation reimbursed at 100%. One course of treatment in a 12-month period, twice per lifetime. |
| 2. Inpatient Substance Abuse: | 7 days detoxification and 30 days inpatient rehabilitation reimbursed at 100%, one course of treatment in 12-month period, twice per lifetime. |
| 3. Outpatient Rehabilitation: | 120 days per lifetime, combination of alcohol and substance abuse. 60-visit maximum per calendar year. Day 1-30 reimbursed at 100%, balance reimbursed at 80%. |

III. Group Health Deductibles/Maximums

A. Annual Deductibles

- Hospitalization - none
- Surgical - none
- Major Medical - $50 Individual/$100 Family

B. Major Medical Maximum - $1,000,000

- Lifetime Maximum (includes mental and nervous lifetime maximum).
- Each eligible dependent has their own major medical maximum.
- $5,000 cap - After the annual major medical deductible has been satisfied, an individual covered under the Major Medical Plan will be reimbursed at 80% of all reasonable and eligible medical expenses through the first of such expenses in a calendar year and, thereafter, for 100% of such expenses in the calendar year (dental claims not included).

Attachment III

# HEALTH MAINTENANCE ORGANIZATIONS (HMO) OVERVIEW

A Health Maintenance Organization (HMO) is a system of health care that provides managed, pre-paid hospital and medical services to its members. As an HMO member, all your care will be coordinated through a Primary Care Physician (PCP), who manages your health care needs. You can choose a physician from the HMO's provider directory that lists a network of doctors in your area. HMO members can receive health care at little or no out-of-pocket cost, provided they use network providers and facilities. There are no deductibles to meet or claim forms to file. In most HMOs, if a physician outside of the health plan is used without authorization from the HMO, the patient is responsible for all bills incurred.

The Port Authority offers the following HMOs:

- Health Insurance Plan of Greater New York (available to NY residents only);
- HMO Blue *Horizon Blue Cross Blue Shield of NJ* (available to NJ residents only);
- Prudential HealthCare HMO (available in CT, NJ, NY, and PA); and,
- Aetna US Healthcare (available in CT, NJ, NY, and PA).

A summary plan description is attached. For additional information please refer to the literature you may request by calling the specific carrier directly (see attached telephone directory).

## COST OF PLAN

Contributions for these plans are not required at this time.

## HOW TO ENROLL

To enroll in an HMO, complete the attached *Benefit Selection Form* and return it to the Employee Benefits Division, One WTC-61 South by November 19, 1999.

**Please Note:** An HMO will only allow you to enroll if they provide service to residents of your zip code. Please contact the carrier directly if you have any questions concerning service area (see attached telephone directory).

## HEALTH MAINTENANCE ORGANIZATION (HMO)
(Continued)

Plan provides basic/major medical coverage through the HMO of your choice. The available HMOs to choose from are:

- HIP New York
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*
- Prudential HealthCare HMO of New York, New Jersey, Pennsylvania and Connecticut
- Aetna US Healthcare of New York, New Jersey, Pennsylvania and Connecticut

Please note that if two Port Authority or PATH employees are married to each other, and they both choose the same HMO, they can only have one HMO contract which must cover both employees and all family members.

A. Hospitalization

Covered in full for unlimited number of days when approved by the HMO.

B. Emergency Room Treatment in the Hospital

Covered in full when service is approved and/or rendered by the HMO, subject to applicable co-payments as follows:

- HMO Blue *Horizon Blue Cross Blue Shield of NJ* has a $35 co-payment.
- Prudential HealthCare HMO has a $25 co-payment in New York and Connecticut and a $50 co-payment in New Jersey and Pennsylvania.
- Aetna US Healthcare has a $35 co-payment.

C. Surgical Procedures

Covered in full when approved by the HMO, including obstetrical care.

D. Major Medical Expenses

**Primary and Preventive Care:** covered in full subject to a $5 co-payment if you choose HMO Blue *Horizon Blue Cross Blue Shield of NJ*, Prudential HealthCare HMO or Aetna US Healthcare (except New Jersey*). HIP New York does not require a co-payment. Covers services such as routine illness and injury, physical exams, routine child care and well baby visits, immunizations (except those required for travel or work), gynecological exams and pap smears, x-rays, lab tests, routine mammograms.

***Note:** Under Aetna US Healthcare of New Jersey, primary care physician visits are covered in full subject to a $10 co-payment, specialty care office visits are covered in full subject to a $15 co-payment and preventive eye and gynecological exams are covered in full subject to a $15 co-payment.

## HEALTH MAINTENANCE ORGANIZATION (HMO)
(Continued)

**Hearing Exams:** Covered in full subject to the applicable co-payments as follows:

- HIP New York: no co-payment.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*: $5 co-payment.
- Prudential HealthCare HMO: $5 co-payment, but only available if the person is under age 18.
- Aetna US Healthcare: $5 co-payment.

**Vision Care:** Eye Exams covered in full subject to the applicable co-payment as follows:

- HIP New York: No co-payment.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*, Prudential HealthCare HMO and Aetna US Healthcare (except New Jersey): $5 co-payment.
- Aetna US Healthcare - New Jersey: $15 co-payment.

**Eye Glasses and Contact Lenses:** Covered as follows:

- HIP New York: Not available.
- HMO Blue *Horizon Blue Cross Blue Shield of NJ*: $50 reimbursement per 24 month period.
- Prudential HealthCare HMO: New Jersey only - available at discount rates in plan affiliated optical shops.
- Aetna US Healthcare: $35 reimbursement per 24 month period.

**Preventive Dental:** Covered as follows:

- HIP New York: Preventive and diagnostic services provided by a HIP New York participating dentist. There is a $5 co-payment for services. Each family member receives two exams (including 2 bitewing x-rays) every 6 months, and one application of fluoride per year for all children up to and including age 15 free of cost. There is a $5 co-payment for one cleaning per calendar year.
- Prudential HealthCare HMO: Not available.
- Aetna US Healthcare: Children through age 12 can visit a participating dentist for 2 routine exams per year. This includes an exam and cleaning, polishing and fluoride treatment. There is a $5 co-payment per visit.

## HMO HEALTH PLAN OPTIONS
(Continued)

E. Mental and Nervous Benefit Comparison

| | Inpatient | Outpatient |
|---|---|---|
| *HIP of* New York | Up to 30 days per year (combined with alcohol and drug services) paid in full. | Short term outpatient therapy. Paid in full |
| HMO Blue* (New Jersey) | 30 days per year paid in full. | 100% after a $25 copayment per visit with a limit of 20 days per year. |
| Prudential HMO (New York) | Up to 30 days per year paid in full. | Reimburses 70% with a 20 visit limit per year. |
| Prudential HMO (New Jersey) | Up to 30 days per year paid in full. | 100% after a $5 copayment per visit with a limit of 20 visits per year. |
| Prudential HMO (Connecticut) | Up to 60 days per year paid in full. | 100% after a $5 copayment per visit with a limit of 20 visits per year. |
| Aetna/ US Healthcare (New York) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |
| Aetna/ US Healthcare (New Jersey) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |
| Aetna/ US Healthcare (Connecticut) | 60 days per year covered in full. | 40 visits per year with $25 copayment per visit. |
| Aetna/ US Healthcare (Pennsylvania) | 35 days per 365 consecutive days, covered in full. | 20 visits per 365 consecutive days, with $25 copayment per visit or 50% of the fee, whichever is less. |

* Combined with Mental and Nervous benefit.

## HMO HEALTH PLAN OPTIONS
(Continued)

F. Alcohol and Substance Abuse Benefit Comparison

| | Inpatient Benefits | Outpatient Benefits |
|---|---|---|
| HIP/NY | Detoxification – Up to 30 days per year, covered In full. (Combined with inpatient mental and Nervous coverage)<br>Rehabilitation – Up to 30 days for alcoholism And/or drug abuse, covered in full. | Up to 60 visits per year for alcohol and drug rehabilitation. Covered in full. |
| HMO Blue *<br>(New Jersey) | Detoxification – Covered in full<br>Rehabilitation – Covered in full (combined 30 day limit) | After a $25 copayment, covered in full with a limit of 20 visits per year. |
| Prudential HMO<br>(New York) | Detoxification – Covered in full<br>Rehabilitation – Covered in full if medically Necessary. | After $5 copayment, covered in full up to 90 days per year for rehabilitative services. 20 family member out patient visits per year. |
| Prudential HMO<br>(New Jersey) | Detoxification – Covered in full<br>Rehabilitation – Covered in full up to 90 days per year if medically necessary. The 90-day limit is combined for in and out patient services. | After $5 copayment, covered in full if medically necessary. 90 day limit for rehabilitative services if medically necessary. The 90-day limit is combined for in and out patient services. |

* Combined with Mental and Nervous benefit.

## HMO HEALTH PLAN OPTIONS
(Continued)

F. Alcohol and Substance Abuse Benefit Comparison

| | Inpatient Benefits | Outpatient Benefits |
|---|---|---|
| Prudential HMO (Connecticut) | Detoxification – Covered in full<br>Rehabilitation – Covered in full if medically Necessary. | After $5 copayment per visit, covered in full up to 90 day for rehabilitative services if medically necessary. 20 family member visits per year. |
| Aetna/US Healthcare (New York) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – Not covered. | 60 visits per year with $5 copayment per visit. |
| Aetna/US Healthcare (New Jersey) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – Not covered. | Not Covered. |
| Aetna/US Healthcare (Connecticut) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – 45 days per year. | Not Covered. |
| Aetna/US Healthcare (Pennsylvania) | Detoxification – After $5 copayment, covered in full for acute phase.<br>Rehabilitation – 30 days per year, lifetime maximum 90 days. | 30 visits with $5 copayment and an additional 30 visits which may be exchanged for up to 15 inpatient days per year, lifetime maximum 120 visits. A 50% copayment of the costs of services applies to second and subsequent courses of treatment for residential care. |

Attachment IV

# DENTAL OPTIONS

## 1. PRUDENTIAL REASONABLE AND CUSTOMARY DENTAL PLAN

A. Dental Expenses
- 80% reimbursement rate based on reasonable and customary charges.
- Orthodontic expenses reimbursed under a fixed schedule of allowances only (will not be applicable toward your annual deductible as indicated below). One treatment per lifetime per eligible dependent under age 19.

B. Annual Dental Deductibles
- $50/Individual
- $100/Family

## 2. PRUDENTIAL SCHEDULE OF ALLOWANCES DENTAL PLAN

A. Expenses are reimbursed under a fixed schedule of allowances (see attached).

B. This plan does not require a deductible.

## 3. DENTCARE DENTAL PLAN

- Generally no out of pocket expenses (call Dentcare for brochure and exceptions).
- Must go to a designated Dentcare dentist.
- Pre-certification needed from the Dentcare Program for all major dental work done by a *Dentcare Dentist*.
- No deductibles.

If two Port Authority and/or PATH employees are married to each other, and they both choose Dentcare, they can only have one Dentcare plan which must cover both employees and all family members.

Port Authority Group Dental Plan
Schedule of Allowances

## Part I — Basic Services

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Diagnostic and Preventive Services** | |
| 0110 | 1. Clinical oral examination* | $ 10.00 |
| 1110 | 2. Cleaning, scaling and polishing* | 15.00 |
| 1210 | 3. Fluoride treatment (up to age 19)* | 8.00 |
| | 4. X-RAYS — individual total not to exceed the allowance for full-mouth series | |
| 0210 | (a) Full mouth or Panorex (at least 10 times)** | 15.00 |
| 0270 | (b) Bitewing, each | 3.00 |
| 0200 | (c) Periapical, single, each | 2.00 |
| 0240 | (d) Intra-oral occlusal (edentulous jaw), each | 7.00 |
| 0321 | (e) Temporo-mandibular joint film | 15.00 |
| 0340 | (f) Anterior/posterior; head and jaws | 15.00 |
| 0290 | (g) Lateral, head and jaws | 15.00 |
| | *Not more than twice annually | |
| | **Not more than once in three years | |
| | **Palliative Services** | |
| 9110 | Emergency treatment for relief of pain | 7.00 |
| | **Restorative Services** | |
| | 1. FILLINGS | |
| | *Silver Fillings* | |
| 2140 | (a) One surface | 12.00 |
| 2150 | (b) Two surfaces | 18.00 |
| 2160 | (c) Three or more surfaces | 27.00 |
| | Tooth Color Fillings | |
| 2330 | (d) Per filling | 12.00 |
| | 2. STAINLESS STEEL CROWN | |
| 2830 | each (up to age 19) | 25.00 |
| | **Oral Surgery (including X-rays, anesthesia and post-operative treatment)** | |
| | 1. EXTRACTIONS | |
| 7110 | (a) Routine or simple and surgical | 10.00 |
| 7220 | (b) Soft tissue impaction | 25.00 |
| 7235 | (c) Partial bony impaction | 40.00 |
| 7245 | (d) Complete bony impaction | 55.00 |
| | (e) Complex including bone removal and sutures | 30.00 |
| | 2. FRACTURES | |
| 7620 | (a) Upper jaw, closed reduction | 200.00 |
| 7640 | (b) Lower jaw, closed reduction | 225.00 |
| 7610 | (c) Upper jaw, open reduction | 300.00 |
| 7630 | (d) Lower jaw, open reduction | 300.00 |
| | 3. OTHER ORAL SURGICAL PROCEDURES | |
| 7430 | (a) Removal of cysts, including necessary extractions | 35.00 |
| 7340 | (b) Alveolectomy, maximum per arch | 30.00 |
| 3410 | (c) Apicoectomy | 35.00 |
| 7285 | (d) Biopsy, including report | 25.00 |
| 7960 | (e) Removal of labial frenum | 40.00 |
| 7260 | (f) Closure of oral antral fistula | 90.00 |
| | **Root Canal Treatment (including X-rays and follow-up care)** | |
| 3315 | 1. Filling one canal | 75.00 |
| 3325 | 2. Filling two canals | 100.00 |
| 3335 | 3. Filling three canals | 130.00 |
| | **Space Maintainers, simple (up to age 19)** | |
| 1510 | Any type | 50.00 |
| | **Periodontic Services (treatment of gums and associated tissues)** | |
| | 1. Periodontal root scaling and planing, including medications | |
| 4341 | (a) Fewer than 12 teeth per sitting | 15.00 |
| 4340 | (b) Per arch | 22.00 |
| | 2. Gum or bone surgery, including post-operative visits, (per quadrant) | |
| 4210 | | 90.00 |
| 4220 | 3. Subgingival curettage | 10.00 |

| | DENTAL SERVICES | MAXIMUM ALLOWANCE |
|---|---|---|
| | **Repair of Dentures and Bridges** | |
| | 1. Broken full or partial denture | |
| 5610 | (a) No tooth damage | $ 20.00 |
| 5620 | (b) Replace one tooth | 30.00 |
| 5630 | (c) Each additional tooth | 7.00 |
| | 2. Replace broken teeth only | |
| 5630 | (a) First tooth | 20.00 |
| 5640 | (b) Each additional | 7.00 |
| 5670 | 3. Reattaching undamaged clasp | 20.00 |
| 5680 | 4. Replacing broken clasp with new clasp | 45.00 |
| 5650 | 5. Adding tooth to partial denture to replace natural extracted tooth, each tooth | 35.00 |
| 5725 | 6. Rebasing upper or lower full or partial denture | 50.00 |
| 2920 | 7. Recement crowns and inlays | 6.00 |
| 6640 | 8. Repair broken facing | 15.00 |

## Part II — Major Services

| | | |
|---|---|---|
| | **Inlays, Gold** | |
| 2510 | 1. One surface | 50.00 |
| 2520 | 2. Two surfaces | 80.00 |
| 2530 | 3. Three or more surfaces, maximum per tooth | 90.00 |
| | **Dentures, Full (including supplying, inserting, fitting and adjustments)** | |
| 5110 | 1. Upper, once in five years | 175.00 |
| 5120 | 2. Lower, once in five years | 175.00 |
| | **Dentures, Partial** | |
| 5220 | 1. Bilateral acrylic or comparable base, either jaw, two or more full clasps and rests, each | 170.00 |
| 5250 | 2. Upper bilateral, chrome cobalt alloy or gold base, two or more clasps and rests, acrylic attachments, each | 200.00 |
| 5230 | 3. Lower, bilateral chrome cobalt alloy or gold base, two or more cast clasps and tests, acrylic attachments, each | 200.00 |
| | **Crowns and Bridgework** | |
| | 1. Bridgework, Removable (one piece casing with clasps and rests) | |
| 5280 | (a) One tooth replaced | 100.00 |
| 5280 | (b) Two teeth replaced | 110.00 |
| | 2. Bridgework, Fixed (single abutments only) | |
| 6780 | (a) 3/4 crown | 85.00 |
| 6790 | (b) Full cast crown | 110.00 |
| 6720 | (c) Full cast with veneer | 140.00 |
| | 3. Pontics | |
| 6230 | (a) Tru-pontic (porcelain or acrylic facing with cast backing) | 95.00 |
| 6210 | (b) Pontic of other type | 85.00 |
| | 4. Crowns | |
| 2740 | (a) Porcelain jacket | 150.00 |
| 2710 | (b) Acrylic jacket | 115.00 |

## Part III — Orthodontic Services

8410 Initial appliance, X-rays, diagnosis, study models, etc. Maximum — $150

Active treatment $35 per month. Not to exceed $840.00

Passive treatment, per 6 month period — $15. Maximum of 3 periods, Total — $45.

Total benefits available ..... $1035 per course of treatment

Note: If a charge is incurred for a service not included in the Schedule, in connection with the dental care of a specific condition, and if the Schedule [illegible] services which, according to customary dental prac- [illegible] charge for the least expensive of the suitable services included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.

Attachment V

## TYPICAL QUESTIONS AND ANSWERS

### 1. HOW DO I CHANGE MY COVERAGE?

If you wish to change your current coverage, please complete the attached *Benefit Selection Form* and return it to Employee Benefits, One WTC-61 South by **Friday, November 19, 1999**. To allow enough time to process your change with the carrier, forms must be received by November 19, 1999.

### 2. WHEN WILL MY NEW COVERAGE BEGIN?

Your new coverage will begin on **January 1, 2000**. All changes in health/dental coverage will be considered final and will remain in effect until the next open enrollment period.

### 3. WHAT IF I DON'T WANT TO CHANGE MY CURRENT COVERAGE?

You will automatically be continued in your present plans if no *Benefit Selection Form* is received.

### 4. HOW CAN I FIND OUT WHAT MY CURRENT COVERAGE IS?

If you are not sure which plan you are enrolled in, call Employee Benefits at (212) 435-6163.

### 5. DID THE TAKEOVER OF PRUDENTIAL HEALTHCARE BY AETNA RESULT IN ANY CHANGES?

While it may not result in changes to the level of benefits currently offered by Prudential, it may affect the level of service.

### 6. WHAT IS A PPO?

A PPO (Preferred Provider Organization) offers the best features of both a traditional indemnity plan and managed care by giving members the freedom to use any provider, either in-network or out-of-network, for medical and hospital care without requiring a referral from a primary care physician to use a specialist.

### 7. WHAT IS A NETWORK PROVIDER?

A network provider is one who participates in a network and has agreed to charge preferred rates for members who seek care. The network includes a broad range of providers including Family Practitioners, Internists, Pediatricians, Neurologists, Oncologists and OB/GYNs. Additionally, the network includes labs, X-ray facilities and mental health providers. Again, you are not restricted to only use network providers.

### 8. WHAT IS THE DIFFERENCE BETWEEN PPO AND HMO PLANS?

The difference is that the PPO is <u>not</u> a managed care plan. You are not required to choose a Primary Care Physician and you will be reimbursed if you use an out-of-network physician under a PPO plan. This allows you and your family direct access to all specialists.

## 9. HOW DO I FIND OUT IF MY DOCTOR IS A MEMBER OF THE UNITED HEALTHCARE PPO NETWORK?

- Check the Provider Directory available directly from United HealthCare;
- Call United HealthCare Member Services at 1-888-441-9815 (select the option to speak with a customer services representative) or call your doctor and ask;
- Check the Internet (www.unitedhealthcare.com). This will also give you directions and an easy to read color map showing the provider's location;

## 10. WHAT IF MY DOCTOR IS NOT A MEMBER OF THE UNITED HEALTHCARE NETWORK?

If you wish to encourage your doctor to join the United HealthCare network, simply have your doctor call United HealthCare Network/Provider Services at 1-800-638-8075 to obtain an application. Due to the thorough credentialing process, in which United checks or verifies board certification, training and education, hospital affiliation and malpractice status, the process can take up to 180 days. However, you can *still* go to your doctor as an out-of-network provider and be reimbursed at 80% of reasonable and customary charges.

## 11. HOW DO I GET UNITED HEALTHCARE OUT-OF-NETWORK CLAIM FORMS?

Your department can obtain claim forms through Corporate Express or you can call United HealthCare. Claim forms are also included with United's reimbursement materials.

## 12. WILL I BE REQUIRED TO CONTRIBUTE FOR MY HEALTH AND/OR DENTAL COVERAGE?

There are no employee contributions necessary for coverage through United HealthCare, any of the HMO's or any of the dental options at this time. Employees who choose or remain in the Prudential/Blue Cross Traditional Indemnity Plan, and are currently contributing to their health coverage, can refer to the Prudential/Blue Cross Traditional Indemnity Plan Overview section of this package for biweekly pre-tax or post-tax contribution rates.

## 13. HOW DOES PRE- AND POST-TAX WORK?

Employees required to contribute to the cost of their health coverage can elect to have these contributions taken out on pre-tax basis by completing the Compensation Reduction Agreement section on the attached *Benefit Selection Form*. Contributions on a pre-tax basis result in a lower taxable income so you pay less Federal Income Tax and less NY State Income Tax. (NJ taxable income is not affected.) If you are currently having deductions taken out on a pre-tax basis and wish to continue doing so, you do not need to complete a new *Benefit Selection Form*.

## 14. HOW DOES PRE- AND POST-TAX AFFECT RETIREMENT?

Your full gross salary is reported to the New York State & Local Employees Retirement System regardless of whether you select pre- or post-tax contributions.

## 15. IF I SWITCH OUT OF THE PRUDENTIAL TRADITIONAL INDEMNITY PLAN, WHEN WILL MY EMPLOYEE CONTRIBUTION STOP?

The last deduction from your paycheck will be on January 22, 2000 (which, due to the retrospective payroll, covers the December 26, 1999 to January 8th period).

## 16. HOW WILL MY PRESCRIPTIONS BE FILLED?

National Prescription Administrators, Inc. (NPA) provides your prescription benefit regardless of the health plan selected. The cost of each prescription is either $2 for generic brand drugs or $5 for name brand. For specific information or questions, please contact NPA directly at 1-800-467-2006.

**Important Note:** CWA 1032 employees who choose or remain in the United HealthCare PPO plan will have the NPA prescription plan. However, if you chose the Prudential Traditional Indemnity Plan or any of the HMO's, your prescription benefit will be provided by that specific carrier.

## 17. WILL MY DENTAL INSURANCE PLAN CHANGE IF I SWITCH HEALTH PLANS?

No. Your dental plan will remain the same unless you choose one of the other dental options available to you on the *Benefits Selection Form*.

## 18. ARE PRE-EXISTING CONDITIONS COVERED?

Yes. There is no pre-existing condition limitation under any of the current healthcare coverage plans.

## 19. DO I NEED TO PRE-CERTIFY HOSPITAL ADMISSION UNDER UNITED HEALTHCARE'S PPO PLAN?

No. Pre-certification for hospital stays and emergency room services is not required in- or out-of-network.

## 20. WHO IS AN ELIGIBLE DEPENDENT?

For this purpose, eligible dependents are defined as an employee's spouse or dependent children. Dependent children are covered until the end of the calendar year in which the child turns age 19. This coverage can extend through the end of the calendar year in which the child turns age 26 provided the child is unmarried, in full-time attendance at an accredited educational institution, and dependent on the employee for support. However, your health carriers will require you to provide verification of your child's full-time student status. Domestic partners, parents and grandchildren are not considered eligible for this purpose.

## 21. HOW CAN I ADD OR REMOVE DEPENDENTS FROM MY COVERAGE?

You can add or remove eligible dependents from your coverage by completing the enclosed *Benefit Selection Form* and returning it to Employee Benefits within thirty (30) days of a change in family status. However, you will be required to provide applicable documentation (i.e. state marriage certificate, divorce decree, birth certificate for children, etc.) in order for the change to be made. Failure to notify Employee Benefits within the required time frame will result in having your request denied by the insurance carrier, and you will not be permitted to add your dependents(s) to your plan coverage until the next open enrollment period.

## 22. WHAT IS A CHANGE IN FAMILY STATUS?

For this purpose, a change in status includes the marriage or divorce of the employee, death of the employee's spouse or dependent children, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, switching from part-time to full-time employment status (or vice versa) by the employee or the employee's spouse, taking of an unpaid leave

of absence by the employee or the employee's spouse, or a significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment.

## 23. HOW DO I CHANGE MY DENTCARE DENTIST, HIP CENTER, PRIMARY CARE PHYSICIAN OR PHARMACY?

Please contact your health and/or dental carriers directly for instructions.

## 24. HOW CAN I OBTAIN A PROVIDER DIRECTORY?

You can obtain a Provider Directory by contacting the specific carrier directly. A list of telephone numbers is attached to this package.

## 25. CAN I WAIVE MY RIGHT TO GROUP HEALTH AND/OR DENTAL BENEFITS?

Yes, provided you are covered by other insurance, such as a spouse's plan. Should you choose to waive your right to coverage, you must complete the Benefits Waiver Section on the attached *Benefit Selection Form* and provide proof of coverage by another carrier. However, you should note that if you waive your health benefits you must also waive your dental benefits and vice versa.

## 26. IF I WAIVE COVERAGE NOW, WILL I BE ABLE TO OBTAIN COVERAGE LATER ?

Yes, provided that a change in family status has occurred within the past thirty (30) days. Otherwise, you will not be permitted to enroll until the next open enrollment period.

## 27. WHO DO I CALL WITH GENERAL QUESTIONS?

You can call Employee Benefits at 212-435-6163.

Attachment VI

# TELEPHONE DIRECTORY

## Health Coverage

| | | |
|---|---|---|
| United HealthCare | 1-888-441-9815 | |
| Prudential Indemnity Plan | 1-800-772-4683 | |
| Empire Blue Cross Blue Shield | 1-800-662-5193 | |
| HIP New York | 1-800-447-8632 | |
| HMO Blue<br>*Horizon Blue Cross Blue Shield of NJ* | 1-800-722-2583 | |
| Prudential Healthcare HMO | 1-800-422-7399 | |
| Aetna/U.S. Healthcare | 1-800-323-9930<br>1-888-277-8742 | Information<br>Enrollment Packages |
| | **PIN Number in NJ:** | **111** |
| | **PIN Number in NY & other states:** | **112** |

## Dental Coverage

| | |
|---|---|
| Prudential Dental | 1-800-772-4683 |
| Dentcare | 1-800-468-0600 |

THE PORT AUTHORITY OF NY & NJ

# The Port Authority of New York & New Jersey and Port Authority Trans-Hudson Corporation

## Medical Plans

PORT AUTHORITY
TRANS-HUDSON CORPORATION

UNITEDhealthcare®

82290073 - 197512 for The Port Authority of New York & New Jersey
and 197944 for Port Authority Trans-Hudson Corporation

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# Schedule of Benefits

## Effective Date of these Plans

**September 1, 1998**

## Medical Benefits

| **Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up To The Dollar Amount And/Or Number Of Days Shown Below.** | | |
|---|---|---|
| | **Network** | **Non-Network** |
| Hospital Services<br>In-Patient<br>Hospital's regular semi-private rate (See ***NOTE**)<br><br>Room and Board<br><br>Maximum Payment Period<br>*Other Fees (incurred on days that payment is* made for Room and Board)<br><br>Other Fees include:<br>- Hospital charges for anesthetics<br>- Hospital charges for giving anesthetics<br>- Charges for transportation to and from the Hospital by professional ambulance<br>- Hospital charges for Other Services and Supplies<br>- Hospital Pre-Admission Tests<br><br>Out-Patient Benefits | Unlimited<br><br>Unlimited | 120 days for *Each Cause*<br>Full Amount<br><br>Unlimited |
| Emergency Room Care | Full Amount | |
| Ambulatory Surgical Center Services | Full Amount | |
| Physician's Services for Surgery<br>Surgeon's Fees<br>Anesthesiologist's Fees<br>Assistant Surgeon's Fees (See page 19) | 100% | 100% Reasonable Charge |
| Laboratory Tests and X-Rays, including one mammogram and one Pap smear per Calendar Year. | 100% | 100% Reasonable Charge |
| Routine Well Baby Care | 100% | 100% Reasonable Charge |
| Hospice Care up to 210 days lifetime | 100% | 100% Reasonable Charge |
| Surgery for Temporomandibular Joint Dysfunction | None | 100% Reasonable Charge |

***NOTE:**

There is maximum number of 120 days for each Non-Network Hospital confinement.

A new maximum of 120 days of Hospital confinements applies:

- 90 days after your last confinement for the same cause or
- If the cause of the later confinement or surgical procedure is a new disability and is completely different from the disability which caused the first *confinement or surgical procedure.*

| Covered Expenses Subject To The Deductible/Copayment | | |
|---|---|---|
| **Maximum Benefits** | | |
| | **Network** | **Non-Network** |
| Lifetime Maximum Benefit | Unlimited | |
| Hearing Loss Benefit per Calendar Year | N/A | $200 |
| **Deductibles/Copayments/Out-of-Pocket** | | |
| Individual Deductible per Calendar Year | N/A | $50 |
| Family Deductible per Calendar Year | N/A | $100 |
| Physician Office Visits Copayment | $5 | N/A |
| Individual Out-of-Pocket Maximum per Calendar Year | N/A | $1,000 |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | | |
| Hearing Loss Benefit | None | 80% |
| Temporomandibular Joint Dysfunction services | None | 80% |
| Emergency Room Care for Non-Emergency treatment | 80% | |
| **All Other Covered Expenses for Medical Benefits** | 100% | 80% |
| **Percentage of Covered Expenses Payable after the Out-of-Pocket Maximum is reached** | 100% | 100% |

Benefits for Organ/Tissue Transplants performed at a Designated Transplant Facility are payable at 100% of Covered Expenses.

Benefits for Organ/Tissue Transplants performed at a Non-Designated Transplant Facility are payable at Plan benefits, subject to the deductible.

## Mental Disorder Treatment and Alcohol or Substance Abuse Treatment

| Mental Disorder Treatment | | |
|---|---|---|
| **Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up To The Maximums Shown Below** | | |
| | **Network** | **Non-Network** |
| **Lifetime Maximum Benefits** | Unlimited | |
| **Calendar Year Maximum Benefits** | | |
| Inpatient | 30 days | |
| Outpatient | None | |
| **Covered Expenses subject to The Deductible/Copayment. Covered Expenses are subject to the same Cash Deductible as Medical Benefits** | | |
| Inpatient | Unlimited | |
| Outpatient | Unlimited | |
| Copayment for Outpatient Treatment | $10 | None |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | 100% | 80% |
| ***Alcohol or Substance Abuse Treatment*** | | |
| **Covered Expenses Are Payable At 100% Of Reasonable Charge (See Glossary) Up To The Maximums Shown Below** | | |
| **Lifetime Maximum Benefits** | Two (2) Confinements | |
| **Calendar Year Maximum Benefits** | | |
| Inpatient | | |
| Alcohol or Substance Abuse Treatment | | |
| • Detoxification Treatment | 7 days | |
| • All other Covered Expense | 30 days | |
| Outpatient | None | |
| **Covered Expenses Subject To The Deductible/copayment. Covered Expenses Are Subject To The Same Cash Deductible As Medical Benefits.** | | |
| **Outpatient** | | |
| Alcohol or Substance Abuse Treatment - Lifetime | 120 visits | |
| Alcohol or Substance Abuse Treatment - Calendar Year | 60 visits | |
| **Copayment for outpatient services** | $5 | None |
| **Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied** | 100% | 80% |
| **Percentage Of Covered Expenses Payable After The Out-of-Pocket Maximum Is Reached For All Mental Disorder Treatment and Alcohol or Substance Abuse Treatment - 100%** | | |

## Pregnancy Benefits

Pregnancy Benefits are payable in the same manner as Medical Benefits.

## Preventive Health Care Benefits

Preventive Health Care Benefits are payable in the same manner as Medical Benefits. See page 23.

| Percentage of Reasonable Charge Payable After Deductibles/Copayments are Satisfied | | |
|---|---|---|
| | **Network** | **Non-Network** |
| Routine physical exam for covered Employees and Dependent spouses, including diagnostic tests and immunizations | 100% | None |
| Routine pediatric care to age 19, including PKU tests and immunizations | 100% | 100% |

## Family Planning Benefits

Family Planning Benefits are payable in the same manner as Medical Benefits

## End of Schedule of Benefits

# Coverage under the Former Plans

This section applies only to persons covered under the prior Plans of the Employer (called the Former Plans) in effect on the day before the Effective Date of coverage under these Plans. The coverage described in this booklet replaces the coverage under the Former Plans.

Coverage and benefits paid under the Former Plans will be considered as *coverage and benefits paid under these Plans for figuring the following under any* benefits of these Plans:

- Benefit limits and maximum amounts. Any Covered Expenses applied toward the benefit limits or maximum amounts under the Former Plans are applied to those same benefit limits or maximum amounts under these Plans.
- Coinsurance percentage.

A person may have satisfied or partially satisfied a deductible requirement under the Former Plans. Expenses counted toward the deductible under the Former Plans will be counted toward any annual deductible under these Plans. They will be counted under these Plans the same way they were counted under the Former Plans.

Certain children are included as Eligible Dependents under these Plans regardless of age. The child must have been covered under the Former Plans. The child must meet the following conditions:

- The child is mentally or physically incapacitated.
- The child is not capable of self-support.
- The child depends on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested.

# Eligibility

## Eligible Employees

All full-time and some part-time Employees of the Employer. Employees *represented for collective negotiations or bargaining may be eligible under the* terms of their agreements.

## Eligible Dependents

A Dependent is a *Qualified Dependent* of an eligible Employee.

1. Qualified Dependent means, among other things, the spouse of an Employee, excluding, in any case:
   - a spouse who is also covered as an Employee under any group medical benefits provided by the Employer,
   - a legally separated or divorced spouse (or one whose marriage has been annulled), unless:
     - the Employee is legally responsible for the support of such legally separated or divorced spouse, and
     - the legally separated or divorced spouse has not remarried, and
     - the Employee has not remarried or, if remarried, has not notified the Employer in writing that such legally separated or divorced spouse should continue to be covered as a Qualified Dependent.

   If the Employee is remarried, a divorced spouse and a current spouse may in no event both be simultaneously covered as a Qualified Dependent.

   The option to cover a legally separated or divorced spouse rather than a current spouse after the Employee remarries may be exercised only once by the Employee.

2. An Eligible Employee's unmarried child from birth through the last day of the Calendar Year in which the child turns age 19.

   An eligible Employee's unmarried child under age 26 through the last day of the Calendar Year in which the child reaches age 26, if the child is a registered student in regular full-time attendance at school. The child must be residing with and mainly dependent on the Employee for care and support. The child cannot be employed on a regular full-time basis by one or more employers for a total of 30 or more hours per week.

   Child includes the following:
   - A stepchild who resides in the eligible Employee's home. The Employee must verify financial support.
   - A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)

## Cost of Coverage

The coverage under these Plans is non-contributory. This means that the Employer pays for the full cost of the coverage for active and retired employees.

## Enrollment Requirements

**Employee Coverage**

An Employee enrolls for Employee coverage by:

- completing an enrollment form, and
- giving the form to the Employer.

An Employee's enrollment is either timely or late.

An Employee is considered a timely enrollee if he or she enrolls during either the Initial Eligibility Period or a Special Enrollment Period.

An Employee is considered a late enrollee when he or she enrolls during the Annual Enrollment Period. See Enrollment Periods below.

**Dependent Coverage**

An Employee must enroll for coverage as an Employee in order to enroll his or her Dependents. If a husband and wife are both eligible Employees, only one may enroll their Dependents for coverage.

No person can be covered both as an Employee and as a Dependent under any group medical and dental health Plan of the Employer.

Initial Dependents are those family members who are eligible Dependents on the *date the Employee first becomes eligible for Employee coverage.*

Subsequent Dependents are family members who become Eligible Dependents after the date the Employee first becomes eligible under one of these Plans. Subsequent Dependents may be added during a Special Enrollment Period.

A Dependent's enrollment is either timely or late.

A Dependent is considered a timely enrollee when he or she is enrolled for coverage during either the Initial Eligibility Period or a Special Enrollment Period.

A Dependent is considered a late enrollee when he or she enrolls during the Annual Enrollment Period.

## Enrollment Periods

The Initial Eligibility Period is the 31-day period which begins on the date the Employee or Dependent is first eligible under these Plans.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Annual Enrollment Period to enroll for coverage.

The Annual Enrollment Period is designated by the Employer each year. It is held before the start of each Plan Year. During this period, all eligible Employees and Dependents can enroll for coverage.

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents.

A Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under one of these Plans was previously offered to the Employee or Dependent.
- The Employee's or Dependent's prior coverage was one of the following:
  - COBRA continuation which was exhausted.
  - Non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated or the contract was cancelled.
- The Employee requests enrollment under one of these Plans not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of Employer contribution.

A Special Enrollment Period is available to Subsequent Dependents. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

**Late Enrollees**

A late enrollee can enroll only during an Annual Enrollment Period.

## Effective Date of Employee Coverage

Employee coverage is effective on the date coincident with or next following the latest of:

- The Effective Date shown in **Schedule of Benefits**.
- The date the Employee enrolls for coverage.
- The date following the day the Employee completes a Waiting Period of 30 days of continuous service with the Employer.

## Effective Date of Dependent Coverage

Coverage for Initial Dependents is effective on the date coincident with or next following the later of:

- The date the Employee becomes covered.
- The date the Employee enrolls the Dependents.

Coverage for a Subsequent Dependent is effective as follows:

- For a spouses, the later of the date the spouse is enrolled and the date of the marriage;
- For a newborn, the date of birth; or
- For an adopted child, the date of adoption or placement for adoption.

### Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for his/her children, these children can be enrolled as timely enrollees as required by OBRA 93.

### Special Provision for Newborn Children

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

The Employee must enroll the child during the 31-day Special Enrollment Period in order for the child to be a timely enrollee and covered beyond the 31 day period.

## Medical Benefits

Medical Benefits are payable for Covered Expenses incurred by the Covered Person while covered under these Plans.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Covered Services and Supplies listed in this Benefit. The Company, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with both of the following:

- The methodologies in the most recent edition of the Current Procedural Terminology.
- The methodologies as reported by generally recognized professionals or publications.

The Covered Expenses must be incurred for the care of an accidental injury or sickness. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

Each Covered Person must satisfy certain Copayments and/or Deductibles in connection with any payment made for certain Covered Services and Supplies. Then these Plans pay the percentage of Covered Expenses shown in the **Schedule of Benefits**.

After coverage under these Plans end, Medical Benefits may be payable as shown in **Extended Benefits**. See page 36.

Covered Services and Supplies for pregnancy are shown in **Pregnancy Benefits**.

Covered Services and Supplies for Mental Disorder Treatment are shown in **Mental Disorder Treatment and Alcohol or Substance Abuse Treatment Benefits**.

Covered Services and Supplies for Family Planning Benefits are shown in **Family Planning Benefits.**

## Copayments and Deductibles

Before Medical Benefits are payable, each Covered Person must satisfy certain Copayments and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Copayments are not counted toward any Deductible. Covered Services and Supplies which require a Copayment are not subject to a Deductible.

A Deductible is the amount of Covered Expenses the Covered Person must pay before Medical Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentage shown in the **Schedule of Benefits**.

The amount of each Copayment/Deductible is shown in the **Schedule of Benefits**. A Covered Expense can only be used to satisfy one copayment or deductible.

### Individual Deductible

The Individual Deductible applies to all Covered Expenses provided by a Non-Network Provider except as shown in **Schedule of Benefits**. It applies each Calendar Year.

Any Covered Expenses a Covered Person incurs during October, November and December of a year which count toward that person's Individual Deductible for that year will also count toward that person's Individual Deductible for the next year.

### Family Deductible

The most a family will have to pay for Individual Deductibles in any Calendar Year is the amount of the Family Deductible. The Family Deductible applies no matter how large a family may be. Only Covered Expenses which count toward a Covered Person's Individual Deductible count toward this Deductible.

### Physician Office Visit Copayment

The Physician Office Visit Copayment applies to Network Physician's Services. It also applies to Network physical therapist's services if the physical therapist bills for his/her services separately from any other charges. It applies to all Covered Services and Supplies given in connection with each office visit.

## Out-of-Pocket Feature

Covered Expenses are payable at the percentage shown in the **Schedule of Benefits** until any Out-of-Pocket Maximum shown in the **Schedule of Benefits** has been reached during a Calendar Year. Then, Covered Expenses are payable at 100% for the rest of that year as shown below.

All Covered Expenses that the Covered Person pays, other than those shown below, count toward the Out-of-Pocket Maximums.

Covered Expenses used to satisfy the following Copayment and/or Deductibles do not count toward any of the Out-of-Pocket Maximums. These Deductibles and Copayments still apply even after the applicable Out-of-Pocket Maximum has been reached:

- Physician Office Visit Copayment.
- Individual Deductible.
- Family Deductible.

### Individual Out-of-Pocket Maximum

When the Individual Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, Covered Expenses, other than those shown in the Out-of-Pocket Feature, are payable at 100% for that same person for the rest of that year.

## Covered Services and Supplies

Covered Services and Supplies must be Medically Necessary and given for the diagnosis or treatment of an accidental injury or sickness.

A *Covered Person and his or her Physician decide which services and supplies are* given, but these Plans only pay for the following Covered Services and Supplies which are Medically Necessary as determined by the Company.

Covered Services and Supplies also include services and supplies that are part of an Alternate Care Proposal (ACP). An ACP is a voluntary course of treatment developed by the Company and accepted by the Employee and attending Physician as an alternative to the services and supplies that would otherwise have been considered Covered Services and Supplies.

Unless the ACP specifies otherwise, the provisions of these Plans related to benefit amounts, maximum amounts, copayments and deductibles will apply to these services.

### Acupuncture Treatment

Covered Expenses for treatment provided by a Physician.

### Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

### Anesthetics

### Chemotherapy

### Durable Medical Equipment

Durable Medical Equipment means equipment which meets all of the following:

- It is for repeated use and is not a consumable or disposable item.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of Durable Medical Equipment are:

- Appliances which replace a lost body organ or part or help an impaired one to work.
- Orthicon devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

The Company decides whether to cover the purchase or rental of the equipment.

## Enteral Formulas

Written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which is left untreated, cause chronic disability, mental retardation or death.

Benefits are payable for enteral formulas for home use for which a Physician has issued a written order. The order must state that the enteral formula is necessary as a disease-specific treatment regimen for diseases which include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive, disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which is left untreated will cause malnourishment, chronic physical disability, mental retardation or death.

Coverage for certain inherited diseases of amino acid and organic metabolism shall include modified solid food products that are low protein, or which contain modified protein which are medically necessary. Coverage for modified solid food products for any calendar year or any continuous period of twelve months for any covered person shall not exceed $2,500.

## Foot Care

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a Covered Service only if needed due to severe systemic disease.

## Hearing Loss

The following are Covered Services and Supplies:

- Necessary test to prove there is a hearing loss.
- Necessary test to show where the hearing loss is.
- Charges for a permanent hearing aid.

Payment for all Covered Services and Supplies for Hearing Loss is subject to Calendar Year Maximum of $200 for each Covered Person.

## Home Health Care

The following Covered Services must be given by a Home Health Care Agency:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy.
- Occupational therapy.
- Speech Therapy.

Covered Services are limited to 200 combined Network and Non-Network visits each Calendar Year. Each period of home health aide care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit.

## Hospice Care

- Room and Board, up to 210 days.
- Other Services and Supplies.
- Part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Home Health Care Services as shown under Home Health Care. The limit on the number of visits shown under Home Health Care does not apply to Hospice patients.
- Counseling for the patient and Covered Family Members.
- Bereavement counseling for Covered Family Members. Services must be given within six months after the patient's death. Covered Services are limited to a total of 15 visits for each family.

Counseling must be given by a Licensed Counselor.

Services for the patient must be given in an inpatient Hospice facility or in the patient's home.

The Physician must certify that the patient is terminally ill with six months or less to live.

Any counseling services given in connection with a terminal illness will not be considered as Mental Disorder Treatment.

## Hospital Services

- Room and Board.

  Covered Expenses for a private room are limited to the regular daily charge made by the Hospital for a semi-private room.
- Other Services and Supplies.
- Emergency Room.

  Emergency room services are Covered Services payable at 100% only if it is determined that the services are Medically Necessary and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services.

  Emergency Room services for non-emergency care are payable at 80%.

## Infertility Treatment

Diagnosis and treatment of infertility, including surgery and inpatient drug therapy.

## Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment.

## Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Handling charges for blood or blood derivatives only if not donated or replaced.

## Medical Transportation Services

*Transportation by professional ambulance, other than air ambulance, to and from* a medical facility.

Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico or Canada.

## Nurse-Practitioner Services

Services of a licensed or certified Nurse-Practitioner acting within the scope of that license or certification.

## Oral Surgery and Dental Services

- Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.
- The following services and supplies are covered only if needed because of accidental injury to natural teeth:
  - Oral surgery.
  - Full or partial dentures.
  - Fixed bridge work.
  - Prompt repair to natural teeth.
  - Crowns.

## Organ/Tissue Transplants

*Benefits for Organ/Tissue Transplants performed at a Non-Designated Transplant* Facility are payable at Plan benefits, subject to the deductible.

Benefits for Organ/Tissue Transplants performed at a Designated Transplant Facility are payable at 100% of Covered Expenses. For benefits performed at a *Designated Transplant Facility, Medical Management must be notified. Call the* toll-free number shown on the ID card and follow the prompts for medical management.

*Medical management must be notified at least ten working days before the* scheduled date of any of the following or as soon as reasonably possible:

- The evaluation.
- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

Services and supplies for Medically Necessary organ or tissue transplants are payable under this Plan.

**Donor Charges for Organ/Tissue Transplants**

- In the case of an organ or tissue transplant, donor charges are considered Covered Expenses ONLY if the recipient is a Covered Person under this Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically *related to the patient is not considered a Covered Service UNLESS the search is made in connection with a transplant procedure arranged by a Designated* Transplant Facility.

If a Qualified Procedure, listed below, is Medically Necessary and performed at a Designated Transplant Facility, the **Medical Care and Treatment** and **Transportation and Lodging** provisions described below apply.

**Qualified Procedures**

- Heart Transplants.
- Lung transplants.
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Bone Marrow/Stem Cell transplants.
- Other transplant procedures when the Company determines that it is Medically Necessary to perform the procedure at a Designated Transplant Facility.

**Medical Care and Treatment**

The Covered Expenses for services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and physician fees.
- Transplant procedures.
- Follow-up care for a period up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, *a Maximum Benefit of $25,000 is payable for all charges made in connection* with the search.

**Transportation and Lodging**

Medical Management will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Transplant Facility.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.
- There is a combined overall lifetime maximum of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

## Orthoptic Training (Eye Muscle Exercise)

Training by a licensed optometrist or an orthoptic technician.

## Outpatient Occupational Therapy

*Services of a licensed occupational therapist, provided the following conditions are* met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

## Outpatient Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

## Physician Services

### Medical Care and Treatment

- Hospital, office and home visits.
- Emergency room services.

### Surgery

Services for surgical procedures.

### Reconstructive Surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:

    - Birth defect.
    - Sickness.
    - Surgery to treat a Sickness or accidental injury.
    - Accidental injury.
- Reconstructive breast surgery following a Medically Necessary mastectomy.
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury.

**Assistant Surgeon Services**

Covered Expenses for assistant surgeon services are limited to 1/5 of the amount of Covered Expenses for the surgeon's Reasonable and Customary Charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not covered.

***Multiple Surgical Procedures***

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered Expenses for any subsequent procedure are limited to 25% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

## *Prescribed Drugs and Medicines for inpatient services only.*

## Private Duty Nursing Care

Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

## Psychologist Services

## Radiation Therapy

## Rehabilitation Therapy

**Inpatient**

- Services of a Hospital or Rehabilitation Facility for room, board, care and treatment during a confinement.
- Inpatient rehabilitative therapy is a Covered Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

**Outpatient**

- Services of a Hospital or Comprehensive Outpatient Rehabilitative Facility (CORF).

- Covered Services for each day of therapy reduces the number of visits under Covered Services for Outpatient Physical Therapy, Outpatient Occupational Therapy or Speech Therapy. This reduction only applies to days of therapy during which the therapy includes services given by a physical therapist, occupational therapist or speech therapist.

### Skilled Nursing Facility Services

- Room and Board.

  Covered Expenses for Room and Board are limited to the facility's regular daily charge for a semi-private room.

- Other Services and Supplies.

Covered Services are limited to the first 60 combined Network and Non-Network days of confinement each Calendar Year.

### Speech Therapy

Services of a licensed speech therapist.

These services must be given to restore speech lost or impaired due to one of the following:

- Surgery, radiation therapy or other treatment which affects the vocal chords
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to accidental injury or organic brain lesion (aphasia).
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

### Spinal Manipulations

Services of a Physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

### Temporomandibular Joint Dysfunction

Examination of the jaw and supporting structure, initial installation, and subsequent adjustments to removable appliances and Medically Necessary surgery to correct a condition known as Temporomandibular Joint Dysfunction (TMJ).

**Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.**

## Mental Disorder Treatment and Alcohol or Substance Abuse Treatment Benefits

Benefits are payable for Covered Services and Supplies for Mental Disorder Treatment given to the Covered Person while covered under these Plans. These Covered Services and Supplies are listed in **Medical Benefits**.

Benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment are subject to the copayments, deductibles and percentage of Covered Expenses payable as shown in **Schedule of Benefits**.

Benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment include, but are not limited to:

- Assessment.
- Diagnosis.
- Treatment planning.
- Medication management.
- Individual, family and group psychotherapy.
- Psychological education.
- Psychological testing.

After coverage under these Plans stop, extended benefits for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment are the same as for Sickness.

Additional Covered Services and Supplies specific to Mental Disorder Treatment are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits**.

## Additional Covered Services and Supplies

### Licensed Counselor Services

Services of a Licensed Counselor for Mental Disorder Treatment.

### Treatment Center Services

- Room and Board.
- Other Services and Supplies.

**Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.**

# Pregnancy Benefits

Benefits are payable for Covered Services and Supplies given to the Covered Person for pregnancy while covered under these Plans. These Covered Services and Supplies are listed in **Medical Benefits.**

**Benefits for pregnancy are paid in the same way as benefits are paid for Sickness.**

Benefits are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery.

- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

After coverage under these Plans stop, extended benefits for pregnancy are the same as for Sickness.

Additional Covered Services and Supplies specific to pregnancy are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits.**

## Additional Covered Services and Supplies

### Birth Center Services

- Room and Board.
- Other Services and Supplies.
- Anesthetics.

### Nurse-Midwife's Services

*Services of a licensed or certified Nurse-Midwife.*

### Routine Well Baby Care

The following services and supplies given during a newborn child's initial Hospital confinement:

- Hospital services for nursery care.
- Other Services and Supplies given by the Hospital.
- Services for a circumcision.
- Physician Services.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# Family Planning Benefits

Benefits are payable for Covered Expenses for Family Planning Benefits incurred by the Covered Person while covered under these Plans.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for the Covered Services and Supplies listed in this Benefit. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

These Family Planning Benefits are subject to the same copayments, deductibles and percentage of Covered Expenses payable as benefits that are paid due to Sickness under **Medical Benefits**.

After coverage under these Plans stop, there are no extended benefits.

## Covered Services and Supplies

### Assisted Reproductive Technology

Covered Services and Supplies for Assisted Reproductive Technology (ART) are limited to a Covered Person who has undergone extensive screening and it has been determined that:

- The ART is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the following assisted reproductive technology procedures:
  - In vitro fertilization services.
  - artificial insemination
  - Gamete intrafallopian transfer (GIFT).
  - Zygote intrafallopian transfer (ZIFT).
  - Microinjection techniques.

The Covered Person must have been unable to become pregnant through more conservative means for a minimum of 12 months, unless one partner has already been diagnosed as infertile.

### Not Covered

- More than three attempts at ART.
- ART if infertility is the result of voluntary sterilization.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# Preventive Health Care Benefits

Benefits, as shown below, are payable for Covered Services and Supplies for Preventive Health Care Benefits given to a Covered Person by a Physician while the person is covered under these Plans.

The Office Visit Copayment shown in the **Schedule of Benefits** applies to the Covered Services and Supplies on the same basis as it applies to Sickness under the **Medical Benefits**.

Benefits are payable at 100% of Covered Expenses after the Copayment or Deductible has been paid.

After coverage under these Plans stop, there are no extended benefits.

## Covered Services and Supplies

- Routine physical exam for covered Employees and Dependent spouses, including diagnostic tests and immunizations, only if provided by a Network Provider.
- Child up to age 19, preventive care services given in connection with routine pediatric care, including PKU tests and immunizations. Preventive care services may be provided by either a Network or Non-Network Provider.

- A routine well-woman exam, if provided by a Network Provider, includes the following:
  - Breast examination and/or mammogram.
  - Pelvic examination.
  - Pap smear.
- A routine well-woman exam, if provided by a Non-Network Provider, includes the following:
  - Mammogram.
  - Pap smear.
- Chromosome testing only if provided by a Network Provider.

**Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.**

# General Exclusions and Limitations

These Plans do not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies received before an Employee or his or her Dependent becomes covered under these Plans.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under these Plans.
- Abdominoplastys, unless Medically Necessary.
- Breast reduction surgery, unless Medically Necessary.
- Chelation therapy, except to treat heavy metal poisoning.
- Completion of claim forms, or missed appointments.
- Cosmetic or reconstructive surgery or treatment. (This is surgery or treatment primarily to change appearance.) It does not matter whether or not it is for psychological or emotional reasons. See **Medical Benefits** for limited coverage of reconstructive surgery.
- Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

  Care that meets one of these conditions is custodial care regardless of any of the following:
    - Who recommends, provides or directs the care.
    - Where the care is provided.
    - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.

- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- *Eye glasses, contact lenses, eye refractions, cochlear implants, unless* required due to an accidental injury or sickness.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's immediate family:
  - The Employee's spouse.
  - The child, brother, sister or parent of the Employee.
- Expenses and associated expenses incurred for services and supplies for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for services which are otherwise Experimental, Investigational, or Unproven that are deemed to be, in the Company's judgment, covered transplant services. The fact that an Experimental, Investigational or Unproven Service, treatment, device and pharmacological regimen, is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- *Services and supplies which the Covered Person is not legally required to pay.*
- Liposuction.
- Services or supplies which are not Medically Necessary, including any confinement or treatment given in connection with a service or supply which is not Medically Necessary.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Occupational injury or Sickness. An occupational injury or Sickness is an injury or Sickness which is covered under a workers' compensation act or similar law.

  For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or Sickness includes any injury or Sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Private duty nursing services while confined in a facility, unless Medically Necessary.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.

- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a Covered Person under these Plans and is undergoing a covered transplant.
- Reversal of sterilization.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Charges made by a Hospital for confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below.

  If that type of facility is otherwise covered under these Plans, then benefits for that covered facility which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.

  - Adult or child day care center.
  - Ambulatory Surgical Center.
  - Birth Center.
  - Half-way house.
  - Hospice.
  - Skilled Nursing Facility.
  - Treatment Center.
  - Vocational rehabilitation center.
  - Any other area of a Hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- Drugs given while not confined in a Hospital, nursing home or similar place that has its own drug dispensary.
- Stand-by services required by a Physician.
- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions and implants. See **Medical Benefits** for limited coverage of oral surgery and dental services.
- Telephone consultations.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity).
- Nutritional counseling, special foods, food supplements, liquid diets, diet plans or any related products, except for Enteral Formulas as described in Medical Benefits.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- Services given by volunteers or persons who do not normally charge for their services.

# Claims Information

## How to File a Non-Network Claim

Claim forms for services provided by a Network Provider are not required.

If the provider does not submit electronically, the following steps should be completed when submitting bills for payment:

- From United HealthCare customer service.
- Get a claim form from the Employee's department.
- Complete the Employee portion of the form.
- Have the provider complete the provider portion of the form.
- Send the form and bills to the address shown on the form.

Make sure the bills and the form include the following information:

- The Employee's name and social security number.
- The Employer's name and contract number (197512 for The Port Authority of New York & New Jersey and 197944 for Port Authority Trans-Hudson Corporation).
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

If the Covered Employee asks for a claim form but does not receive it within 15 days, the covered Employee can file a claim without it by sending the bills with a letter, including all of the information listed above.

## When Claims Must be Filed

Claims forms must be submitted within 15 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of loss was given to the Company as soon as was reasonably possible.

## How and When Claims Are Paid

All payments will be paid to the covered Employee as soon as the Company receives satisfactory completed claim forms, except in the following cases:

- If the covered Employee has financial responsibility under a court order for a dependent's medical care, the Company will make payments directly to the provider of care.

- If the Company pays benefits directly to Network Providers, unless it has been documented that the Network Provider has been reimbursed for Covered Expenses.
- If the covered Employee requests in writing that payments be made directly to a provider. A covered Employee does this when completing the claim form.

These payments will satisfy the Company's obligation to the extent of the payment.

The Company will send an Explanation of Benefits (EOB) to the covered Employee. The EOB will explain how the Company considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee will receive a written explanation.

Any benefits continued for Dependents after a covered Employee's death will be paid to one of the following:

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.
- A provider of care who makes charges to the covered Employee's Dependents for Covered Services and Supplies.
- The legal guardian of the covered Employee's Dependent.

## Legal Actions

The covered Employee may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee lives allows for a longer period of time.

## Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to the Company within 90 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and the Company will provide the claimant with a written response within 60 days of the date the Company receives the claimant's request for review. If, because of extenuating circumstances, the Company is unable to complete the review process within 60 days, the Company will notify the claimant of the delay within the 60 day period and will provide a final written response to the request for review within 120 days of the date the Company received the claimant's written request for review.

If the denial is upheld, the Company's written response to the claimant will cite the specific Plan provision(s) upon which the denial is based.

# Coordination of Benefits

Coordination of benefits applies when a covered Employee or a covered Dependent has health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

## Definitions

**"Other Plans"** are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.
- No-Fault motor vehicle laws.

**"Primary Plan"**: A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

**"Secondary Plan"**: Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

**"Allowable Expenses"** means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense.

When this Plan is a secondary plan, the benefit is based on the primary carrier's allowable expense.

For example, if the primary carrier has an indemnity plan and the secondary plan is a network plan, the secondary plan coordinates against the full allowable expense of that indemnity plan.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

If you are retired and Medicare Eligible, see the section on Retired Employees or Their Dependents Who Are Medicare Eligible in the Retired Employee provision.

## How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

## Which Plan Pays First

*When two or more plans provide benefits for the same Covered Person, the benefit* payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
  - Medicare is secondary to the plan covering the person as a dependent.
  - Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

  If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the plan of the parent with custody for the child.
  - Second, the plan of the spouse of the parent with the custody of the child.

- Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

If you are a retired employee and not Medicare eligible, see the section on Retired Employees or Their Dependents Who Are Not Yet Medicare Eligible in the Retired Employee provision.

## Right to Exchange Information

*In order to coordinate benefit payments, the Company needs certain information.* It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this.

## Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Employer or Plan will not have to pay that amount again.

## Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Company may recover the amount paid from the other plan or organization or person.

*Benefits may be paid that are in excess of what should have been paid under this* Plan. The Company has the right to recover the excess payment.

# Recovery Provisions

## Refund of Overpayments

If benefits are paid under this Plan for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Plan if:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment made under this Plan exceeded the benefits under this Plan.

The refund equals the amount of benefits paid in excess of the amount that should have been paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Employer get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

## Reimbursement of Benefits Paid

If benefits are paid under this Plan for expenses incurred on account of a Covered Person, the Employee or any other person or organization that was paid must make a refund to the Plan if that person or organization recovers funds from a source other than this Plan as a result of claims against any other party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

## Subrogation

In the event a Covered Person suffers an injury or Sickness as a result of an allegedly negligent or wrongful act or omission of a third party, the Plan has the right to pursue subrogation against any person or insurer.

The Plan will be subrogated and succeed to the Covered Person's right of recovery against any person or insurer. The Plan may use this right to the extent of the benefits under this Plan.

The Covered Person agrees to help the Plan use this right when requested.

# Effect of Medicare and Government Plans

## Medicare

When a Covered Person becomes eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

### When This Plan Pays Primary to Medicare

This Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

### When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan for Covered Persons who are Medicare eligible if:

- The employee is a Retired Employee.
- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See **How this Plan Pays When Medicare is Primary**.

### Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person must enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan.

## How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare eligibles. It does not apply to any Covered Person unless that Covered Person becomes eligible under Medicare and Medicare is the Primary payer.

The amount of charges for Covered Expenses under this Plan is determined first. However, the amount of Covered Expenses is based on the amount of charges *allowed under Medicare rules instead of the Reasonable Charges as defined by* the Plan. Then the amount payable under Medicare for the same expenses is subtracted from the amount of Covered Expenses. This Plan pays 80% of the difference between the two amounts after the deductible.

This plan is designed to provide payment toward the outstanding balance left on medical expenses after Medicare Part B has paid their share. The plan determines the amount of covered expenses remaining after Medicare has made payment. It applies the $50 plan's deductible to this amount. Any covered expenses above the deductible amount are reimbursed at 80%.

When this plan determines the amount of the covered expense, it takes into consideration the Medicare Approved Amount for the service in question. If a doctor accepts the Medicare Assignment of Benefits, they have agreed to reduce *their charge to the Medicare Approved Amount. If the doctor has not agreed to* accept the Medicare Assignment of Benefits, they cannot charge more than the Medicare Limiting Amount. The Medicare Limiting Amount is currently set at 115% of the Medicare Approved Amount. Certain individual states have limited the amount a doctor can charge to 110% or 105% of the Medicare Approved Amount.

Here is an example illustrating the calculation of benefits available under this plan. The example assumes that both the Medicare Part B Annual Deductible of $100 and the plan annual deductible of $50 have been met before this claim occurred.

| | **DOCTOR ACCEPTS MEDICARE ASSIGNMENT** | **DOCTOR DOES NOT ACCEPTS MEDICARE ASSIGNMENT** |
|---|---|---|
| **DOCTOR'S CHARGE** | $100 | $100 |
| **MEDICARE APPROVED AMOUNT** | $80 | $80 |
| **DOCTOR'S REVISED CHARGE** | $80 | $92 (limit = 115% of approved amt) |
| **MEDICARE PAYMENT (80% of approved amount)** | $64 | $64 |
| **BALANCE LEFT OVER AFTER MEDICARE PAYMENT** | $16 | $28 |
| **THIS PLAN PAYS 80% OF OUTSTANDING BALANCE** | $12.80 | $22.40 |
| ***PATIENT RESPONSIBILITY*** | ***$3.20*** | ***$6.00*** |

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

### Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

## Termination of Coverage

### Employee Coverage

Employee coverage ends on the earlier of the following:

- The day this Plan ends.
- The end of the month in which the person stops being an eligible Employee.

If you become a Retired Employee while covered under this Plan, please see the provision titled Retired Employee.

#### Disability

Coverage under this Plan is continued during a period of short or long term disability. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

### Leave of Absence or Temporary Layoff

For information regarding leave of absence or temporary layoff, see your Human Resources Manual.

## Dependent Coverage

Coverage for all of an Employee's Dependents ends on the day the Employee's coverage ends.

Coverage for an individual Dependent ends on the earliest of:

- The day the Dependent becomes covered as an Employee under this Plan.
- The day the Dependent stops being an eligible Dependent.
- The last day of the month in which the Dependent Child is no longer a full-time student.

### Continuation of Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as Dependents coverage under this Plan continues and as long as the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

# Extended Benefits

There are extended benefits under **Medical Benefits**, **Mental Disorder Treatment and Alcohol or Substance Treatment** and **Pregnancy Benefits**.

Extended benefits are payable for a Totally Disabled Covered Person for up to 12 months. Extended benefits are only payable for Covered Services and Supplies given during the 12-month period after the person's coverage ends.

The person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Covered Services or Supplies are given.

Extended benefits are only payable for Covered Services and Supplies given for the accidental injury, Sickness, or pregnancy causing Total Disability.

# Continuation of Health Coverage (COBRA)

**Under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, current or former employees and their eligible dependents who are covered under a group health plan have the right to elect to temporarily continue health coverage at their own expense if the coverage terminates due to a "Qualifying Event" as defined below. Those eligible to continue coverage become "Qualified Beneficiaries" under the law. CobraServ has been retained as the third party administrator to notify you of your group health care benefits continuation rights when and if the occasion arises. CobraServ can be reached at (800) 877-7994.**

If coverage under these Plans would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

*Coverage will continue until the earliest of the following dates:*

- 18 months from the date the Qualified Beneficiary's health coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.
- If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or work hours being reduced, that Qualified Beneficiary may elect an additional 11 months of coverage under these Plans, subject to the following conditions:
    - The Qualified Beneficiary must provide the Employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
    - The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
    - If the Qualified Beneficiary entitled to the additional 11 months of coverage has nondisabled family members who are entitled to continuation coverage, those nondisabled family members are also entitled to the additional 11 months of continuation coverage.
- 36 months from the date the health coverage would have stopped due to the Qualifying Event other than those described above.
- The date these Plans stops being in force.
- The date the Qualified Beneficiary fails to make the required payment for the coverage.
- The date the Qualified Beneficiary becomes entitled to benefits under Medicare.

- The date the Qualified Beneficiary, after electing this continuation, becomes covered under any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a Qualified Beneficiary's preexisting condition.)

If the Qualified Beneficiary is already covered under any other group health plan and elects continuation of health coverage under these Plans, the Qualified Beneficiary can continue coverage under that other group health plan. If the Qualified Beneficiary does not stop coverage under that other plan, coverage under this continuation will stop.

If after the first Qualifying Event another Qualifying Event occurs, coverage can be continued for Dependents for an additional period, for a total of 36 months from the date of the first Qualifying Event.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

## Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the latter of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the date the person receives notice of the right to continue coverage is sent.

Unless otherwise specified, an Employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

## Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

## Notification Requirements

A Qualified Beneficiary must notify the Employer within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage is legally dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible Dependent.

CobraServ will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

## Conversion

At the end of this continuation period, a Qualified Beneficiary may be eligible for a conversion privilege if one is generally available under the plans.

## Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

## Special Terms that Apply to this Continuation Provision

### Qualifying Event

A Qualifying Event is any of the following which results in loss of coverage for a *Qualified Beneficiary*:

- The Employee's employment ends (except in the case of gross misconduct).
- The Employee's work hours are reduced.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is legally dissolved.
- The Employee becomes legally separated from his/her spouse.
- The Employee's Dependent child stops being an eligible Dependent.

A bankruptcy is a Qualifying Event for certain Retired Employees and their Dependents under certain conditions. If there is a bankruptcy, Retired Employees should contact the Employer or CobraServ for more information.

### Qualified Beneficiary

Any of the following persons who are covered under these Plans on the day before a Qualifying Event:

- The Employee.
- An Employee's spouse.
- An Employee's former spouse (or legally separated spouse).
- A Dependent child, including a child born to or placed for adoption with the Employee during a period of continued coverage.

# Continuation of Health Coverage During Family and Medical Leave (FMLA)

**The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period for certain family and medical reasons. This provision of the Plan is intended to comply with the law and any pertinent regulations. See the Employer (Human Resources Manual) to find out how this continuation may apply to you.**

### Reasons for Taking Leave

FMLA leave is granted for any of the following reasons:

- Care of a child after birth.
- Care of a child after placement of that child with the Employee for adoption or foster care.
- Care of the Employee's spouse, child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the Employee unable to work.

See the Employer to find out if you are eligible for a leave.

### Continuation of Health Coverage

For the duration of a FMLA leave, the Employee may continue benefits for himself or herself and his or her Dependents on the same terms as if the Employee had continued to work. The Employee must pay the same contributions toward the cost of the coverage that he or she made while working.

### Reenrollment after a FMLA Leave

If any or all of an Employee's coverages end while the Employee is on a FMLA leave, the Employee can reenroll for coverage when he or she returns to work from the FMLA leave.

The Employee and any Dependents will be considered timely enrollees if the Employee reenrolls within thirty-one days from the date he or she returns to work. Any waiting period will be applied as if there had been no break in coverage.

# Conversion Coverage

If the covered Employee's group health coverage stops under these Plans, the covered Employee may buy individual health insurance (called "Conversion Coverage").

Proof of insurability will not have to be given. However, if the benefits under Conversion Coverage are greater than those under these Plans, the covered Employee and his or her covered Dependents will be asked to give proof of insurability for the greater benefits.

If the covered Employee has Dependents coverage when the group coverage stops, the Conversion Coverage will be for the covered Employee and all Covered Family Members on the day such coverage stops. The covered Employee must apply for Conversion Coverage on the same basis as the coverage he or she has under these Plans. The covered Employee cannot apply for single Conversion Coverage unless he or she is enrolled for Employee Only coverage under these Plans. A Dependent child over age 19 will be issued single Conversion Coverage because only Dependent children under 19 are covered as family members under Conversion Coverage.

An individual policy will be issued if the person converting is eligible and lives in one of the following states:

| | |
|---|---|
| Georgia | Oregon |
| Maine | Puerto Rico |
| Minnesota | South Dakota |
| New Hampshire | Vermont |
| New Mexico | Virginia |
| New York | |

If the person converting lives in a state or jurisdiction of the United States not listed above and is eligible, Conversion Coverage will be provided through The Group Conversion Trust. The person will receive a Certificate of Insurance instead of an individual policy.

See **Conversion Coverage for Medicare Eligibles** at the end of this provision if the covered Employee or a covered Dependent is Medicare Eligible.

## Conditions for Conversion

### For Covered Employees

- These Plans must be in force, and
- the person is no longer an eligible Employee.

If a covered Employee's group health coverage stops because these Plans end and are replaced by other plans provided by the Employer, the covered Employee will not have the right to buy Conversion Coverage.

The person's Employer may continue coverage under these Plans when the person becomes a Retired Employee. In this case, the person cannot buy Conversion Coverage until the continued coverage stops.

### For Covered Dependents

If the covered Employee dies, the covered Employee's wife or husband or any guardian of the covered Employee's Dependent children may buy Conversion Coverage for the covered Dependents.

If the covered Employee's marriage is dissolved, the covered Employee's former spouse may buy Conversion Coverage. This can happen at either of the following times:

- When the marriage is legally dissolved.
- At the end of any period of continuation of coverage under these Plans, but only if these Plans are in force on that date.

Any of a covered Employee's covered Dependents may buy Conversion Coverage *if one of the following is true:*

- The Dependent stops being eligible.
- *The Dependent is 19 or older when the covered Employee buys Conversion* Coverage. (Only Dependent children under 19 are covered under a covered Employee's new family coverage.)

## How to Apply

Application must be made within 31 days after the group coverage stops.

Get an application from the Company.

*The first premium must be paid before Conversion Coverage can be put in force.*

Conversion Coverage will be effective on the date that the group coverage stops. In some cases a covered Employee can choose to continue group coverage after employment ends. In some cases a covered Employee's Dependents can choose to continue their group coverage after the covered Employee's death. In these cases Conversion Coverage will go into effect when the continued coverage stops but only if these Plans are in force on that date.

If the covered Employee dies within the 31-day conversion period, the covered Employee's wife or husband or any guardian of the covered Employee's Dependents may apply for Conversion Coverage for those covered Dependents.

## Limitations

Conversion Coverage may have greatly reduced benefits at a much higher cost. In most cases, the benefits will be limited to Hospital and surgical benefits only.

The benefit amounts for Conversion Coverage will be governed by the following:

- The rules of the Company.
- The laws of the state or jurisdiction where the person lives when he or she applies.

A copy of the individual policy or Certificate of Insurance is on file with the state insurance authority, where required. A copy may also be obtained from the Company.

The Company might limit the benefits of, or refuse to issue, Conversion Coverage because the covered Employee or a Dependent has other health coverage. Each person will be told the rules when they apply.

## Conversion Coverage for Medicare Eligibles

A Medicare Eligible who lives in one of the following states is not eligible for Conversion Coverage:

| | |
|---|---|
| Georgia | Oregon |
| Maine | Puerto Rico |
| Minnesota | South Dakota |
| New Hampshire | Vermont |
| New Mexico | Virginia |
| New York | |

*Conversion Coverage of a Medicare Eligible who lives in any other state or jurisdiction* of the United States (except Michigan) will be provided through The Group Conversion Trust. Michigan residents will be covered under an individual policy.

# Retired Employee Coverage

Retired Employees are eligible for the benefits as described below after they stop being an Active Employee.

As a Retired Employee, Plan Benefits are continued. The continued coverage will be the same coverage in effect as for Active Employees at the time of retirement, except continued benefits for Medicare Eligibles are modified as shown in **Medicare and Other Government Plans**.

### Retired Employees or Their Dependents Who Are Not Yet Medicare Eligible

Plan benefits for Retired Employees or their Dependents who are not Medicare eligible are payable in the same manner as Plan benefits for Active Employees and their Dependents, except as shown above.

### Retired Employees or Their Dependents Who Are Medicare Eligible

Unless a change is stated below, all coverage remains the same as the coverage for Active Employees and their Dependents. When Retired Employees or their Dependents become Medicare eligible, Plan benefits are changed. These Plan changes apply to all Covered Expenses incurred on or after the date the person becomes both Medicare eligible and is either a Retired Employee or a Dependent of a Retired Employee.

Plan benefits are changed as follows:

- Preventive Health Benefits will stop.
- The Network Provider provision no longer applies. Plan benefits are no longer paid at the Network or Non-Network level.
- Plan benefits are payable at 80%, except that your Medicare Part A deductible and other Part A expenses will be paid at 100%.
- An Individual Deductible of $50 applies to each Covered Person each Calendar Year. All other deductibles and copayments under the Plans no longer apply.

- A Family Deductible of $100 applies each Calendar Year. The Family Deductible applies no matter how large a family may be. Only Covered Expenses which count toward a Covered Person's Individual Deductible count toward this Deductible. All other deductibles and copayments under the Plans no longer apply.
- Any Covered Expenses incurred in the Calendar Year in which the Covered Person becomes Medicare eligible may be used to satisfy the $50 Individual Deductible for that Calendar Year. This applies even if the expenses are *incurred prior to becoming Medicare eligible.*
- Any Covered Expenses a Covered Person incurs during October, November and December of a year which count toward that person's Individual Deductible for that year will also count toward that person's Individual Deductible for the next year.

**Plan Changes for Mental Disorder Treatment and Alcohol or Substance Abuse Treatment**

The same $50 Individual Deductible that applies to all other Plan benefits also applies to Mental Disorder Treatment and Alcohol or Substance Abuse Treatment.

**Maximum Benefits**

If you are age 65 or over and you retire on or after September 1, 1998, the Maximum Benefit for all other Plan benefits for each Covered Person is unlimited.

The Maximum Benefit includes any amount paid under the Employer's group plan for Medicare eligible Retired Employees or their Dependents in effect on the day before the effective date of these Plans.

## Medicare Benefits Are Primary to These Plan Benefits

Medicare benefits are primary to this Plan's benefits for Medicare eligible Retired Employees or their Dependents.

Medicare benefits are payable first. Then this Plan pays benefits (with the changes stated above) for Covered Expenses which are more than the amount payable for the same expenses under Medicare.

If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating Physician), this Plan determines the amount of Covered Expenses based on the amount of charges allowed by Medicare.

If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating Physician), this Plan determines the amount of Covered Expenses based on the lesser of the following:

- The Reasonable Charge (See Glossary).
- The amount of the Limiting Charge as defined by Medicare.

This plan is designed to provide payment toward the outstanding balance left on medical expenses after Medicare Part B has paid their share. The plan determines the amount of covered expenses remaining after Medicare has made payment. It applies the $50 plan's deductible to this amount. Any covered expenses above the deductible amount are reimbursed at 80%.

When this plan determines the amount of the covered expense, it takes into consideration the Medicare Approved Amount for the service in question. If a doctor accepts the Medicare Assignment of Benefits, they have agreed to reduce their charge to the Medicare Approved Amount. If the doctor has not agreed to accept the Medicare Assignment of Benefits, they cannot charge more than the Medicare Limiting Amount. The Medicare Limiting Amount is currently set at 115% of the Medicare Approved Amount. Certain individual states have limited the amount a doctor can charge to 110% or 105% of the Medicare Approved Amount.

Here is an example illustrating the calculation of benefits available under this plan. The example assumes that both the Medicare Part B Annual Deductible of $100 and the plan annual deductible of $50 have been met before this claim occurred.

| | **DOCTOR ACCEPTS MEDICARE ASSIGNMENT** | **DOCTOR DOES NOT ACCEPTS MEDICARE ASSIGNMENT** |
|---|---|---|
| **DOCTOR'S CHARGE** | $100 | $100 |
| **MEDICARE APPROVED AMOUNT** | $80 | $80 |
| ***DOCTOR'S REVISED CHARGE*** | $80 | $92 (limit = 115% of approved amt) |
| **MEDICARE PAYMENT (80% of approved amount)** | $64 | $64 |
| **BALANCE LEFT OVER AFTER MEDICARE PAYMENT** | $16 | $28 |
| ***THIS PLAN PAYS 80% OF OUTSTANDING BALANCE*** | $12.80 | $22.40 |
| ***PATIENT RESPONSIBILITY*** | ***$3.20*** | ***$6.00*** |

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

## Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

### Definitions

#### Retired Employee

Retired Employee means an Employee who meets all of the following:

- The Employee is retired by the Employer, consistent with retirement arrangements recognized by resolution of the Employer's Board or its Committee on Operations or is separated after the Employee would have met the age and length of service required to be retired under the Employer's pension plan which would have been applicable had the Employee been a member.
- The Employee was covered under this Plan or the Former Plan on the day before the date of retirement.
- Employees not eligible for Medicare are covered with pre age 65 coverage.

#### Totally Disabled or Total Disability

A Retired Employee's inability due to accidental injury or Sickness to perform the normal activities of a person in good health and of like age and sex. A Retired Employee or Retired Employee's Dependent who meets this definition and is eligible for Medicare will have these Plans as Secondary.

# Glossary

*(These definitions apply when the following terms are used.)*

### Ambulatory Surgical Center

A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
  - It provides at least one operating room and at least one post-anesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It has immediate access to a blood bank or blood supplies.
  - It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

An Ambulatory Surgical Center which is part of a Hospital, as defined herein, will be considered an Ambulatory Surgical Center for the purposes of these Plans.

## Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law.
  - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity.
  - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
  - It is operated under the full-time supervision of a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) or registered graduate nurse (R.N.).
  - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.

- It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.
- It is expected to discharge or transfer patients within 24 hours following delivery.

A Birth Center which is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of these Plans.

## Calendar Year

A period of one year beginning with a January 1.

## Comprehensive Outpatient Rehabilitation Facility

A facility which is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured or sick persons and which fully meets one of the following two tests:

- It is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility.
- It meets all of the following tests:
  - It provides at least the following comprehensive outpatient rehabilitation services:
    - Services of Physicians who are available at the facility on a full or part-time basis.
    - Physical therapy.
    - Social or psychological services.
  - It has policies established by a group of professional personnel (associated with the facility) including one or more Physicians to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full or part-time Physician.
  - It has a requirement that every patient must be under the care of a Physician.
  - It is established and operated in accordance with the applicable licensing and other laws.

## Covered Family Members or Covered Person

The Employee and the Employee's wife or husband or former spouse and/or Dependent children who are covered under these Plans.

## Each Cause

A person may be confined in a Hospital more than one time. More than one surgical procedure may be performed on one person. The Company will consider all Hospital confinements and all surgical procedures to occur because of the same cause unless the person recovers completely from the injury or Sickness which caused the first Hospital confinement or surgical procedure before the next confinement or procedure, or in the case of pregnancy, the later Hospital confinement or surgical procedure is caused by a different pregnancy, or

- as to Dependents only, the disability which causes the later Hospital confinement or surgical procedure is completely different from the disability which caused the first Hospital confinement or surgical procedure, or

- the Employee returns to work for one full day before having another Hospital confinement or surgical procedure.

## Employee

A person on the payroll of the Employer and regularly employed by the Employer on a full-time basis of not less than 50% of normal hours in a pay period or as contractually negotiated.

## Experimental, Investigational or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case are determined to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Company, in its judgment, may deem an Experimental, Investigational or Unproven Service covered under these Plans for treating a life threatening sickness or condition if it is determined by the Company that the Experimental, Investigational or Unproven Service at the time of the determination:

- is proved to be safe with promising efficacy; and
- is provided in a clinically controlled research setting, and
- uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

## Home Health Care Agency

An agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare.
- It is established and operated in accordance with the applicable licensing and other laws.

- It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
  - It has a full-time administrator.
  - *It maintains written records of services provided to the patient.*
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.
  - Its employees are bonded and it maintains malpractice insurance.

## Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice.
- It is licensed in accordance with any applicable state laws.
- It meets the following criteria:
  - It provides 24 hour-a-day, 7 day-a-week service.
  - It is under the direct supervision of a duly qualified Physician.
  - It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
  - The main purpose of the agency is to provide Hospice services.
  - *It has a full-time administrator.*
  - It maintains written records of services given to the patient.
  - It maintains malpractice insurance coverage.

A Hospice which is part of a Hospital will be considered a Hospice for the purposes of these Plans.

## Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a Hospital.
- It meets all of the following tests:
  - It maintains on the premises diagnostic and therapeutic facilities for *surgical and medical diagnosis and treatment of sick and injured persons* by or under the supervision of a staff of duly qualified Physicians.
  - It continuously provides on the premises 24-hour-a-day nursing service by *or under the supervision of registered graduate nurses.*
  - It is operated continuously with organized facilities for operative surgery on the premises.

## Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

## Medically Necessary or Medical Necessity

Health care services and supplies which are determined by the Company to be medically appropriate, and

(1) necessary to meet the basic health needs of the Covered Person; and

(2) rendered in the most appropriate manner and type of setting appropriate for the delivery of the service or supply; and

(3) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and

(4) consistent with the diagnosis of the condition; and

(5) required for reasons other than the convenience of the Covered Person or his or her Physician; and

(6) demonstrated through prevailing peer-reviewed medical literature to be either:

(a) safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,

(b) safe with promising efficacy

(i) for treating a life threatening Sickness or condition, and

(ii) in a clinically controlled research setting; and

(iii) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, Sickness, mental illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary used in this booklet relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

## Medicare

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

## Mental Disorder Treatment

Mental Disorder Treatment is treatment for both of the following:

- Any Sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/ or physiological dependence or addiction to alcohol or psychiatric drugs or medications, regardless of any underlying physical or organic cause, and
- Any Sickness where the treatment is primarily the use of psychotherapy or other psychotherapist methods.

All inpatient services, including Room and Board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a Sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the Sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy *or substance abuse treatment is not considered Mental Disorder Treatment.*

Prescription Drugs unless prescribed while in-patient are not considered Mental Disorder Treatment.

## No-Fault Automobile Insurance Law

The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

## Network Provider

A provider which participates in the network.

## Non-Network Hospital

A *hospital (as defined) which does not participate in the network.*

## Non-Network Provider

A provider which does not participate in the network.

## Nurse-Midwife

A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Midwives.

## Nurse-Practitioner

A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Practitioners.

## Other Services and Supplies

Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

## Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropody (D.P.M.; D.S.C.).
- Doctor of Chiropractic (D.C.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).
- Doctor of Osteopathy (D.O.).
- Doctor of Podiatry (D.P.M.).

## Plan/Plans

The Employee medical benefits for The Port Authority and PATH are referred to as this Plan or these Plans.

## Pre-Admission Tests

Tests performed on a Covered Person in a Hospital before confinement as a resident inpatient provided they meet all of the following requirements:

- The tests are related to the performance of scheduled surgery.
- The tests have been ordered by a Physician after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital.

## Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

## Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

## Reasonable Charge / Reasonable and Customary

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

## Room and Board

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

## Sickness

The term "Sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

## Skilled Nursing Facility

If the facility is approved by Medicare as a Skilled Nursing Facility then it is covered by these Plans.

If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Sickness.
- It maintains a daily medical record of each patient who is under the care of a licensed Physician.
- It is authorized to administer medication to patients on the order of a licensed Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A Skilled Nursing Facility which is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of these Plans.

## Total Disability or Totally Disabled

- *An Employee's inability to perform all of the substantial and material duties of* his or her regular employment or occupation.
- A Dependent's inability to perform the normal activities of a person of like age and sex.

## Treatment Center

A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and Board (if these Plans provides inpatient benefits at a Treatment Center).
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

## End of Summary Plan Description

## Notice to Employees

This booklet describes Employer-sponsored health benefits under the The Port Authority of New York & New Jersey Medical Plan or Port Authority Trans-Hudson Corporation (PATH) Medical Plan (collectively called "these Plans").

All benefits becoming due under these Plans are funded by The Port Authority of New York & New Jersey and Port Authority Trans-Hudson Corporation (collectively called "the Employer").

The Port Authority and PATH have entered into an arrangement with United HealthCare Service Corp. (called "the Company") which provides for the Company to process benefit claims and provide certain other services under these Plans.

This booklet is intended to describe the medical plans being provided to certain employees of The Port Authority of New York and New Jersey and Port Authority Trans-Hudson Corporation by arrangement with United HealthCare Service Corp., as of March, 2001. The medical plans described in this booklet, which first became effective for certain employees as of September 1, 1998, are subject to change from time to time, e.g. through collective bargaining negotiations when required, or as otherwise legally permitted, so employees, retirees and qualified dependents should confirm the benefits described with United HealthCare at (877) 259-1391. This booklet does not in any way constitute a contract between the Port Authority of New York and New Jersey or Port Authority Trans-Hudson Corporation and its or their employees.

The Company has arranged with certain health care providers to participate in a network. These health care providers, called "Network Providers", have agreed to discount their charges for Covered Services and Supplies.

If Network Providers are used, the amount of Covered Expenses for which a Covered Person is responsible will generally be less than the amount owed if Non-Network Providers had been used. However, because the total charges for Covered Expenses may be less when Network Providers are used, the portion that the Covered Person owes will be less. Covered Persons are issued an identification card (ID Card) showing that they are eligible for the network discounts. A Covered Person should show this ID Card every time health care services are given. This is how the provider knows that the patient is covered under a network plan. Otherwise, the person could be billed for the provider's normal charge.

A directory of Network Providers will be made available. A Covered Person can also call Member Services to determine which providers participate in the Network. The telephone number for Member Services is on the ID Card.

United HealthCare Service Corp. does not insure the benefits described in this booklet.

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2010 Retirement Incentive: Vision Benefits
(Civilian Represented & Non Represented)

# THE PORT AUTHORITY

OF NY & NJ

# VISION CARE BROCHURE

Administered by:

NVA®

National Vision Administrators

Effective: 01/01/98

The Port Authority of New York and New Jersey has selected NATIONAL VISION ADMINISTRATORS (NVA) as administrators of the Vision Benefit Program effective January 1, 1998. We have designed this Benefit Program along with NVA, an innovative leader in the field with your convenience in mind. NVA's highly qualified staff will assist you when needed.

Please read this brochure completely and keep it for future reference.

## HOW TO OBTAIN YOUR BENEFITS

NVA has a network of participating Ophthalmologists, Optometrists, and Opticians to serve you. A directory of local participating providers will be supplied to each eligible employee.

When making your appointment with an NVA Participating Provider, please notify them that your coverage is administered by NVA and sponsored by The Port Authority of New York and New Jersey. When you arrive for your vision care appointment, simply present your NVA Vision Care identification card. You do not need to obtain a vision claim form. The provider will telephone NVA to verify your vision care eligibility and inform you of your eligibility status prior to rendering services. To verify benefit eligibility yourself prior to scheduling your eye care appointment, you may contact NVA's Customer Service Department at the following toll free number **1-800-672-7723**.

## PARTICIPATING PROVIDERS

If you use a Participating Provider your eye exam will be covered in full. If corrective eyewear is necessary, you will be covered up to the plan allowance for lenses, frames or contact lenses after meeting a $25.00 materials deductable. Any costs exceeding the plan allowance are the responsibility of the patient.

## ELIGIBILITY

**EMPLOYEES:** Eligibility for and termination of benefits under this vision care plan is determined

by the same rules that apply to your other health care benefits. Benefits become effective on the 31st day after starting employment.

**DEPENDENTS** are defined as the spouse, unmarried dependent children through the end of the year in which they turn 19; unmarried dependent children who are full-time students through the end of the year in which they turn 26.

**HOW OFTEN BENEFITS ARE PROVIDED**
**EXAMINATION:** Once every calendar year
**LENSES:** Once every calendar year
***FRAMES:*** *Once every 2 calendar years*
**CONTACT LENSES:** Once every calendar year
This benefit includes disposables and is available in lieu of the lenses and frames benefit. (When contact lenses are selected the frame benefit is depleted for the following 2 calendar years).

***COVERED BENEFITS***
**VISION EXAMINATION:** A complete analysis of eyes and related structures; prescribing corrective lenses as needed.
**LENSES:** To correct vision problems - lenses may be plastic or impact resistant glass.
**FRAMES:** The plan offers a wide selection of frames, at no cost to you after the materials deductable is met.
**CONTACT LENSES:** The plan will contribute an allowance towards the purchase of contacts. (In lieu of lenses and frames.)
Medically Necessary Contacts: This enhanced allowance (within the plan limits) will be considered for payment by NVA when an NVA Participating Provider secures prior authorization for the following conditions: a) Following cataract surgery, b) To correct extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, c) Anisometropia, d) Keratoconus.

**VISION SERVICES AND MATERIALS THAT ADD EXTRA COSTS**
This plan is designed to cover your basic visual needs rather than cosmetic materials. Extra

materials that are not covered by the Plan may be purchased through the NVA participating doctor at a controlled cost.
Lenses - The wholesale cost plus 25%.
Example: Gradient Tint wholesale cost $10.00 plus 25% ($2.50) = $12.50
Frames - the difference between the wholesale cost of the frame and the maximum allowance plus 20% of the difference.
Example: $60.00 wholesale cost - $40.00 plan allowance = $20.00 difference. $20.00 difference + (20%) $4.00 = $24.00.

Photochromatic (gray and brown) light or dark; Tinted (other than Pink #1 or #2),gradient or fashion colors; Progressive or no-line multifocals; A frame costing more than the plan allowance; Coatings: Mirror, Anti-reflective, Super A.R., Color, Edge, Ultra Violet; Polish edges;Smart Segment; Scratch resistant (lab or manufacturer applied); Rimless; Polycarbonate; Prescription Sunglasses.

NON-COVERED ITEMS
There are no benefits for professional services or materials connected with:
Medical or surgical treatments (These may, however, be covered under your Medical Benefit Plan); Drugs or medications (These may, however, be covered by your Prescription Drug Plan);Non-prescription lenses including sunglasses; Examinations or materials not listed as a covered service; Replacement of lost, stolen, broken, or damaged lenses; Services or materials provided by Federal, State, Local Government or Worker's Compensation; Examination, procedures training or materials not listed; Industrial 3(mm) safety lenses and safety frames with side shields; Parts or repair of frame.

**NON-PARTICIPATING PROVIDERS**

If you select a non-participating provider you must pay the provider's full fee and obtain an itemized receipt which must contain the following information:

a) Cardmember's Identification Number
b) Patient's name
c) Date service began
d) The services and materials you received.
e) Signature of employee or spouse

Mail to:

**NVA**
**P.O. Box 2187**
**Clifton, NJ 07013**

**NON-PARTICIPATING REIMBURSEMENT SCHEDULE**

| | |
|---|---|
| Vision Examination with Tonometry | $35.00 |
| MATERIALS (pair) | |
| Single Vision Lenses, up to | $15.00 |
| Bifocal Lenses, up to | $25.00 |
| Trifocal Lenses, up to | $35.00 |
| Lenticular Lenses, up to | $60.00 |
| Frames, up to | $40.00 |
| **CONTACT LENSES** | |
| Contact Lenses, with exam up to Including Disposables | $75.00 |

Medically Necessary Contacts, up to the enhanced plan allowance.

THERE IS NO ASSURANCE THE NON-PARTICIPATING REIMBURSEMENT SCHEDULE WILL COVER THE ENTIRE COST OF THE EXAMINATION, LENSES, FRAMES OR CONTACTS.

This brochure is written in layman's language for your convenience. It is not intended to interpret, extend, or change the rules and regulations of the plan. Should any differences arise in

interpretation between the plan and this brochure, the plan shall govern.
Any and all questions or requests for information should be directed to:

**National Vision Administrators**
**P.O. Box 2187**
**Clifton, NJ 07013**
**Toll Free Line 800-672-7723**

**Contact Fill:** NVA provides you with the convenience and savings of Contact Fill, our mail order contact lens replacement service. You may access Contact Fill's services online at www.contactfill.com or by calling them toll-free at 866.234.1393. Contact Fill provides contact lens wearers with significant savings packaged with the convenience of home delivery. Plan discounts applicable at participating retail locations do not apply to purchases made through Contact Fill due to the already low prices.

**Plan Specific Details Online:** The NVA website is easy to use and provides the most up to date information for program participants:

- *Locate a nearby participating provider by name, zip code, or City/State*
- *Verify eligibility for you or a dependent*
- *View benefit program and specific details*
- *Review claims*
- *Print ID cards (when allowable)*
- *Nominate a non-participating provider to join the NVA network*