

AGREEMENT
CITY OF TROY
DEPARTMENT OF PUBLIC SAFETY
BUREAU OF FIRE
AND
TROY UNIFORMED
FIREFIGHTERS' ASSOCIATION
LOCAL 86, I.A.F.F., AFL-CIO
JANUARY 1, 2013 THROUGH DECEMBER 31, 2016

TABLE OF CONTENTS

ARTICLE I.	PURPOSE AND INTENT.....	1
ARTICLE II	DEFINITIONS	1
ARTICLE III	RECOGNITION AND BARGAINING UNIT	3
ARTICLE IV	NO STRIKE, NO LOCKOUT PLEDGE	3
ARTICLE V	ASSOCIATION DUES	3
ARTICLE VI	MANAGEMENT RIGHTS AND RESPONSIBILITIES	4
ARTICLE VII	RIGHTS OF EMPLOYEES	6
ARTICLE VIII	GRIEVANCE PROCEDURE	8
ARTICLE IX	HOURS OF WORK AND OVERTIME, MANNING AND RECALL, SAFETY STAFFING.....	9
ARTICLE X	PERMANENT, PROBATIONARY AND PROVISIONAL FIREFIGHTERS.....	14
ARTICLE XI	SENIORITY	15
ARTICLE XII	HOLIDAYS.....	16
ARTICLE XIII	LEAVES OF ABSENCE.....	17
A.	Sick Leave.....	17
B.	Vacation Leave.	18
C.	Personal Leave.	20
D.	Military Leave.....	22
F.	Leave of Absence for Association Representatives.....	22
ARTICLE XIV	HEALTH INSURANCE	23
ARTICLE XV	RETIREMENT PLAN	25
ARTICLE XVI	WAGES AND OUT-OF-GRADE WORK	26
ARTICLE XVII	UNIFORM ALLOWANCE AND UNIFORMS	27
ARTICLE XVIII	SPECIAL CONFERENCES.....	28
ARTICLE XIX	NEWLY CREATED AND VACANT POSITIONS.....	28
ARTICLE XX	PROFESSIONAL TRAINING AND IMPROVEMENT COURSES.....	29
ARTICLE XXI	VACANCIES AND TRANSFERS	30
ARTICLE XXII	WAIVER CLAUSE.....	32
ARTICLE XXIII	MISCELANEOUS PROVISIONS.....	32
ARTICLE XXIV	PARAMEDICS	35
SIGNATORIES.....		38

SCHEDULE "A"	39
Salary Schedule.....	39
Longevity	41
SCHEDULE "B"	42
207-A PROCEDURE.....	42
APPENDIX A-1.....	46
APPENDIX A-2.....	104

2013-2016 TROY UFA CONTRACT

AGREEMENT, entered into _____, 2017 between **THE CITY OF TROY, NEW YORK**, a New York Municipal Corporation (hereinafter also referred to as the “Employer” or the “City”), for the calendar years 2013, 2014, 2015 and 2016 and **THE TROY UNIFORMED FIREFIGHTERS’ ASSOCIATION, LOCAL 86 I.A.F.F., AFL-CIO**, a labor organization existing under the law of the State of New York (hereinafter referred to as the “Association”).

ARTICLE I. PURPOSE AND INTENT

The general purposes of this agreement are to set forth equitable terms and conditions of employment, to provide for the expeditious and orderly resolution of disputes between the parties and otherwise to maintain amicable and cooperative labor relations between The City of Troy, New York and the members of the Troy Uniformed Firefighters’ Association, Local 86, AFL-CIO, all in accordance with the New York Civil Service Law, The Public Employees’ Fair Employment Act of 1967 as legislatively amended and judicially interpreted, together with the provisions of the Charter and the local laws of the City of Troy, New York.

In expressing their mutual desire to promote harmonious labor relations, the parties recognize and declare that the general safety of the public community is paramount so that any disputes arising between the parties shall be adjusted and resolved without interruption of essential services to the public.

THEREFORE, in consideration of the mutual covenants and promises hereinafter contained, the parties, acting by and through their duly authorized representatives, agree as follows:

IT IS HEREBY AGREED BY AND BETWEEN THE PARTIES THAT ANY PROVISION OF THIS AGREEMENT REQUIRING LEGISLATIVE ACTION TO PERMIT ITS IMPLEMENTATION BY AMENDMENT OF LAW OR BY PROVIDING THE ADDITIONAL FUNDS THEREFORE, SHALL NOT BECOME EFFECTIVE UNTIL THE APPROPRIATE LEGISLATIVE BODY HAS GIVEN APPROVAL.

ARTICLE II DEFINITIONS

- A. “Association” means the Troy Uniformed Firefighters’ Association.
- B. “Firefighter” and/or “Employee” means a uniformed person, without regards to gender, (inclusive of emergency medical technicians and paramedics), employed by the Bureau of Fire of the City of Troy, exclusive of the ranks of Battalion Chief and above.
- C. “Service” or “Length of Service” includes all service with the Bureau of Fire of the City of Troy, starting with the first day of appointment.

- D. “Employer” means the City of Troy.
- E. “Chief” means the Chief of Fire.
- F. “Bureau” means the Bureau of Fire of the Department of Public Safety of the City of Troy and when herein shall mean also the City of Troy.
- G. “Grievance” shall mean a claimed violation, misinterpretation or inequitable application of the existing rules, procedures or regulations covering the terms and conditions applicable to the employees of the Bureau and shall include also all the provisions of this Agreement.
- “Policy Grievance” shall mean a Grievance wherein the Grievant is the Association collectively and which the matter has been determined by its Executive Officers as, either:
- 1) affecting the Association independent of the employees, or
 - 2) having Bureau wide implications, or
 - 3) significantly affecting more than one employee.
- H. “Association Officer” shall mean an employee who is an officer or an appointed representative of the Association.
- I. “Executive Board” shall mean the appointed members and elected officers of the Association as defined in the Association’s By-Laws.
- J. “Bargaining Committee” or “Negotiating Committee” shall mean a committee composed of not more than five (5) members who will meet and negotiate with the City concerning this Agreement or future Agreements.
- K. “Safety Committee” shall mean a committee appointed by the President of the Association with the approval of the Executive Board.
- L. “Court Appearance” shall mean that an employee must appear or give testimony in any court, before a grand jury, or before any other judicial or quasi-judicial body, or in any departmental or agency hearing which may compel his or her attendance either by subpoena or by direction of his or her superior officer on a matter related to his or her employment as a firefighter.
- M. “Day”, “Tour of Duty” or “Work Day” shall be considered synonymous terms specifying the period of work assignment of a firefighter (excepting only the Fire Inspector), to wit, twenty-four (24) hours.
- N. “Commanding Officer” shall mean the officer in charge of a Company.

- O. “Company” shall mean the employees assigned to an individual piece of apparatus such as an engine, ladder truck, rescue squad vehicles, medical emergency vehicle or ambulance.
- P. “Paramedic” shall mean any firefighter who has received certification from the State of New York of at least an A-EMTP.
- Q. “Fire Surgeon” shall mean a physician selected by the City.
- R. “Chief Executive Officer” shall mean the mayor.

ARTICLE III RECOGNITION AND BARGAINING UNIT

Pursuant to and in accordance with all applicable provisions of the Civil Service Law of the State of New York, as amended, the Employer hereby recognizes the Association as the exclusive bargaining representative for the purpose of collective bargaining in respect to rate of pay, wages, hours of employment for all firefighters of the Fire Bureau, excluding the Chief, the Deputy Chief, Assist. Chief and the Battalion Chiefs, for the term of this Agreement.

ARTICLE IV NO STRIKE, NO LOCKOUT PLEDGE

The Association agrees that during the term of this Agreement, and as long as it is or continues to be the recognized or certified bargaining representative of the employees covered by this Agreement, it will not engage in a strike or cause, instigate, encourage or condone a strike by its members. Similarly, the City agrees that it will not lockout or provoke its employees, or in any other way penalize or discriminate against them for the purposes of creating pressure upon such employees to accept its terms and conditions during negotiations.

ARTICLE V ASSOCIATION DUES

- A. The City agrees to deduct Association membership dues and assessments in accordance with the Constitution and By-Laws of the Association from the pay of each member of the bargaining unit who executes or has executed an “Authorization for Payroll Deduction” form. Such form shall be provided by the Association.
- B. Deductions shall be made only in accordance with the provisions of said “Authorization for Payroll Deduction” and the provisions of this agreement.
- C. A properly executed copy of such “Authorization for Payroll Deduction” form for each member of the bargaining unit for whom Association membership dues are to be deducted hereunder shall be delivered to the City before any payroll deductions are made

and shall become effective with the first full payroll after the authorization form is tendered to the City.

- D. Deductions for any calendar month shall be remitted to the designated financial officer of the Association not later than the 10th day following the calendar month in which the deduction was made. Each month the City shall furnish the designated financial officer of the Association with a list of those for whom the Association has submitted a signed “Authorization for Payroll Deduction” form. If there is no deduction made, and the Association has submitted a signed “Authorization for Payroll Deduction” form, the City shall include this information and the reason for this with its list to the designated financial officer for the Association.
- E. The City shall not be liable by reason of the Agreement for the remittance of payment of any sum other than that constituting actual deductions made from the wages earned by the employees.
- F. Membership in the Association shall not be a condition of employment or a preference in the continuation of employment; however, the Association shall be entitled to the benefit of the provisions of the “agency shop” legislation enacted by the Legislature of the State of New York (1977) and as the same may thereafter be amended, upon attainment of membership equal to eighty percent (80%) of the bargaining unit employees and for such annual periods as the Association maintains said percentage membership, upon full compliance by the Association with the terms and provisions of such legislation.

ARTICLE VI MANAGEMENT RIGHTS AND RESPONSIBILITIES

- A. Except as otherwise provided herein, and subject to other controlling statutes and laws, the government and management of the City, the control and management of its properties and the maintenance of municipal functions and operations are reserved to the City and all lawful prerogatives of the City shall remain and shall be solely and exclusively the City’s rights. Paramount among those rights, but by no means exclusive, are the rights involving public policy, determination of the mission, purpose and duties of the various departments and bureaus within the City, their budgets, organization, number of employees, and the numbers, types, and grades of positions of employees assigned to an organization unit, work project, tour of duty, technology of performing the work, the rights to manage and direct work forces, to decide the number and location of stations and other facilities, to determine the work to be performed within the unit, maintenance and repair, amount of supervision necessary, machinery and tool equipment, work methods, practices and procedures, schedules of work, together with the selection, procurement, designing, engineering and control of equipment and material in order to operate and manage its affairs in all respects in accordance with law.

The foregoing notwithstanding no work presently within the job duties of or performed by members of the bargaining unit shall be contracted to be performed by a non-member of the unit or subcontracted to any other party except as expressly permitted by the City Charter.

- B. The Charter places responsibility on the Mayor as Chief Executive Officer of the City for enforcing the laws of the State and City, exercising supervision and control over executive departments of the City, for preparing and submitting an annual budget, for directing the proper performance of all City departments for carrying out all other Charter responsibilities and provisions so designated. It is the responsibility of the Mayor and of the City Council to enact local laws, ordinances, resolutions and to appropriate money. Similarly, it is the responsibility of the City to determine classification, status and tenure of employees, to establish rules, to initiate promotions and disciplinary actions, to certify payrolls and to review appointments in the City's service. The foregoing, however, is limited by State and Federal laws where applicable and by controlling provisions of this Agreement.
- C. The City shall have the exclusive right to adopt, revise and enforce departmental and working rules, regulations and practices, to carry out cost and general improvement programs including the right to hire, to suspend, to demote or to discharge, to take other disciplinary action against employees for just cause, to assign, to promote or transfer, to determine the amount of overtime to be worked, to relieve employees from duty for legitimate reasons, subject to overriding provisions of this Agreement.
- D. The City is obligated, legally and morally, to provide equality of opportunity, consideration and treatment of all employees and to establish policies and regulations that will insure such equality of opportunity, consideration and treatment in all phases of the employment process.
- E. It is further intended that this Agreement and its supplements shall be an implementation of the Charter and Legislative authority of the City Council, the authority of the Mayor and of rules and regulations promulgated by the City and the provisions of the Public Employees' Fair Employment Act.
- F. The City will not aid, promote or finance any labor group or organization purporting to engage in collective bargaining or make any agreement with any such group and the City shall not:
 - 1. Interfere with, restrain or coerce employees in the exercise of their rights, to join or refrain from joining a labor organization, except where permitted by law to avoid a conflict of interest.

2. Initiate, create, dominate, contribute to or interfere with the formation or administration of any employee organization meeting the requirements of law.
3. Discriminate in regard to employment or conditions of employment in order to encourage or to discourage membership in a labor organization.
4. Discriminate against any employee because he/she has given testimony or taken part in any grievance procedure or other hearings, negotiations or conferences as part of the labor organization recognized under the terms of this Agreement.
5. Refuse to meet, to negotiate or to confer on proper matters with representatives of the Association as set forth in this Agreement.

ARTICLE VII RIGHTS OF EMPLOYEES

- A. Firefighters hold the status of public officers by the nature of their office, employment and duties.
- B. The well-being of the community depends to a large extent upon the manner in which firefighters perform their duty. Thus, their employment is in the nature of a public trust.
- C. The powers and duties given to the Bureau and its employees involve them in all manner of contracts and relationships with the public. Out of these contracts may come questions concerning the actions of employees of the Bureau. These questions may require immediate investigation by a chief officer. In an effort to insure that these investigations are conducted in a manner conducive to good order and discipline, the following rules are adopted:
 1. The interrogation of an employee shall be at a reasonable hour, preferably when such employee is on duty, unless the urgency of the investigation dictates otherwise, in which event reassignment of such employee should be employed. In the event neither of the above alternatives is feasible and such employee's time is lost, such employee shall be compensated therefore pursuant to the provisions of Article IX, C.
 2. Interrogation shall take place either at the Fire Headquarters or at the Office of the Corporation Counsel at the election of the City, or at such other places as to which the City and the Association may agree.
 3. An employee shall be informed of the nature of the investigation before any interrogation commences, including the name(s) of the complainant(s). The addresses of the complainants and/or witnesses need not be disclosed. However, sufficient information reasonable to appraise such employee of the allegation should be provided. If it is known

that such employee is being interrogated as a witness only, he/she must be so informed at the initial contact.

4. The questioning shall not be overly long. Reasonable respites shall be allowed. Time also shall be provided for personal necessities, meals, telephone calls and rest periods as are reasonably necessary.
 5. The employee shall not be threatened with transfer, dismissal or other disciplinary punishment. No promises of reward shall be made as an inducement to answering questions.
 6. An employee who is under arrest or who is a suspect in a criminal investigation or whose arrest may be occasioned as a consequence of this interrogation or who may thereby be placed in jeopardy of personal freedom or employment shall be afforded all Constitutional rights prior to and throughout the investigation.
 7. Interrogation records shall be the property of the City, but a copy will be made available to the Association or to the employee upon request.
 8. In all cases, the City shall afford an opportunity upon request, to consult with counsel and/or his/her Association representative before being questioned concerning a violation of law or the Rules and Regulations. Counsel and/or a representative of the Association may be present during interrogation.
- D. No entry shall be placed in an employee's personnel file without giving written notice thereof to the employee within five (5) days of the making of such entry. Every employee shall have the right to examine his/her personnel file at any reasonable time upon request, and to enter in his/her file such written exculpatory or explanatory matter as he/she may determine.
- E. In the event that an investigation results in the institution of disciplinary action, a representative of the Association shall be entitled to participate in all stages of the proceedings and shall be provided with a copy of all charges and specifications, recommendations and decisions, if requested by the employee.
- F. Unless the affected employee should otherwise agree, with prior notice to the Association, all disciplinary proceedings shall be controlled by Article V of the Civil Service Law of the State of New York and the grievance and arbitration procedures herein. Such agreement shall in no event constitute a precedent in other cases.
- G. No employee shall be required to submit to a polygraph test during the investigation of alleged departmental misconduct.

ARTICLE VIII GRIEVANCE PROCEDURE

A. DECLARATION OF BASIC PRINCIPLE.

Every Employee shall have the right to present a grievance in accordance with the procedures herein, free from interference, coercion, restraint, discrimination or reprisal and shall have the right to representation of his/her own choosing at all stages of the grievance procedure.

For the purposes of this Article, a “day” shall mean a 24-hour calendar day inclusive of Saturdays and Sundays but exclusive of legal holidays as set forth in Article XII herein.

B. INDIVIDUAL GRIEVANCE:

FIRST STAGE

An employee who claims to have a Grievance shall present the Grievance in writing to the Chief within ten (10) days after learning of the situation which created or caused the Grievance. The Chief shall discuss the Grievance with the Employee and shall make such investigation as he/she deems appropriate. Within ten (10) days after presentation of the Grievance, the Chief shall make his/her decision and communicate the same in writing to the employee and to the Association.

SECOND STAGE

If any employee presenting a Grievance is not satisfied with the decision made by the Chief, he/she may within ten (10) days thereafter, request in writing, a review and determination of the grievance by the Mayor.

Within ten (10) days after the request for review has been submitted, the Mayor shall make a decision and communicate the same in writing to the employee and to the Association. The Mayor’s decision shall be final unless such individual Grievance is timely joined by the Association as a Policy Grievance, in which case the Grievance shall proceed directly to the Policy Grievance, Third Stage level.

C. POLICY GRIEVANCE

FIRST STAGE

A Policy Grievance may be initiated by the Association, and shall be submitted in writing to the Chief within Sixty (60) days of the event giving rise to the Grievance.

Within ten (10) days after the Policy Grievance has been submitted, the Chief shall make a decision and communicate the same in writing to the Association.

SECOND STAGE

If the Association does not accept the decision of the Chief, an appeal therefore may be taken to the Mayor within ten (10) days from the receipt of the Chief's decision.

The Mayor shall make a decision and communicate the same in writing to the Association within ten (10) days.

THIRD STAGE

If the Association is not satisfied with the Mayor's decision, it may, within twenty (20) days therefrom request Arbitration by the New York State Public Employment Relations Board (PERB). The Arbitration shall proceed in accordance with the rules and procedures established by PERB. Fees and expenses of the Arbitrator shall be paid in full by the losing Party, except as may otherwise be apportioned by the Arbitrator.

The decision(s) of the Arbitrator shall be binding upon all parties.

**ARTICLE IX HOURS OF WORK AND OVERTIME, MANNING AND RECALL,
SAFETY STAFFING**

- A. The basic work week for all employees shall be forty (40) hours averaged over a calendar year. In view of the requirements that the City be protected twenty-four (24) hours a day, seven (7) days per week, the Chief of Fire shall schedule assignments and tours of duty subject to the provisions of this Agreement.
- B. The basic work day (tour of duty) for all employees (excepting only the Fire Inspectors) shall be twenty-four (24) hours.
- C. Any employee working in excess of one (1) tour of duty shall be guaranteed a minimum of one (1) hour of work and be compensated for all such additional time, at one-and-one-half (1 ½) times the regular hourly rate as defined in Schedule "A" annexed. The employee may elect to take compensatory time (based on the on-and-one-half (1 ½) times the hours worked) in lieu of cash payment. However, compensatory time earned by an employee shall be paid upon thirty (30) days written notice, minimum of twelve (12) hours, at a rate in effect at the time paid or can be accumulated to the extent allowed by State and Federal Law. A firefighter recalled to duty as set forth in paragraph K shall be compensated for all time so spent, commencing with the time his recall was activated, at one-and-one-half (1 ½) his/her regular hourly rate and shall be guaranteed not less than four (4) hours pay.
- D. In the event that the City finds it necessary to change the present Table of Organization of the Bureau of Fire, the City will notify the Association thereof, in writing, not less than ten (10) days prior to the effective date of the proposed reorganization. The Association

shall have an opportunity to be heard thereon and to examine the proponents thereof. The provisions of Article XVIII (Special Conferences) shall be applicable thereto.

- E. In the event overtime is required on a particular occasion, other than a recall under paragraph K, strict seniority on a platoon shall apply.
- F. No preference for overtime shall be given to persons who have heretofore filed or will file a notice of intention to retire, it being the intent of the parties that overtime shall be made available, when required, on a strict seniority basis connected to non-contiguous platoons, i.e., the first platoon shall work required overtime on the third platoon and vice versa; the second platoon shall work required overtime as may be required on the fourth platoon and vice versa.
- G. All employees who may be entitled to overtime shall be limited in overtime to a maximum of eighteen thousand (\$18,000) dollars annually.
- H. Employees who happen to be at the scene of a fire or other emergency and who render assistance shall not be entitled to wages that would otherwise have been earned during such time unless they are employees of a unit being recalled. However, in all other respects the provisions of Article XXIII (1) will apply.
- I. Cancelling Time-Off/Overtime:

In order to be fair to all parties with regard to cancelling time off the following will be used:

(1) If a request to cancel time off is received and approved at least twelve (12) hours prior to the start of the overtime, the overtime will be cancelled.

(2) Notification received after the twelve (12) hour period will result in the individual scheduled for overtime working, and being paid for the minimum hours stated below. The individual requesting the cancellation must use the same minimum. Present minimum time off allowed are:

Personal Leave – two (2) hours
Comp Leave – two (2) hours
Bonus Leave – four (4) hours

- J. Daily Manning:
 - 1. If a firefighter is not immediately available for the filling of daily manning vacancies he/she shall be skipped over. The firefighter replacement shall be from a non-contiguous platoon.

2. Officers or firefighters on authorized leave, except vacation or Kelly Day, shall not be called when their platoon is working.
3. Overtime for manning shall be given to the non-contiguous platoon, (opposite platoon). This will be done for overtime known in advance. The duty battalion chief will fill vacancies for the opposite platoon from the men working in his/her shift, i.e.:

- 1st plt. vacancy will be filled from the 3rd plt.
- 2nd plt. vacancy will be filled from the 4th plt.
- 3rd plt. vacancy will be filled from the 1st plt.
- 4th plt. vacancy will be filled from the 2nd plt.

A block of vacancies will be given out at approximately 1700 hours. Any vacancies occurring after 1700 hours will be counted as separate openings.

4. If a vacancy occurs for the oncoming shift for which there was no advance notice, the vacancy will be filled by the shift going off duty, i.e. up to four (4) hours. Over four (4) hours will be given to the non-contiguous shift and to the returning personnel, if available.
5. Twelve consecutive hours shall be the maximum overtime unless authorized by the Chief or if overtime cannot be filled from their list because of unavailable personnel, the battalion chief will use other platoons as set forth in Paragraph J sub 3.
6. Safety staffing – Beginning January 1, 2001, the Bureau of Fire will schedule 22 firefighters, and up to 2 additional safety staffing firefighters per day for a total of 24 firefighters per day for a maximum of 300 days. In no event shall the Bureau be obligated to schedule more than 600 individual safety staffing tours of duty per year, and it may schedule less than that number if such safety staffing tours of duty are not necessary to achieve a daily compliment of 24. The parties intend that if the Bureau meets its maximum safety staffing obligation hereunder (600 individual tours of duty per year), nothing herein will require the Bureau to achieve a compliment greater than 22 firefighters working per day. However, the City may, in its sole discretion and in accordance with this agreement, utilize safety staffing for more than the maximum 600 tours of duty. Safety staff personnel will be paid in accordance with the safety staffing rates in Schedule “A”. If the overtime compensation of UFA members exceeds \$265,000*, the Bureau will schedule 21 firefighters and up to 3 additional safety staffing firefighters per day. For the purpose of this clause “overtime” means all overtime compensation paid or credited (regardless of form) to achieve a staffing level of 22. For example, overtime for recall, paramedic training, EMT training, supervisory training, personal leave payments, payments for prior years’ compensatory time and Chiefs’ overtime are excluded.

7. The \$265,000* overtime cap was calculated using staffing levels which existed on 8/17/00. If the City fails to fill a vacancy within thirty (30) days, the parties agree to hold a labor-management meeting as soon as reasonably practicable to adjust the \$265,000* overtime cap upwards fairly and proportionately. If the City increases the force strength, the parties agree to adjust the cap downward fairly and proportionately.

*Note: The parties will negotiate a new OT cap figure taking into consideration factors affecting the cap such as compensation increases and staffing levels.

8. The UFA and City agree that the straight time rate for the safety staffing will be used exclusively for safety staffing and has no precedential value whatsoever for determining the appropriate pay rate for other types of work. Safety staffers will be chosen exclusively from UFA members.
9. The UFA and the City agree to form a committee called the “Safety Staffing Policy Committee”. It is the goal of this Committee to develop a set of written safety staffing policies which will be used by the Troy Fire Department to implement the safety staffing contemplated by this Agreement. The Committee will meet as often as often as necessary, but in any event, no less than once a month. The Committee will have as its goals:
 - a. To develop the policies which will assure that all members of the UFA have an equal opportunity to work on the safety staffing assignments. Safety staffing will only be assigned on a rotating basis. No member who is qualified to work as a Firefighter will be skipped for safety staffing.
 - b. To develop policies which provide reasonable prior notice to UFA members, as much as one month in advance if practical, of when his or her safety staffing assignment will occur unless unexpected vacancies occur.
 - c. To develop the policies which implement other portions of this agreement, (e.g. No trades; no use of personal leave; refusal of safety staffing on 24 hours’ notice; filling of refused safety staffing assignments, etc.).
10. In the event that an officer is assigned to an entire company for safety staffing, he or she will ride the seat but the previously bid out of grade will be paid to the acting officer on that apparatus.
11. Except in cases of an emergency, safety staffing firefighters will be assigned as the third person on an engine company only.
12. Firefighters will be allowed to work a maximum of two (2) safety staffing days per month. It is the intent of both parties that this agreement will not create or increase overtime, and will comply with the FLSA.

13. A safety staffing tour of duty will be 24 hours in length, from 0800 to 0800. Firefighters may refuse a safety staffing assignment by providing a minimum of 24 hours' notice prior to the scheduled safety staffing assignment. Firefighters will not trade safety staffing assignments, or use personal leave or other leave time after accepting a safety staffing assignment unless an emergency arises and then, only with the permission of the chief officer.
14. Whenever an officer is recalled on overtime to meet minimum manning requirements, the second officer position on the same apparatus may not be filled with out-of-grade.
15. Leave Time – All compensatory and bonus time off will be calculated on the basis of twenty-six (26) men on duty. Personal leave can be taken as per Article XIII (C).

Regular Comp	Two (2) hour blocks
Holiday Comp	Two (2) hour blocks
Bonus Leave	Four (4) hour blocks
Personal Leave	as per contract

All requests for time off (except PL) must be received by 1800 of the duty day. Requests will be handled by seniority until 1800 hours, after which time will be given out on a first request basis.

Personnel will be prioritized in deployment according to the apparatus structure set up in the operating table of organization.

16. Manning re-opener may be requested by the Troy UFA at any time of a public safety fee charge is paid by any university or college. The parties may put forth such proposal(s) as they deem appropriate. Said re-opener will not guarantee an increase in manning levels but decreases in manning levels will not be discussed. Troy UFA will give 30 days notice of intent to negotiate.
- K. **RECALL:** The employer recognizes its obligation to utilize fully the service of its own firefighters in situations which may also require outside assistance under the Mutual Aid Program. Recall of off-duty firefighters and officers shall be placed in operation before or simultaneously with issuing any Mutual Aid call. The following procedures shall be put into effect in the event that recall of Fire Officers and Firefighters becomes necessary.
 1. In the event of a third alarm fire or depletion of all on-duty personnel, there shall be an automatic re-call. Recall shall be by shift seniority on the non-contiguous shift. A minimum of six (6) firefighters will be recalled. All recalled members will be entitled to a minimum of four (4) hours' pay.

The Chief of Fire or the Assistant Chief in the absence of the Chief shall make the determination that public safety requires the recall of additional personnel. Upon any

recall, the Deputy or Battalion Chief shall effect notification of the employees as needed. If a Firefighter is not immediately available, he/she shall be skipped over. If the recall is ordered less than four (4) hours before the end of the duty shift, the platoon to be the one that would normally have reported at the change of shifts, otherwise the platoon to be recalled shall be the non-contiguous platoon. A record shall be maintained of each Firefighter recalled, showing whether or not the employee reported for duty. A copy of such record shall be provided to the Association without delay.

2. Such Firefighters and Officers shall be selected in the manner provided in Section "1" by seniority.
3. An Officer or Firefighter scheduled for vacation, absent because of work-related disability, or who has reported sick, shall not be subject to recall.
4. In the event that the Chief of Fire or Assistant Chief in charge decides that the situation requires more men than available in the two (2) platoons, he/she may call additional employees of either of the remaining platoons as, in his/her opinion, the circumstances may require. All of the terms and conditions set forth herein shall be applicable to the recalled employees in that platoon.
5. In the event that the Troy Fire Department personnel are dispatched outside of City limits the Chief or the Assistant Chief (or the Battalion Chief in their absence) shall recall an equal number of firefighters as are committed to the scene of mutual aid.

ARTICLE X PERMANENT, PROBATIONARY AND PROVISIONAL FIREFIGHTERS

Subject to the provisions of the Civil Service Law and the applicable rules of the Civil Service Commission, employees of the Bureau of Fire are hereby classified as follows:

- A. Permanent Employees: A permanent employee is one who has completed the probationary period after appointment from a Civil Service List.
- B. Probationary Employees: A newly appointed employee shall be deemed on probation for the minimum period required by the Rules and Regulations of the Civil Service Commission. The City may extend the probation period beyond the minimum and up to the maximum period provided by law upon giving notice to the employee as to the reason why the appointment has not been made permanent. The employee shall, during probation, be entitled to all the benefits available under this Agreement. The same provisions shall apply to an employee who has received a promotional appointment and is required to serve a probationary term by law or by rules of the Civil Service Commission.

- C. Provisional Employees: A provisional employee is one who is holding a position without appointment from a Civil Service List. The term of appointment of a provisional employee shall be in accordance with the Civil Service Law and the position shall be filled as soon as it is possible to do so by permanent appointment.

ARTICLE XI SENIORITY

- A. Seniority shall be determined as of the date of the employee's appointment from a Civil Service List as a firefighter in the City of Troy. If two (2) or more employees are appointed on the same day, the person standing highest on the Civil Service eligibility list shall be considered the senior appointee. Officer seniority shall be determined as of the date of the Civil Service promotion but if two (2) or more officers of equal rank are promoted on the same day the firefighter holding the higher mark shall be the senior appointee. If two (2) or more officers are promoted on the same day to the same rank and have equal grades on the Civil Service examination, the officer with the greater length of service shall be senior. If a tie exists after applying the above standards to any employee, whether officer or firefighter, a flip of a coin will determine seniority.

Included, for purposes of seniority, shall be time spent in the armed forces on military leave from the Bureau, time lost because of duty-connected disability, sick leave, or authorized leave of absence not to exceed one (1) year. A leave of absence to engage in other employment or field of endeavor shall not be included.

- B. An up-to-date seniority list showing the names, length of service dates, Civil Service examination grades, where necessary, and rank shall be furnished to the Association every six (6) months. A copy of the list shall be maintained for inspection by employees.
- C. Employees shall lose their seniority for the following reasons:
1. Resignation.
 2. Dismissal without reinstatement.
 3. Retirement.
 4. Unexcused failure to return to work when recalled from layoff.
 5. Unexcused failure to return to work after expiration of formal leave of absence.
- D. Seniority shall be a major factor in filling job openings, unless the senior employee is not qualified to perform the duties required. It is recognized, however, that the public safety must not be jeopardized through artificial constraints resulting from the application of strict seniority.

- E. In determining preference for the purpose of selection of assignments, seniority within rank shall control except as provided by Article XXI, paragraph “B”.
- F. Seniority within the Bureau shall govern layoffs and recalls. The employee lowest on the Seniority list shall be the first laid off and the last to be recalled.

ARTICLE XII HOLIDAYS

- A. All employees whose tour of duty does not require them to work shall be released from duty without loss of pay on the following holidays:

New Year’s Day	Independence Day
Martin Luther King Day	Labor Day
Lincoln’s Birthday	Columbus Day
Washington’s Birthday	Veterans’ Day
Easter Sunday	Thanksgiving Day
Memorial Day	Christmas Day

- B. Furthermore, each employee shall be paid twelve (12) additional days pay whether he/she is required to work on any of the above-mentioned holidays. Such additional holiday pay shall be accumulated from December 25 of each year and paid in a lump sum on the first pay day of December of the following year.
- C. An employee on unpaid holiday leave of absence or layoff shall not receive holiday pay during such leave.
- D. Holiday pay will not be paid to an employee scheduled to work on a holiday who fails to report for such work, unless he/she provides a good satisfactory reason for the absence.
- E. Whenever civilian city employees are excused from work because of a special event not included in the regular leave calendar (such as Good Friday, death of an important public figure or any other occasion declared a holiday by the City, State or other Federal authorities), equal times off shall be allowed to employees of the Bureau, either on the same day, or if required to work that day, on another day. This provision shall not apply to the practice of allowing clerical employees to leave work at 4:00 p.m. during July and August.
- F. When an employee’s tour of duty falls on a holiday as defined in paragraph “A” above, and said employee works such tour, he/she shall be granted six (6) hours compensatory time in addition to any other compensation as specified in paragraph “B” above. Only the tour starting at 8:00 a.m. on the holiday will be entitled to the compensatory time. Such compensatory time, to the extent allowed by State and Federal Law, not used within one year shall be banked until retirement to be paid at the rate in effect at the time of

payment. For the purpose of this section, Martin Luther King Day, Lincoln's Birthday, Washington's Birthday, Memorial Day, Labor Day and Columbus Day, will be the day in which the rest of the City employees have off. New Year's Day, Easter Sunday, Independence Day, Veterans' Day, Thanksgiving Day and Christmas Day shall be the Traditional Day.

ARTICLE XIII LEAVES OF ABSENCE

A. Sick Leave

1. All employees shall be allowed time off for illness without limitation. Any employee absent because of illness shall notify the Desk Officer of the Communications Center of such absence and the reason therefore at the beginning of his/her scheduled tour of duty on the first day of such absence, unless his/her physical condition prevents him from giving such notice, in which event, notice shall be given as soon as possible.
2. Whenever an employee is reported sick or disabled, it shall be the duty of the Fire Surgeon to inquire into the employee's condition as soon as possible and, if in his/her judgment, such employee may be unable to perform his/her duties or may require the attention of a physician, said surgeon shall issue a certificate relieving the employee from duty.
3. If an employee becomes disabled because of injuries received in the course of his/her employment with an employer other than the City of Troy and, when injured, such employee is not engaged in the activities related to his/her duties as an employee of the City of Troy and the employee is receiving Workers' Compensation benefits from such Employer or his/her insurance carrier, the employee shall be continued on sick leave for such period of disability up to the maximum provided in Section 73 of the Civil Service Law.
4. If the Surgeon determines that an employee is not physically fit for duty as a firefighter, his/her sick leave will be continued until such time as the Surgeon certifies him fit for full active duty.
5. If an employee does not take any sick leave during any consecutive six (6) month period, he/she shall accrue twelve (12) hours of "bonus time" which he/she may elect to take during the next twelve (12) months or to bank until retirement at which time he/she shall be paid for such earned at the rate in effect at the time of payment, or use them to accelerate retirement.

B. Vacation Leave.

1. Vacation leave is authorized absence from duty with pay. No seasonal, temporary or part-time employee is eligible for vacation leave. Provisional employees as defined in Article X above, are entitled to vacation leave.
2. Vacation leave shall be earned in accordance with the following schedule:

<u>TIME EMPLOYED</u>	<u>VACATION LEAVE EARNED</u>
6-12 months	0 calendar days
13-60 months	14 calendar days
61-120 months	21 calendar days
121-180 months	28 calendar days
181-240 months	35 calendar days
241-300 months	42 calendar days

Employees hired before 1/1/2001 will receive a maximum of forty-two (42) calendar days of vacation, except that Tier 1 employees hired before 1/1/2001 will receive forty-nine (49) calendar days of vacation at 301 months of service.

Firefighters hired after 1/1/2001 will have the following vacation schedule:

13-60 months	14 calendar days
61-120 months	21 calendar days
121-240 months	28 calendar days
241+ months	35 calendar days

3. Employees shall receive credit for a month worked for every month in which they receive wages for a minimum of fifteen (15) calendar days. Time lost by an employee by reason of absence without pay shall not be considered in computing earned credits for vacation leave. Credits for months earned shall be computed from the date of the appointment as an employee of the City of Troy.
4. "Kelly Days" (compensatory time off to average the work week) shall be earned by each employee on the basis of one (1) Kelly Day for each thirteen (13) weeks in the year in which the employee works for seven (7) or more weeks. Kelly Days which occur during a vacation period shall be added thereto. Vacation days shall be counted as time worked for purposes of calculating Kelly Days. All Kelly Days will be selected by shift seniority.
5. Effective July 1, 1998, employees may accumulate vacation leave credits for future use to a maximum of forty-two (42) calendar days. However, Employees hired before October 18, 2001 may bank 49 calendar days once they have 301 months or more of service.

6. Vacation leave schedules shall be designated by the City so as to permit the continued operation of all City functions without interference. Available vacation leave period schedules shall be posted prior to January 1 of each year. All vacation periods shall be for a minimum of seven (7) calendar days. Vacation leave for periods of less than seven (7) calendar days will be allowed only when good cause exists. Fourteen (14) calendar days is the maximum that may be selected on the initial vacation pick. A maximum of fourteen (14) additional days may be selected on the subsequent vacation picks. After selections are approved, they shall be final, except for emergencies or, if permitted, by the schedules.
 - (a) Vacation period shall commence on a Saturday and end on a Friday.
 - (b) Assignment of vacations (one employee per vacation group per vacation period) shall be based on Bureau seniority on each platoon within each group. For the purpose of picking vacations, there shall be four (4) vacation groups per platoon with a practically equal number of employee positions per group.
 - (c) During a vacation period, not more than four (4) members from a platoon shall be on vacation. In the event of a transfer, if the successful bidder moves within their platoon, their prior vacation bids will remain intact. If the successful bidder moves outside their platoon and has previously selected a vacation slot during the period June 1 through September 30, their vacation entitlement during that period will be conditioned on no more than 4 persons on their platoon being on vacation during that selected slot. In the case of the successful bidder moving outside their platoon, the successful bidder will forfeit their selected vacation slot and be allowed to reselect other available vacation slots and be given priority regardless of seniority.
 - (d) Vacations may be cancelled or added with the approval of the Chief of Bureau, up to 1600 hours, the platoon work day prior to the start of the platoon vacation period. Such approval shall not be unreasonably withheld.
7. No employee shall utilize vacation leave credits prior to the completion on one hundred twenty (120) calendar days of employment.
8. Employees shall be entitled to compensation for unused vacation leave in any of the following circumstances:
 - (a) upon the employee giving at least five (5) working days for twenty (20) calendar days written notice regarding termination of his/her employment with the City;

- (b) upon the employee being placed on indefinite layoff or separated from the City for reasons other than disciplinary action;
- (c) upon the employee entering military service;
- (d) any employee entitled to vacation leave time who may die prior to his/her receipt of said benefit shall have an amount equivalent to his/her pay for such unused vacation leave time paid to his/her next-of-kin or estate;
- (e) any employee may, with written approval of the Mayor, continue to work in lieu of taking a vacation, in which event he/she shall be paid for his/her vacation time as well as for working time;
- (f) any employee entitled to vacation benefits who may become ill or incapacitated prior to the taking of such vacation shall have the right to postpone the taking of such vacation time until such time as he/she is physically capable of so doing. If such vacation cannot be rescheduled within the same calendar year and exceeds in whole or part the maximum accumulation allowed under this Article, such excess over the maximum accumulation shall be credited as compensatory time which, if not taken by December 31 of any year, will be paid for on the following February 1.

9. A leave of absence without pay, or a resignation followed by reinstatement or re-employment in City service within one (1) year following such resignation, shall not constitute an interruption of continuous service for the purpose of this section; however, that leave without pay or the period between resignations and reinstatements or re-employment during which the employee is not in City service shall not be counted in determining eligibility for additional vacation leave credits under this section.

10. Employees may utilize earned vacation leave credits in case of illness or death of family members other than those defined under the personal leave provisions of this contract as “immediate family”. Advance notice of not less than twenty-four (24) hours shall be required, if possible.

C. Personal Leave.

1. Employees shall be entitled to an annual maximum of forty-eight (48) hours of personal leave. Said leave may be taken upon the giving of prior reasonable notice to the Duty Battalion Chief. The taking of any part of the forty-eight (48) hours must be in two (2) hour blocks. Such blocks may be combined, but must be taken consecutively and without interruption to a maximum of twenty-four (24) hours.

2. (a) The Chief Executive Officer shall allow personal leaves of twelve (12) hours duration on December 24, 25, 31 and January 1 except that no employee may take more than one (1) such leave on these four (4) dates.

Requests for personal leaves for these dates must be submitted to the Chief not later than 12:00 noon on December 10. Leave shall be granted on the basis of overall service time with the Bureau regardless of rank. No personal leave shall be granted on these dates that, at the time of the Chief Executive Officer's approval, necessitate either the recall of personnel or the removal of a piece of apparatus from duty. Except for vacations, personal leave shall take priority over all other leaves.

(b) All holiday leaves will be given in four hour blocks starting at 0800 hours. Leaves of less than four hours will begin on an even hour within the four hour block.

(c) Notwithstanding anything to the contrary elsewhere in this agreement, personal leave may be granted for an emergency situation, regardless of manning levels.

3. Employees shall be granted up to five (5) consecutive calendar days with pay due to death in one's immediate family, the last day of which shall be the day following the funeral except, however, as may be otherwise authorized by the Chief. The term "immediate family" shall mean natural or foster step parents, or grandparents, children, brothers, sisters, spouse, father-in-law, mother-in-law or any relative residing in the household of the employee.
4. An employee shall be allowed all necessary release time with pay to take Civil Service examinations for positions within the Department of Public Safety. Such employee will not be required to work as of and after midnight of the night preceding the examination.
5. Employees who are within eighteen (18) months of their retirement date (20 years) shall be entitled to one eight (8) hour day leave with pay to be used anytime within that eighteen (18) month period for the purpose of seeking retirement/career and/or related financial counseling or planning.

The City shall facilitate the same by making available at the employee's option free consultation with appropriate City personnel to assist in such counseling and/or planning and to provide such information as the City may have with respect to the employee's rights and benefits upon retirement from the Bureau.

An Employee who chooses to remain with the Bureau for three and one half (3 ½) years after his/her retirement date is thereafter entitled to another one eight (8) hour day leave with pay, to be used anytime for the purposes set forth above.

6. Members shall be paid for unused personal leave as of the last day of the year, to a maximum of twelve (12) hours of unused personal leave, not later than February 1 of the following year.

D. Military Leave.

1. The City will abide by the re-employment rights as provided in the Selective Service Act and in the New York State Military Law, as they are in effect or may be amended. Employees who are members of the National Guard or of a Military Reserve organization, will be granted a leave of absence without pay if called to active duty.

2. As more fully set forth in Section 242 of the Military Law, firefighters who are members of the National Guard or any Military Reserve organization and who are required to attend training sessions or other military duty shall be granted leave of absence with full pay for a period not to exceed thirty (30) days and such leave will not be charged to vacation or any other leave provisions of this Agreement.

E. Leave of Absence Without Pay.

1. The Chief of the Bureau of Fire may grant leaves of absence without pay to employees for periods of up to ten (10) consecutive working days, not to exceed fifteen (15) working days per calendar year. Leaves in excess of ten (10) working days must be approved by the Mayor. No leave shall exceed one (1) year.

2. Refusal of a leave of absence without pay by the Chief shall be appealable directly to the Mayor but shall not be a subject for the grievance procedure.

3. Employees shall request such leaves of absence in writing in advance of the date so desired; however, the Mayor or the Chief may make exceptions in emergency situations.

4. For leaves exceeding thirty (30) days, the employee may continue such benefits as hospitalization, life insurance, etc., at his/her own expense.

5. If two (2) or more employees request leave for the same period and the City cannot spare more than one, the senior employee shall be given preference, unless the other employee needs time for cogent, emergency reasons.

F. Leave of Absence for Association Representatives.

Association officers, representatives and delegates will be allowed all necessary release time with pay to participate in negotiations with the employer, adjustment of grievances, arbitration hearings and other functions relative to the operation of this Agreement. They also will be given leave with pay to attend association and executive board meetings and

to participate in and attend conferences and conventions of affiliated associations and organizations. Three (3) members will be given time to attend such conventions.

G. Trade Work Policy.

1. A "Leave/Leave Change Request" form shall be completed by the person requesting the trade off. The form shall have the requesting member's name, his/her signature and the date the request was made. The date and the time of the trade shall be indicated. The box marked "other" shall be checked off and the name of the person who will "trade work" will be indicated.
2. The on-duty battalion chief must approve or disapprove the leave slip request.
3. Approved forms shall be kept with the daily platoon sheet for that date and sent to the chief's office with the daily sheet.
4. Trades are authorized with the understanding that a man shall be working for another individual and therefore the taking of time off by the person trade working shall not be allowed.
5. The individual trade working must be qualified for the position.
6. When a formal training class is scheduled, the trading of time shall not be allowed during the class period without approval from the Chief's office.
7. Should the individual trade working not report for work or leave sick or injured, the individual trading-off is responsible to see that his/her position is filled. Leave time of the City's choice shall be deducted from the trade-off person until the opening is filled.
8. Multiple trades during a tour for one individual shall be allowed with permission of on-duty Battalion Chief.
9. Personnel allowed to trade cannot work longer than thirty-six (36) hours in a forty-eight (48) hour period. This includes their own platoon assignment.

ARTICLE XIV HEALTH INSURANCE

- A.1. The City shall continue in effect the City's Self-insured Health Plan with benefit levels identical to those provided the employees and dependents hereunder by the City on June 29, 1982 and as thereafter added, and as further improved in 1994 by adoption of the Blue Shield Point of Service Plan.
2. All members of the UFA will join the current city-wide Blue Shield health insurance program. Except as modified by paragraph A(3) below, the City agrees to provide

coverage which is equal to or better than the firefighters' existing coverage. The health insurance program, which is the UFA's existing coverage, will be Appendix "1" to the collective bargaining agreement and will be incorporated by reference in the agreement.

3. Effective September 1, 2007, the Traditional Blue PPO 898 will be modified as per the three (3) page document, attached as Appendix "2", except as follows:

Increase the copay for "specialty" visits to \$10. These include: Physical Therapy, Occupational Therapy, and Speech Therapy for a total of 180 visits. Home Health Care visits will have a \$10 co-pay for 200 visits. Diabetic supplies will have a \$5 co-pay.. It is also agreed that outpatient mental health visits will be reduced from 30 to 20 total annually. It is also agreed that inpatient substance abuse will be reduced from 7 days detox and 30 days rehabilitation to 7 days detox only – annually. (There will be no other reduction of benefits under the existing health plan.)

4. The cost of individual and dependent coverage under the above plan for permanent full-time employees will be provided by the City.
 5. Additionally, the City shall institute, provide and maintain a family G.H.I. dental plan of the spectrum 160 level of benefits including full reimbursement for basic prosthetics and orthodontic expenses or other carrier plan or equivalent for members of the Association and their dependents to which the City shall contribute one hundred percent (100%) to the annual premium for coverage of the members and fifty (50%) to the annual premium for coverage of their dependents, except that beginning January 1, 1989, the City shall pay one hundred percent (100%) of the annual premium for coverage of members and their dependents. There will be a \$2,000 annual cap per person on all dental work inclusive of orthodontic work.
- B. In addition to the benefits provided above, in accordance with Section 207-a of the General Municipal Law, an employee injured in the course of duty who requires hospitalization will be provided with care at the expense of the City.
 - C. In the event that at any time during the term thereof, the City shall unilaterally or otherwise increase, improve or otherwise enrich the benefits of any medical or dental insurance or similar programs for any employees or groups of employees outside the fire bargaining unit, then and in any such event, the Association shall be immediately entitled to notice thereof from the City and upon demand shall be entitled to enter into new negotiations with the City relative to the medical, dental or other similar insurance programs.
 - D. The City shall make available to employees retiring as of and after January 1, 1982, individual and dependent health insurance coverage equal to that provided active

employees and shall contribute to the premium cost of such coverage the cost thereof to the City as of July 1, 1981.

- E. The City shall make available to employees retiring as of and after January 1, 1988, individual and dependent health care coverage inclusive of dental coverage equal to that provided active employees and shall contribute to the premium cost of such coverage the cost thereof to the City at a rate of one hundred percent (100%) for health and medical insurance and fifty percent (50%) for dental insurance.
- F. Employees hired by the City on and after July 1, 1996, shall together with their dependents, have the same benefits under this article as present employees except that they shall contribute fifteen percent (15%) of the premium costs for individual and for dependent coverage throughout their employment with the City and throughout their retirement.
- G. The City guarantees that the benefits, costs and availability to UFA members under the current prescription drug plan will be equal to or better than the plan in existence on July 19, 2007 except as modified as follows:

Prescription co-pays will be increased to \$5 for generic drugs, \$15 for preferred brand name drugs and \$35 for non-preferred brand name drugs. Express Scripts will be offered a 90 day supply for the co-pay price of 60 day supply. The City will offer the Can RX Prescription Plan until each member is offered the opportunity to use this plan, Express Scripts will be offered to the member, free-of-charge. Should the Can RX Prescription Plan become unavailable, the parties will negotiate the impact of the same. (The change will not be effective until the contract is fully executed.)
- H. The City shall make available for each member a Health Savings Account/Child Care Account so the member may use pre-tax dollars to pay for qualifying expenses.
- I. Members shall have sixty (60) days from signing of new collective bargaining agreement to retire under existing health, prescription and dental coverage.

ARTICLE XV RETIREMENT PLAN

- A. The City shall be a participant in the New York State Policemen and Firemen's Retirement System and shall subscribe to the following plans.
 - 1. Non-contributory "25-Year Plan" (Section 384 and Section 375-c, e, g, h and i of the Retirement and Social Security Law).
 - 2. The City shall provide to all employees, without cost to such employees as elect to subscribe thereto, either the twenty (20) year retirement plan provided for in Section 384-

d of the Retirement and Social Security Law or the twenty-five (25) year Retirement plan provided in Section 384 (f), (g), or (h) of the Retirement and Social Security Law.

3. The City shall provide to all Tier 1 employees without cost to such employees, the one (1) year final average provision set forth in section 302 (9) (d) of the Retirement and Social Security Law.
 4. “In addition, effective January 1, 2002, the City will provide to all Tier 2 employees without cost to any Tier 2 employee the one (1) year final average salary benefit as provided in Retirement and Social Security Law Section 443(f). The quid pro quo for this benefit is the UFA’s agreement to accept a zero percent (0%) salary increase in the year 2002.”
 5. The City shall provide to all employees, without cost to such employees as elect to subscribe thereto, the benefits provided for in Section 384-e of the New York Retirement and Social Security Law.
- B. The following “fringe” retirement benefits shall be subscribed to:
1. Additional retirement benefits provided for in Section 341 (k) of the Retirement and Social Security Law (military service and World War II credit) in accordance with terms set forth in said statute.
 2. As available, reopening of the privilege of having service credited for a past period of military leave without pay.
 3. The right to purchase credit for service while a member of any other New York State or subdivision of the State’s retirement system.
- C. Eligible employees of the bargaining unit shall have the right to subscribe to the plans specified in Sections “A” and “B”. The City shall bear the entire cost of the contribution prescribed for the employees by the State of New York.

ARTICLE XVI WAGES AND OUT-OF-GRADE WORK

1. Wages:
The wage, salary scale and matters of economic consideration shall be as set forth in Schedule “A” attached hereto and made a part hereof by this reference.
2. Out-of-Grade:
An employee who is temporarily assigned to perform duties of a higher grade or rank shall be paid at the rate of the higher rank for every hour so employed.

3. The requirements for out-of-grade work (Firefighters only) shall be phased in over the terms of the contract to more closely mimic those requirements currently in place for sitting for promotional exams, e.g.:

2007 – 3 years as a Firefighter for out of grade as Lieutenant.

5 years as Firefighter for out of grade as Captain

2008 – 3.5 years as Firefighters for out of grade as Lieutenant

6 years as Firefighter for out of grade as Captain

2009 – 4 years as Firefighter for out of grade as Lieutenant

7 years as Firefighter for out of grade as Captain

4. Lieutenants:

Unless requested by the Lieutenant, there will be no out-of-grade movement except within house.

Lieutenants that bid the covering officer position shall cover all open Lieutenants' and Captains' positions. (In other words that Lieutenant will move to officer openings). This position may be used as a drill instructor.

ARTICLE XVII UNIFORM ALLOWANCE AND UNIFORMS

- A. Employees shall receive an annual allowance of \$402 for the purchase and replacement of official uniform items. This allowance shall be earned at the rate of Thirty-three and 50/100 Dollars (\$33.50) per month for each month in which the employee worked or received regular compensation for fifteen (15) days. Effective January 1, 2008, the uniform allowance will be increased to \$805 annually. The vouchers and pay will be accomplished on or before February 1 of each year.
- B. Such allowance shall be paid in cash or as a voucher to the employee in one annual lump sum on or before February 1 of each year.
- C. Payment of this allowance shall be in addition to and separate from the cost of protective equipment and apparel as mandated by the Federal OSHA Standard (29 C.F.R. Section 1910.156(e)(1)(i) and the New York State Public Employee Occupational Safety and Health Regulations (2 N.Y.C.R.R. Part 800), it being the intent of the parties that such be supplied at the City's expense without charge-back or deduction from the allowance.
- D. All new or replacement equipment or wearing apparel hereafter acquired by the City shall meet all Federal and State OSHA Standards and be fire-resistant and of non-melting material. This requirement shall not be satisfied by the uniform allowance herein above provided.

- E. A newly appointed firefighter shall receive, at the City's expense, the following at the time of appointment: one (1) summer and one (1) winter work jacket, one (1) pair of shoes, four (4) work uniforms, two (2) pair suspenders, one (1) sweater, one (1) Nomex hood, one (1) pair of turn-out pants, one (1) blue cap, one (1) belt. Provisional employees shall receive the dress uniform at the conclusion of the probationary period.
- F. Newly promoted, transferred or reassigned employees shall be supplied by the City, at the City's expense, all additional uniforms, clothing and equipment required in connection with the new position.
- G. In the event that the City hereafter changes the Uniform worn by firefighters, the City will supply such new uniform at its expense and without charge-back or deduction to or from the employee's uniform allowance.
- H. Employees shall maintain their uniform in a neat and clean manner at all times. Directives by superior officers to repair, replace or clean uniform items shall be obeyed immediately.

ARTICLE XVIII SPECIAL CONFERENCES

The City and the Association agree to meet and to confer on matters of mutual interest upon the written request of either party. The request shall state the nature of the matters to be discussed and reason(s) for requesting the conference. Discussion shall be limited to matters set forth in the request, but it is understood that these special conferences shall be held at a time and place which is mutually agreeable. Each party shall be represented by not more than five (5) persons at special conferences.

ARTICLE XIX NEWLY CREATED AND VACANT POSITIONS

Newly created and/or vacant positions shall be filled from the Civil Service lists within thirty (30) days; provided, however, that if any list would expire prior to that time, the position will be filled before the expiration of the new list in existence at the time the vacancy occurs or the new position is created. If it is necessary that a position be filled temporarily until a list of propounded, the Bureau shall post the position and candidates who would be eligible to take the Civil Service examination may apply for the temporary job. The provisions of Article XXI (Vacancies and Transfers) shall apply. The person filling the Position temporarily shall be compensated at the rate that the permanent position will pay.

If a firefighter paramedic is not certified by the next scheduled re-test immediately following his/her failure, his/her position shall be deemed vacant and such paramedic shall then bid another position in accordance with Article XXI, excepting, however, that the position shall be vacated if

no other firefighter paramedic is available to bid or no employee with greater seniority elects to take such position.

ARTICLE XX PROFESSIONAL TRAINING AND IMPROVEMENT COURSES

A. The City and the Association agree that as many employees as possible participate in professional, educational and training courses whenever available. To facilitate the availability of such courses, the following criteria are hereby adopted.

1. The City shall post on bulletin boards located at all fire houses, announcements of all courses to be given which are either compulsory for a segment of the staff, are prerequisites to promotion or improved assignment, or may be optional for the purpose of improving the professional standing of the employee. All eligible employees shall have an opportunity to bid for the prerequisite and optional courses. In the event that there are more bids than openings available, the senior personnel will be given the preference subject to any special requirements by the institution giving the course.
2. Compulsory Courses: The City shall arrange all compulsory courses and training programs in such a manner so that any firefighter required to complete such course or participate in such course or participate in such training program shall be able to do so during his/her regular scheduled tour of duty.
3. Optional Courses: Any employee attending an optional education course related to the furtherance of his/her proficiency as a firefighter, with approval of the City given in advance, shall, if necessary, be given release time with pay, and shall upon successful completion be reimbursed by the City for the cost of the tuition and other expenses advanced by him in the taking of such course.
4. Prerequisite Courses: Whenever a course is given, which is a prerequisite for promotion or for improved or advantageous assignment, the timing of such course shall be so arranged as to permit all eligible and interested personnel to register in sufficient time to become a candidate for the position. Candidates in number up to three times the number of positions available selected on a seniority basis from the candidates for such positions shall, if necessary, be reassigned for the duration of such course so that they may participate in such course during duty time.
5. Special Courses: Whenever a special course is announced by an educational institution which will result in the improvement of the professional capacity of a firefighter, the City will arrange to permit as many of the personnel as are eligible to attend such a course, keeping in mind the criteria that if only a limited number can attend, seniority shall be the primary requirement for eligibility insofar as the City is concerned.

6. Compensated Attendance: Any time outside of regular employment hours at required courses or training sessions necessary for New York State Emergency Medical Technician or Paramedic certification shall be considered work hours and shall be paid for at time and one-half.
7. School. Personnel who are attending school while on duty shall not be covered by overtime.

(Exception): If the unit they are assigned to cannot be covered by qualified on-duty personnel (example: Paramedic unit).

ARTICLE XXI VACANCIES AND TRANSFERS

In selecting personnel hereunder, the following criteria shall be applied:

- A. 1. Vacancies shall be posted and employees desiring to be transferred to such assignments shall submit their written request to the Chief of Fire. The Bureau shall prepare a list of such applicants and appointments thereto shall be made by seniority unless the assignment requires special qualifications which the senior applicant is not eligible to meet. Therefore, whenever a position is available for which special qualifications or skills are required, the Bureau immediately shall arrange for training programs and those interested in filling the position shall be required to satisfactorily complete the course or program. The filling of the position on a permanent basis shall be deferred until the prerequisite training program has been completed and the selection made in accordance with the Article. Any firefighter bypassed in selection of such assignment shall be advised in writing of the reason therefore and may, if he/she believes the employer is in error, file a grievance.
2. Probationary Firefighters will not be eligible to bid shift and position vacancies during their term of probation. During the probation period the Department has the right to assign and reassign the probationary firefighter to shifts and positions.
3. The Fire Department will post for all shift and position vacancies within 15 calendar days of the occurrence of a vacancy. A vacancy occurs on the effective date of a resignation, retirement, promotion or reassignment of the prior occupant of the position.
4. A bid to fill a vacancy will remain open for no more than eight (8) calendar days.
5. Movement to fill a vacancy will occur no later than sixty (60) calendar days from the date of the bid award for the initial vacancy and any other bid generated as a result of the initial vacancy.

B. Day-to-Day Assignment:

1. Openings shall be bid by seniority; however; an employee may not use his/her seniority for lateral or downgrade assignment if such move to a lateral assignment would cause additional movement of personnel. Only the covering Lieutenant and/or the officer on the Apparatus cross-trained lateral to the squad may bid laterally or be assigned laterally.

The Bureau may detail a junior, qualified employee from one duty post to another temporarily vacant position within the same firehouse and/or between firehouses whenever the failure to do so would require the removal of a Company from service.

2. Captain Vacancies:

Step 1 Seniority among Lieutenants on the platoon shall govern.

Step 2 Seniority among Firefighters on the platoon who meet the requirements of Article XVI, Section 3 shall govern when Lieutenants are not available.

3. Lieutenant Vacancies:

Step 1 Seniority among Firefighters on the platoon shall govern so long as they meet the requirements of Article XVI, Section 3.

If no employees bid for such vacancies, the most qualified junior employee of the appropriate rank as outlined above shall be assigned.

C. In the event the City finds it necessary to upgrade an employee to fill a temporary vacancy in the rank of Battalion Chief, such assignment shall be made on the basis of seniority from among those available Captains working on the same platoons.

D. Rescue Squad:

1. Vacancies that are filled on the Rescue Squad will be filled by qualified personnel based on "on duty" platoon seniority. However, an employee may not use his/her seniority for lateral or downgrade assignment if such a move to a lateral or downgrade assignment would cause additional movement of personnel.

2. When the officer on the squad is off or detailed, the senior Squad qualified Lieutenant on the platoon may bid the vacancy, and if no Lieutenant is available, the senior Squad qualified firefighter on the platoon may bid the vacancy. Only Squad qualified personnel shall fill in on the Squad. However, an employee may not use his/her seniority for lateral or downgrade assignment if such a move to a lateral or downgrade assignment would cause additional movement of personnel.

ARTICLE XXII WAIVER CLAUSE

The parties acknowledge that during the negotiations which resulted in this Agreement each had the unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by the law from the area of collective bargaining and that the understandings and agreements arrived at by the parties after the exercise of that right and that opportunity are set forth in this agreement. Therefore, the City and the Association for the life of this Agreement each voluntarily and unqualifiedly waives the right and each agrees that the other shall not be obligated to bargain collectively with respect to any subject matter referred to or covered by this agreement.

ARTICLE XXIII MISCELANEOUS PROVISIONS

1. Since employees are presumed to be subject to duty twenty-four (24) hours per day, seven (7) days per week, any action taken by an employee on his/her time off, which would have been taken by an employee on active duty if present, or available, shall be considered official action and the employee shall have all of the rights and benefits concerning such action as if he/she were on active duty.
2. In the event that an employee is faced with a civil claim or sued, arising out of an incident or incidents related to his/her service with the bureau, the City shall provide legal counsel for him/her protection, at no cost, and hold him harmless from any and all financial loss, including punitive damages.
3. The Bureau will furnish for the use of the Association space for bulletin boards in various parts of the headquarters buildings and in other locations where Bureau personnel may be stationed. The Bureau will also provide the Association with mutually agreed upon office space. The Bureau will place available meeting rooms at the disposal of the Association.
4. Employees who are required to use their personal automobile for official purposes shall be compensated by the City at the standard mileage rate determined by the Internal Revenue Service for the applicable year, and appropriate highway toll charge(s).
5. The City shall within thirty (30) days of employment or execution of this Agreement provide each employee a handbook containing the Rules and Regulations of the Bureau and a copy of this Agreement.
6. The Association recognizes its responsibility as bargaining agent and agrees to represent all employees in the bargaining unit, without discrimination, interference or coercion.

7. Negotiation of a subsequent agreement shall commence not later than one hundred twenty (120) days before the budget submission date immediately preceding the expiration date hereof.
8. Wages, hours and all other conditions of employment legally in effect at the execution of this Agreement shall, except as improved herein, be maintained during the term of this Agreement. No employee shall suffer a reduction in such benefits as a consequence of the execution of this Agreement.
9. Firefighters required to appear in Court, as that term is defined in Article II (L), when not on a scheduled tour of duty shall be paid not less than a minimum of three (3) hours of Court time.
10. If any Article or Section of this Agreement or any Supplement thereto should be held invalid by operation of law or by any tribunal of competent jurisdiction, or if compliance with any enforcement of any Article or Section should be restrained by such tribunal, the remainder of this Agreement and its Supplements shall not be affected thereby, and the parties shall enter into immediate collective bargaining negotiations for the purpose of arriving at a mutually acceptable replacement for such Article or Section.
11. (a) The Safety Committee of the Association shall be free to inspect any equipment used in the work of the Bureau and to advise the Chief, in writing, of any faulty equipment found. The Chief, or his/her designee, will as soon as possible, not to exceed twenty-four (24) hours, inspect the subject equipment and determine whether it shall remain in service. Any employee who believes that a piece of equipment is unsafe and dangerous to life and limb, may request the Safety Committee to examine the same. In the event of dispute between the Safety Committee and the Chief's designee as to whether the continuance in service of the subject equipment constitutes a danger to life and limb of an employee, the subject equipment shall be recalled from service until a judgment is rendered by an Appellate Committee consisting of the Mayor, the President of the Association and the Chairman of the Safety Committee. Such Committee shall convene and render its decision within twenty-four (24) hours of the recall of the subject equipment. In the event the Association is dissatisfied with the decision of the Appellate Committee, the parties shall immediately and directly go to the Final Stage of Grievance as provided in Article VIII.

(b) A separate Joint Safety Committee, consisting of two (2) representatives designated by the Association and two (2) representatives designated by the City, shall meet and discuss all matters of safety affecting the members of the Bureau, including, but not limited to the total number of employees reporting to a fire

and/or to a medical emergency, together with the minimum number of employees to be assigned to each piece of fire fighting apparatus or medic rig. The only safety matter expressly excepted from the authority of this Joint Committee shall be that in Paragraph 11 (a) herein above.

12. (a) This agreement shall become effective as of January 1, 2013 and shall terminate on December 31, 2016. This Agreement shall supersede all Rules, Regulations, Ordinances, Charter provisions and directives inconsistent with the terms hereof. If the parties hereto have failed to agree upon a new contract on or before December 31, 2016, all of the terms and conditions set forth in this Agreement and any supplement and modification thereof, shall continue in full force and effect until the date of execution of the new Agreement.

(b) In the event that any other labor unit in the City of Troy is awarded by arbitration a greater salary percentage increase than contained in this agreement, the parties agree to reopen negotiations limited to salary increase. Thirty (30) days' notice is to be given the U.F.A. for the re-opener.
13. The City will provide a minimum of ten (10) parking spaces for each firehouse at no cost to the Firefighters. Such parking area shall not be located more than two hundred fifty (250) feet from the firefighter's respective firehouse.
14. The daily work schedule shall provide for one (1) twenty-four (24) hour work day on duty followed by three (3) consecutive days off duty.
15. Verbal orders concerning policy matters and involving all Bureau personnel and issued by the Chief shall be confirmed in writing within three (3) working days thereof and posted in each house.
16. Deferred Compensation Plan. The City shall offer to the employees such deferred compensation plan as may be established by the City and amended from time to time. The participation in said plan by any employee shall be at his/her option and shall be in accordance with the rules and regulations set forth in said plan as well as any applicable state and/or federal laws.
17. There shall exist a labor-management committee consisting of the Association President and two (2) members designated by the Association President representing the Association, the Chief and two (2) members designated by the Chief representing the City to meet quarterly and additionally as the members may mutually agree to consider matters of mutual concern and make non-binding recommendations including the method of uniform acquisition, excluding, however, the City's contribution to the uniform allowance.

18. (a) “Employees may elect to work Kelly days to a maximum of eight (8) such days during their tenure with the department. However, the Chief shall permit each employee to work up to four (4) additional Kelly days, if the employee, by working such additional Kelly day, will fill a vacancy that otherwise would be filled with overtime.”

(b) Any employee required to pay 15% of health insurance premium shall receive an additional Kelly Day annually. The Employee may work, at the overtime rate, the additional Kelly Day or receive time off, at his/her discretion. The UFA member may work any regularly scheduled day as his/her fifth Kelly day for pay. The member must inform the Battalion Chief of his/her intent on the previous work day. If the member wishes to have time off in lieu of pay, he must place his/her request 30 days prior to requested time off. The time off will be scheduled at the discretion of the Fire Chief, so as not to adversely affect the staffing or budget of the department.
19. Each Firefighter and Officer must keep his/her superior officer advised of his/her current telephone number and address.
20. Captain Prevention/EMS: The Captain position in prevention may also cover some of the duties of the EMS coordinator.
21. The 207(A) procedure agreement extant between the parties, executed on September 16, 1993, and as amended herewith, is made a part of this contract and shall be known as Schedule “B”. Further, the light duty therein described shall extend to and include personnel who are placed on non duty connected sick leave on and after July 1, 1996. All light duty personnel are subject to eight (8) or twenty-four (24) tour, or such portion thereof as may be medically permitted.
22. The City will adopt a workers’ compensation policy to cover all employees in the bargaining units as soon as reasonably practicable but not later than 1/1/2002.

ARTICLE XXIV PARAMEDICS

1. It shall be the policy of the City of Troy to be the primary provider of advanced life support care within the city, exclusively through its Bureau of Fire, and to maintain ALS apparatus inclusive of ambulance(s) in service at all times. There shall be a minimum of three (3) paramedics on duty at all times.

Recognizing its present operation of an ambulance component as part of its delivery of advance life support services, the city expresses and re-iterates its intent to continue operation of fire ambulance(s) in addition to the operation of other ALS apparatus.

2. Movement or transfer of paramedics will be allowed on or between ALS apparatus at any time for training purposes. All paramedics shall be required to work ALS apparatus to fulfill minimum skill level mandated and set by the department and REMO until all have so qualified. Rotation of paramedic personnel may occur without regard to strict seniority. Exchange of paramedic officer positions may occur without the paying of out-of-grade for training purposes and to meet set requirements.
3. Paramedics are required to bid all paramedic openings that are provided in the table of organization.
4. A firefighter-paramedic can only bid out of a paramedic position as the same are provided in the table of organization if there are more paramedics available to the Bureau than there are openings for such paramedics under the table of organization.
5.
 - (a) The paramedic courses will be paid for entirely by the City.
 - (b) The employee taking the initial paramedic course agrees to waive any overtime for the entire course.
 - (c) Any Paramedic who surrenders his/her certification before its normal expiration, without medical cause, shall reimburse the City proportionately for the unused part of the cost of his/her training.
 - (d) The employee will be given full release time to attend day or evening courses at Hudson Valley Community College, and required hospital rotation. Hospital rotation may occur during day hours.
 - (e) When employees are attending day or evening paramedic courses, or performing any required hospital rotations, replacement personnel shall not be called in.
6. Upon initial certification, paramedics will receive a premium pay bonus of \$1,251.00. This shall be in addition to the premiums provided for under Schedule "A".
7. The Lieutenant Paramedic position in the Bureau shall require New York State Paramedic certification, and promotion to such position shall be filled in the normal manner of selection from a Civil Service Lieutenant's List; however, in the event the selected candidate is not certified as a paramedic at the time of appointment, he/she shall be given one opportunity to obtain such certification at the next immediate regional course. Permanent promotion shall not be made until such course has been successfully completed.
8. Lieutenants on ALS units who lose their paramedic status must remain on the unit until there is a Lieutenant opening and a qualified paramedic officer to take his/her place.

9. Paramedic officers and firefighters cannot bid out-of-grade if there are no available paramedics working to take their place on an ALS unit.
10. Members hired after July 1, 1996 will be required to obtain paramedic certification within forty-five (45) months of their appointment. They may not proceed to Step 4 firefighter grade, notwithstanding period of service in the Bureau, until such certification is obtained.

However, if paramedic training extends beyond the duration of step 3 level because of unavailability, scheduling or delay in training, the member shall be retroactively made whole at the 4th step level upon his or her successful completion of the paramedic course. Those members who do not certify as a paramedic are not eligible for any promotional exams.

11. Members hired after July 1, 1996 shall be required to maintain their paramedic status for a minimum of nine (9) years unless they provide a medical or psychological waiver from the fire surgeon, or receive a waiver from the Mayor.
12. Members hired after July 1, 1996, who voluntarily surrender their paramedic status without medical or psychological waiver may not proceed beyond step 2 pay level, or if above step 2, will return to that pay scale level.
13. Members hired after July 1, 1996 shall not receive any premium pay for being a paramedic. However, effective January 1, 2002, any member hired after July 1, 1996, shall receive premium pay as provided in Schedule "A" (1)(D) for being a certified paramedic available to perform paramedic duties.
14. This contract shall be subject to the Troy Supervisory Board to the extent required by law.


SIGNATORIES

IN WITNESS HEREOF, THE PARTIES HAVE ENTERED INTO THIS AGREEMENT on this
31st day of August, 2017.

TROY UNIFORMED FIREFIGHTERS' ASSOCIATION LOCAL 86, IAFF, AFL-CIO

By: 
FRANCIS RAZZANO, PRESIDENT

THE CITY OF TROY, NEW YORK

By: 
PATRICK MADDEN, MAYOR

APPROVED AS TO FORM.

By: 
JAMES CARUSO
CITY OF TROY CORPORATION COUNSEL

2. All New York State certified paramedics will be entitled to receive paramedic premium pay in the amount of \$3,200 annually, providing such member remains available to perform paramedic duties, and \$1,250 annually, for each firefighter who possesses a valid State of New York authorization to engage in basic life support (EMT) procedures. Such premium pay shall be added to and made a part of the base salaries. Such premium pay shall be paid in two equal payments: (1) at the last pay period of June; and (2) at the first pay period of December of each year. For 2007 only, the difference from the June 2007 payment shall be added to the December 2007 payment. Effective January 1, 2012, the Paramedic stipend will be increased \$150.00 for a total of \$3350.00 per year. Effective July 1, 2016 the Paramedic stipend will be increased \$250.00 for a total of \$3600.00 per year. This \$250.00 increase will be payable in April, 2017. Effective July 1, 2016 the EMT stipend shall be increased \$250.00 for a total of \$1500.00 per year. This \$250.00 increase will be payable in April, 2017. Effective December 31, 2016 the Paramedic stipend will be increased an additional \$250.00 for a total of \$3850.00 per year. Effective December 31, 2016 the EMT stipend will be increased an additional \$250.00 for a total of \$1750.00 per year. These payments will be made in the normal course in 2017 and thereafter.

3. Safety staffing will be paid at the following hourly rates*:

	1/1/2012	12/31/2016
Captain – EMT	\$31.31	\$33.00
Lieutenant – EMT	\$29.24	\$30.93
Firefighter (7)-EMT	\$27.32	\$29.01
Firefighter (6)-EMT	\$27.32	\$27.56
Firefighter (5) – EMT	\$26.26	\$26.50
Firefighter (4) – EMT	\$24.46	\$24.70
Firefighter (3) – EMT	\$21.39	\$21.63
Firefighter (2) – EMT	\$19.85	\$20.09
Firefighter (1) – EMT	\$16.55	\$16.79
Starting Firefighter (0) – EMT	\$15.80	\$16.42

* These hourly rates are based on the 2013-2016 annual salary schedule plus \$1,250 EMT premium divided by 2080. Effective December 31, 2016 the EMT rate will be increased to \$1750 and a new step 7 will be added.

4. LONGEVITY:
 - A. To those employees who have completed five (5) years of service the sum of Eight Hundred and 00/100 Dollars (\$800) annually.
 - B. To those employees who have completed ten (10) years of service the sum of One Thousand and 00/100 Dollars (\$1000) annually.
 - C. To those employees who have completed fifteen (15) years of service the sum of Twelve Hundred and 00/100 Dollars (\$1200) annually.
 - D. To those employees who have completed nineteen (19) years of service the sum of Fourteen Hundred and 00/100 Dollars (\$1400) annually.
 - E. To those employees who have completed twenty-four (24) years of service the sum of Sixteen Hundred and 00/100 Dollars (\$1600) annually.
 - F. To those employees who have completed twenty-nine (29) years of service the sum of Two Thousand and 00/100 Dollars (\$2000) annually.

Such allowances shall become effective as of the anniversary date of the employee's appointment to staff. All longevity payments shall be made in lump sum on the first pay day in December of each year. In addition, all firefighters will receive a one-time payment, to be paid upon request, of \$1,450 once they have completed 20 years.

5. To determine overtime rate, the total annual salary as set forth in Schedule "A", inclusive of longevity and shift differential, premium pay shall be divided by two thousand (2,000).
6. There shall be no lay-offs of permanent employees. It being the intent of the parties that each and every member with permanent status of the Troy Uniformed Firefighters Association employed as of July 1, 2016 shall be assured employment through December 31, 2016 or until a successor collective bargaining agreement is reached. Each member shall be continued in employment in at least his or her present capacity without reduction or diminution of benefits, regular schedule "A" wages, salary premium pay and longevity.

SCHEDULE "B"

PERFORMANCE OF DUTY INJURY/ILLNESS

207-A PROCEDURE

This Schedule is intended:

1. To establish the mechanics of application for, and allowance of, benefits pursuant to General Municipal Law, Section 207-a relating to the payment of salary, medical and hospital expenses of firefighters with injuries or illness incurred in the performance of duties; and
2. To establish a list of specified types of light duty as may be appropriate.

This schedule is not to be construed as repealing or restricting any rights of either of the parties to this Agreement or substantively affecting additional requirements as contained in the statute of otherwise determined by law.

A. Procedure

1. In all cases where it appears that a Firefighter has an injury or illness which was apparently incurred in the line of duty, the firefighter, or in the event he/she is physically unable to make application, then someone acting on his/her behalf, shall submit an Application for Disability Benefits Form (hereinafter "Application") to the Chief. The Application shall be submitted to the Fire Chief within thirty (30) days after the incident which gave rise to the injury or illness causing disability. In the event the injury or illness is not readily discoverable and is of a latent nature, then the Firefighter shall make application within thirty (30) days of the discovery by the Firefighter of the injury/illness giving rise to the disability.
2. Upon receipt by the Fire Chief of the Application, the Fire Chief shall make an initial determination as to the eligibility for disability benefits within thirty (30) days. His/her decision shall be communicated in writing to the subject Firefighter.
3. The Application for Disability Benefit Form shall set forth the following information:
 - a) the time and place of the incident;
 - b) the names and addresses of any witnesses to the incident;
 - c) the nature and extent of the Applicant's injury or illness;
 - d) the name and addresses of any and all treating physicians and hospitals;
 - e) a detailed statement by the Firefighter as to how and in what manner the injury or illness was incurred during the line of duty.

4. After filing the Application, the Applicant shall authorize the release to the City's physician of all relevant medical information which is relevant and material to the incident and/or alleged disability. The Applicant shall submit to reasonable and usual medical examination as required by the Fire Chief for the purpose of treatment care or inspection or the making of any initial determination as to eligibility for disability benefits.
5. The Fire Chief is authorized to cause periodic medical review from time to time by the City's physician or in the event of his/her unavailability by one other physician selected by the Fire Chief in order to determine the Applicant's continued eligibility for benefits. Such medical reviews shall be at reasonable intervals appropriate to the usual course of treatment of the subject injury or illness.
6. Any injured or sick Firefighter who shall refuse to permit medical inspections as provided for herein, or to accept commonly prescribed medical treatment or hospital care, except surgery, recommended by the City's physician shall be deemed to have waived all of his/her rights under this procedure in respect to expenses incurred for such medical treatment or hospital care and to salary or wages payable after such refusal.
7. In the event the Chief determines that a Firefighter is not eligible for benefits, or that a Firefighter is no longer entitled to continued benefits he/she shall so notify in writing within thirty (30) days of his/her receipt of said Application.
8. A Firefighter who does not accept the Chief's decision of ineligibility may demand a review Hearing. Such demand shall be in writing and be served upon the Chief's Office with a copy to the Corporation Counsel's Office within thirty (30) days of receipt of the Chief's decision.
9. The CEO (Mayor) shall appoint an impartial arbitrator to conduct the Hearing. The costs and expenses of the arbitrator shall be borne fully by the losing party, unless otherwise apportioned by the Arbitrator. In the event the Applicant shall be responsible for costs and expenses, the City is authorized to deduct an equivalent sum directly from the applicant's wages.

Both the City and the Applicant shall have the right to seek review of any adverse determination by the arbitrator pursuant to Article 78 of the Civil Practice Law and Rules.

B. Light Duty

1. If a Firefighter receiving General Municipal Law Section 207-a benefits is not eligible for, or is not granted a New York State accidental disability allowance pursuant to the Retirement and Social Security Law, the Chief shall obtain a medical opinion from the City's physician as to whether or not the Firefighter is

able to perform his/her regular duties as a result of such injury or illness; and if the Firefighter is not able to perform his/her regular duties, whether he/she is able to perform specified types of light duty.

2. If it is medically determined by the City's physician that the Firefighter is in fact able to perform the light duty specified, the Chief may issue a written Order directing the Firefighter to report for such specified light duty assignment as may be available, provided that such assignment is consistent with his/her status as a Firefighter and is limited to the types of duty hereinbelow set forth.
3. In the event there is a dispute as to the Firefighter's ability to perform light duty assignments or if a Firefighter receiving Section 207-a benefits disagrees with an Order directing him to report for light duty assignment, he/she may request a Hearing as provided for in Paragraphs A8 and A9 of this Article.
4. A Firefighter who is receiving benefits under Section 207-a shall notify the Chief in writing of a change in medical condition which, according to his/her physician, enables him to return to full and regular duty or to perform certain light duty within twenty-four (24) hours of receipt of such information by the Firefighter. Failure to notify the Chief shall constitute grounds for termination of Section 207-a benefits as provided for in paragraph A6 herein or for disciplinary action.

C. LIGHT DUTY DESCRIPTIONS IN BUREAU OF FIRE

FIRE PREVENTION BUREAU

- A. Inspections – under the direction of the Chief of Fire Prevention, participate on inspection tours. Requires minimum walking and climbing of stairs.
- B. Lectures – prepare and present lectures to schools and interested groups of Fire Prevention activities. Would require minimum walking and standing.
- C. Extinguisher Demonstrations – extinguisher demonstrations to interested groups. Explaining operation while someone else would be doing actual operation. This would require minimum walking and standing.
- D. Recordkeeping – recordkeeping in Fire Prevention Office. This would require filing and updating of all records and answering telephones. No walking or heavy lifting involved. This is a desk job.

TRAINING

- A. Training Exercises – under the direction of the training instructor, would assist the instructor by explaining the training exercises and supervising the doing of same. Use the

blackboard, overhead projector, video equipment and slide trays when teaching these exercises. Minimum walking involved. No lifting or physical exercise involved.

- B. Recordkeeping – recordkeeping and filing of daily records. Would assist instructor in preparing class lessons. Minimum walking and standing required.

CHIEF'S OFFICE

Engage in the ordinary and usual recordkeeping and administrative functions of the Chief's Office.

FIRE STATION DUTIES

- A. Sitting at the watch desk answering the telephone, receiving fire calls and relaying to personnel all alarms. Operate doors by using button to open and close. Keeping journal book up to date. Maintaining watch on station when fire apparatus is out. Desk job.
- B. Checking Vehicles – assist in checking vehicles for small tools, fluid levels, etc. No physical exertion.
- C. Cleaning Vehicles – assist in applying water with hose. Others will do the actual cleaning. No physical exertion.
- D. Assist in the usual and ordinary housekeeping and maintenance functions in maintaining the cleanliness and good repair of posted quarters.

APPENDIX A-1

CITY OF TROY

Health Care Benefits



**Blue Shield
of Northeastern New York**

CITY OF TROY

Health Care Benefits

Booklet Updated 2/96

TABLE OF CONTENTS

INTRODUCTION.....SECTION I

WHO IS COVEREDSECTION II

IN-NETWORK AND OUT-OF-NETWORKSECTION III

MANAGED BENEFITS PROGRAMSECTION IV

INPATIENT HOSPITAL CARESECTION V

OUTPATIENT HOSPITAL CARESECTION VI

FREE STANDING AMBULATORY
SURGERY CENTER CARESECTION VII

HOME CARESECTION VIII

INFUSION THERAPYSECTION IX

HOSPICE CARESECTION X

TREATMENT OF ALCOHOLISM AND
SUBSTANCE ABUSESECTION XI

SKILLED NURSING FACILITY SERVICES.....SECTION XII

COVERED MEDICAL SERVICESSECTION XIII

EXCLUSIONSSECTION XIV

PRESCRIPTION DRUGSECTION XV

COORDINATION OF BENEFITSSECTION XVI

TERMINATION OF YOUR COVERAGESECTION XVII

RIGHT TO NEW CONTRACT AFTER
TERMINATION.....SECTION XVIII

GENERAL PROVISIONS.....SECTION XIX

SECTION I

INTRODUCTION

Your Coverage Under This Plan

The City of Troy has purchased a group health insurance contract from us. Under that contract we will provide the benefits described in this booklet to members of the group; that is, to employees and retirees of the City or to members of the organization. However, this booklet is not a contract between you and us. You should keep this booklet with your other important papers so that it is available for your future reference. The contract and this booklet are referred to as "this Plan."

Words We Use

Throughout this Plan, Blue Shield of Northeastern New York ("Blue Shield") will be referred to as "we", "us", or "our". The word "you", "your" or "yours" refers to you, the person to whom this booklet is issued and whose name appears on the Blue Shield Identification Card. and to any members of your family who are covered under this Plan.

Care Must Be Medically Necessary

We will not make payments under this Plan if we determine that the service or care was not medically necessary. Medically necessary care is care which, according to our criteria, is:

consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;

in accordance with standards of good medical practice; not for your convenience or that of your Doctor or other provider;

the most appropriate supply, level of care or service which can be safely provided to you; and

in the most appropriate setting for the treatment of your condition.

Examples of unnecessary care are: when you are admitted to a Hospital for care which could have been provided in a Doctor's office, or provided without admission to a Hospital as a bed patient; when you are in a Hospital for longer than is necessary to treat your condition; when services are performed in a Free Standing Ambulatory Surgery Center which could have been performed in a Doctor's office; when hospitalized, you receive ancillary services not required to diagnose or treat your condition; when the care is provided in a more costly facility or setting than is necessary; when you receive an inappropriate or non-essential service to diagnose or treat your condition; when you receive procedures not essential to diagnose your condition; when the services you receive are more costly than is necessary for the proper treatment of your condition. In these situations we will determine, in our sole judgment, whether the service provided to you qualifies for payments under this Plan. In making our determination we will examine the information supplied to us by your Doctor or

hospital or any other provider of care. The fact that your Doctor prescribed the care does not automatically mean that the care qualifies for our payments under this Plan.

SPECIAL PROVISIONS

THIS PLAN CONTAINS SPECIAL PROVISIONS REQUIRING YOU, YOUR DOCTOR OR PROVIDER TO OBTAIN OUR CERTIFICATION BEFORE RECEIVING CERTAIN SERVICES COVERED UNDER THIS PLAN (SEE SECTION FOUR). PLEASE READ THIS PLAN BOOKLET CAREFULLY.

Our Operating Area

Throughout this booklet when we refer to "Our Operating Area", we mean the counties of Clinton; Essex; Warren; Washington; Saratoga; Fulton; Montgomery; Schenectady; Rensselaer; Albany; Schoharie; Greene; Columbia; Ulster; Sullivan; Orange; Dutchess; and Putnam in the State of New York.

SECTION II

WHO IS COVERED

Who is Covered Under this Plan

You, the person to whom this booklet is issued, are covered under this Plan. If you have a type of coverage other than individual coverage, the following members of your family may also be covered depending on the type of coverage which applies:

Your wife or husband, unless you are divorced or your marriage has been annulled, or you are legally separated.

Your unmarried children who are under 19 years of age.

Your unmarried children who are older than the age dependent status would otherwise have terminated and who, in our sole judgment, are unable to work or support themselves because of mental illness, developmental disability or mental retardation, as defined in the New York State Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which dependent status would otherwise have terminated. The child's disability must be certified by a physician. In addition to this certification we have the right to check whether a child is and continues to qualify as an incapacitated child.

If you select family or child coverage, benefits are provided for your unmarried children who are over age 19 but who are not yet age 25 who are full-time students at an accredited institution of learning and whose principal residence when not away at school, is the same as yours. A full-time student is one who is enrolled for the number of hours of courses the school considers to be full-time attendance. An accredited institution of learning is an accredited college; university; or similar institution of higher education. The term "school" does not include on-the-job training courses, correspondence schools and night schools. In addition, this child must be eligible to qualify as your dependent on your federal income tax return. Benefits will be provided until this child's 25th birthday, or until September 1st of the year in which such child graduates; or until the child fails to meet any other of the above requirements. In no event will benefits be provided beyond the 25th birthday.

The names of all persons covered under this Plan must have been specified on the application for this Plan or provided as described below. No one else can be substituted for those persons.

Children Defined

When we refer to your children, we mean:

Your natural child.

A legally adopted child.

A child for whom you have been appointed the legal guardian by court order.

A step child dependent upon you for support.

A child for whom you are the proposed adoptive parent and who is legally dependent upon you during the waiting period prior to the adoption becoming final.

Newborn Child

If you have family coverage or children coverage, your newborn child will be covered at birth if you comply with the requirements below. In addition, if you have individual or spousal coverage, you may obtain coverage of your newborn child from the moment of birth if you comply with the requirements below.

If a child of yours who is covered under this Plan gives birth, that newborn grandchild will not be covered unless you adopt the child or are appointed the legal guardian of the child by court order.

Adopted Newborns

- When We Will Cover Adopted Newborns From the Moment of Birth.

If you have family or children coverage, or switch to family or children coverage in accordance below, we will cover a proposed adoptive newborn from the moment of birth if the following conditions are met:

you (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the hospital after birth and

you file a petition pursuant to Section 115-C of the New York State Domestic Relations Law within 30 days of the infant's birth.

- When We Will Not Cover Adopted Newborns From the Moment of Birth

Notwithstanding the provisions above, we will not cover adopted newborns from the moment of birth if one of the child's natural parents has coverage available to cover the newborn's initial hospital stay, or if a notice of revocation of the adoption has been filed or one of the natural parents revokes their consent to the adoption. If we pay benefits to cover an adopted newborn and the notice of the adoption is revoked or one of the natural parents revokes their consent, we will be entitled to recover any sums paid by us for care of the adopted newborn.

Notification of Change in Your Coverage

- To Add A Spouse or Child

If you need to add a spouse or child to your coverage, you must complete and return to us an application for this other coverage and any requested documentation. Your new coverage will be effective as of the date of marriage, birth or adoption if you return to us a completed application and requested documents within 30 days of the wedding, birth or adoption and the applicable premium is paid. If you do not return a completed application for your new coverage within 30 days, your spouse or child will be added to your coverage as of the next premium due date after receipt of the completed application and requested documentation, so long as the applicable premium is paid.

- When Coverage Of A Spouse Or Child Terminates

If you have other than individual coverage, you should notify us of any event that affects your coverage, such as, your divorce, the death of your spouse, Medicare eligibility or a child marrying or reaching the age at which coverage terminates. You must sign and return to us a form provided by us for that purpose, together with any requested documentation.

If such change results in your seeking a different type of coverage, at a lower premium (such as a switch from family to individual coverage) the form and requested documentation must be returned within 30 days of the event in order for the change in premium to be effective on the date of the event. If you do not return a completed form and any requested documentation within 30 days of the event, your change in premium will be effective as of the next premium due date after they are received.

Nothing in this paragraph is designed to affect the provisions of Section Eighteen governing terminations of coverage. This paragraph only involves the effective date of changes in premiums due to terminations of coverage under Section Eighteen.

SECTION III

IN-NETWORK AND OUT-OF-NETWORK

In-Network Benefits

You are eligible for In-Network benefits when the services are rendered by your Primary Care Physician (PCP) or the provider is a specialist who was referred by your PCP, and who communicates with that PCP regarding services provided to the patient. The following providers are considered PCP's:

1. General Practitioner
2. Family Practitioner
3. Internist
4. Pediatrician

If you need to see a Specialist, it is your responsibility to obtain a referral from your PCP. If you do not obtain a referral prior to receiving the services of a Specialist, then the services will not be eligible for reimbursement In-Network.

Most In-Network benefits are reimbursed at 100% of the allowed amount. Office visits associated with the following In-Network services are reimbursed at 100% of the allowed amount after a \$10 per visit copayment.

- A. Primary Care Physician Home and Office Visits
- B. Consultation, Diagnosis, Treatment by Specialists
- C. Routine Physical Exams
- D. Second Surgical Opinion
- E. Ambulance Service
- F. Mammography Screenings
- G. Cervical Cytology Screenings
- H. Diabetes Education

Hospital services are always considered to be In-Network. Ambulance services are always considered to be In-Network.

For members where Medicare is the primary payor, services will always be considered In-Network.

Out-of-Network Benefits

If you are not eligible for In-Network benefits as described above, most services are eligible for reimbursement as an Out-of-Network benefit. When receiving care Out-of-Network, deductibles are imposed and benefits are generally reduced to 70% of the allowed amount for that particular service.

Deductible Provisions

Payments of Out-of-Network services under this contract are subject to a yearly deductible. You must pay the first \$250 of benefits in each calendar year for these services. The deductible applies to each person covered under this Contract or Group Plan.

If you have other than individual coverage, after deductible payments for members of the same family covered under this Contract or Group Plan total \$600 in a calendar year, no further deductible will be required for any covered family member for the remainder of that calendar year.

Our Payments

In-Network

Except as otherwise provided or noted above, for In-Network services rendered by a provider which has a written agreement with us regarding payment for covered services (i.e. a Participating Provider), we will pay 100% of the lesser of the actual charge or the amount listed in our Schedule of Allowance, or if there is no allowance listed, 100% of the reasonable charge for the services,

Except as otherwise provided, for In-Network services rendered by a provider which does not have a written agreement with us regarding payment for covered services (i.e. a Non-Participating Provider). we will pay 100% of the usual, customary and reasonable charge for the services.

Out-of-Network

Except as otherwise provided or noted above, for Out-of-Network services rendered by a provider which has a written agreement with us regarding payment for covered services (i.e. a Participating Provider), we will pay 70% of the lesser of the actual charge or the amount listed in our Schedule of Allowance, or if there is no allowance listed, 70% of the reasonable charge for the services. The payment of the remaining 30% of our allowed amount is your responsibility.

Except as otherwise provided, for Out-of-Network services rendered by a provider which does not have a written agreement with us regarding payment for covered services (i.e. a Non-Participating Provider), we will pay 70% of the usual, customary and reasonable charge for the services. The payment of the remaining balance billed by the provider is your responsibility.

SECTION IV

MANAGED BENEFITS PROGRAM

PAYMENTS UNDER THIS GROUP PLAN FOR CERTAIN SPECIFIED SERVICES WILL BE DENIED OR REDUCED IF YOU DO NOT FOLLOW THE PROCEDURES SET FORTH IN THIS SECTION. HOWEVER, THE MANAGED BENEFITS PROGRAM DOES NOT APPLY TO SERVICES RENDERED TO YOU WHEN MEDICARE IS THE PRIMARY PAYOR.

THE MANAGED BENEFITS PROGRAM

The Managed Benefits Program establishes the process by which we determine in advance if certain care is medically necessary. In order for you to receive full benefits for the services subject to the Managed Benefits Program we must determine that your care is medically necessary in advance of you receiving the services. The criteria we will use to determine medical necessity is described in Section One. In order for us to make a Managed Benefits determination, you must follow the rules set forth below:

Pre-Admission Review and Certification of Hospital Inpatient Care and selected Outpatient Procedures

Before you are admitted to the hospital as an inpatient, you or your Doctor must call us so that we can review the reason for your hospital care and certify or non-certify your admission to the hospital. We will certify your admission if the proposed care is medically necessary and appropriate. This requirement applies to non-emergency admissions to a hospital. A non-emergency admission is an admission which is medically necessary but is not for emergency care (see below for the definition of an emergency).

If your Doctor wishes to schedule you for a non-emergency admission, you must comply with the following procedure: you or your Doctor must call the toll free pre-admission review number shown on your Identification Card or you may submit our preprinted request form to us. This should be done at least two weeks prior to your admission to the hospital. In the case of an anticipated maternity admission, you should notify us at least two weeks prior to your planned due date. It is your responsibility to make sure this review process is followed.

If we determine that it is not medically necessary for you to have inpatient care, we will notify you and your Doctor. If your Doctor provides us with additional information which, in our opinion, justifies an inpatient admission, we will certify the admission. Or, after talking with us, your Doctor may arrange to have your care provided on an outpatient basis. If we determine that the proposed services are not medically necessary and appropriate, certification for those services will not be given.

The following surgeries, regardless of where the procedure is performed, also need to be pre-certified:

Arthroscopy
Breast Reduction
Carpal Tunnel Surgery
Myelogram
Myringotomy
Nasal Surgery
TMJ Surgery
Small Joint Replacement

We will make our determination to certify or non-certify your non-emergency admission within three business days after we receive your call or request form. You and your Doctor will be notified.

If you or your Doctor disagree with our determination, you or your Doctor may appeal our decision by following the steps described below.

IF YOU FAIL TO SEEK CERTIFICATION OF YOUR NON-EMERGENCY ADMISSION PRIOR TO YOUR ADMISSION TO THE HOSPITAL AS REQUIRED ABOVE, THEN IN ADDITION TO THE DEDUCTIBLE AND COINSURANCE, YOU WILL ALSO BE RESPONSIBLE FOR AN ADDITIONAL PAYMENT OF THE LESSER OF 50 PERCENT OF THE AMOUNT WE WOULD OTHERWISE HAVE PAID FOR THE ADMISSION OR \$500. IF YOU DO NOT SEEK CERTIFICATION AND WE DETERMINE, IN OUR SOLE JUDGMENT, THAT THE ADMISSION OR SERVICES WERE NOT MEDICALLY NECESSARY, WE WILL NOT MAKE ANY PAYMENT FOR THE ADMISSION OR SERVICES OR FOR THE SERVICES PROVIDED IN PREPARATION FOR THE ADMISSION. BECAUSE WE DO NOT PROVIDE ANY BENEFITS IN A NON-PARTICIPATING HOSPITAL IN OUR OPERATING AREA, YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF 100 PERCENT OF THE CHARGES OF A NON-PARTICIPATING HOSPITAL IN OUR OPERATING AREA, WHETHER OR NOT WE APPROVED YOUR NON-EMERGENCY ADMISSION.

Notification of Admissions as a bed patient for Emergency Care

You must comply with the following procedure: you, a family member, your Doctor, or the hospital must call the toll-free number shown on your Blue Shield Identification Card within one business day following your emergency. It is your responsibility to make sure that the review process is followed. All admissions for emergency care must be reviewed and certified by us within one business day following notification of the admission.

Care is considered an emergency when all of the following conditions are met: There is an accident, injury or sudden, unexpected onset of a medical condition;

immediate medical care is necessary;

the immediate care is necessary to prevent what could reasonably be expected to result in either placing your life in jeopardy or causing serious impairment to your bodily functions.

IF YOU FAIL TO NOTIFY US WITHIN ONE BUSINESS DAY OF AN EMERGENCY CARE ADMISSION, THEN IN ADDITION TO THE DEDUCTIBLE AND COINSURANCE, YOU WILL ALSO BE RESPONSIBLE FOR AN ADDITIONAL PAYMENT OF THE LESSER OF 50 PERCENT OF THE AMOUNT WE WOULD OTHERWISE HAVE PAID FOR THE ADMISSION OR \$500. IF YOU DO NOT NOTIFY US AND WE DETERMINE THAT YOUR ADMISSION OR SERVICES WERE NOT MEDICALLY NECESSARY WE WILL NOT MAKE ANY PAYMENT FOR THE ADMISSION OR SERVICES. BECAUSE WE DO NOT PROVIDE ANY BENEFITS IN A NON-PARTICIPATING HOSPITAL IN OUR OPERATING AREA. EXCEPT IN AN EMERGENCY, IF WE DETERMINE, IN OUR SOLE JUDGMENT, THAT NO EMERGENCY EXISTED, YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF 100 PERCENT OF THE CHARGES OF A NON-PARTICIPATING HOSPITAL IN OUR OPERATING AREA.

If you or your Doctor disagree with our determination, you or your Doctor may appeal our decision by following the steps below.

Pre Certification Review of Certain Other Services

Before you receive services for Skilled Nursing Facility care, infusion therapy, hospice care, home care, or Magnetic Resonance Imaging (MRI) covered by this Plan you, your Doctor or provider must call us so that we can review the proposed treatment plan and certify or non-certify such services or care. We will certify your services or care if the proposed care is medically necessary and appropriate.

If your Doctor wishes to schedule you for Skilled Nursing Facility care, infusion therapy, home care, or MRI, you must comply with the following procedure: you, your Doctor or provider must call the toll-free Managed Benefits number shown on your Identification Card, or you may submit our preprinted request form to us at least 2 weeks prior to such services. It is your responsibility to make sure this review process is followed.

If we certify your services or care as medically necessary, we will notify you; your Doctor or Provider.

If we determine that it is not medically necessary for you to have inpatient care or proposed services, we will notify you, and your Doctor or provider. If your Doctor or provider supplies us with additional information which, in our opinion justifies the care, we will certify the care. If additional medical necessary information is not provided, the care or services will not be certified.

We will make our determination to certify or non-certify your care or service within three business days after we receive your call or request form.

If you or your Doctor or Provider disagree with our determination, you, your Doctor or Provider may appeal our decision by following the steps described below.

IF WE DETERMINE THAT YOUR SKILLED NURSING FACILITY CARE, INFUSION THERAPY, HOME CARE, OR MRI WERE MEDICALLY NECESSARY BUT YOU DID NOT SEEK CERTIFICATION PRIOR TO RECEIVING SUCH SERVICES IN ADDITION TO THE DEDUCTIBLE AND COINSURANCE, YOU WILL ALSO BE RESPONSIBLE FOR AN ADDITIONAL PAYMENT OF THE LESSER OF 50 PERCENT OF THE AMOUNT WE WOULD OTHERWISE HAVE PAID FOR THE SERVICE OR \$500. IF YOU DO NOT SEEK CERTIFICATION AND WE DETERMINE, IN OUR SOLE JUDGMENT, THAT THE SERVICES WERE NOT MEDICALLY NECESSARY, WE WILL MAKE NO PAYMENT FOR THE SERVICES.

Review of Your Hospital Stay, Infusion Therapy, Hospice care, Home Care, and Skilled Nursing Facility Stay

Whenever you are admitted to a Hospital or Skilled Nursing Facility for inpatient care, receive infusion therapy, hospice care, or home care we will review your condition and your medical records at regular intervals to determine whether it is medically necessary for you to continue to receive such services.

If we determine it is not medically necessary for you to continue to receive such care, we will contact your Doctor or provider. If your Doctor or provider supplies us with additional information which, in our sole judgment, justifies the continuation of such services, we will certify them. If additional medical necessity information is not provided, continuation of services will not be certified.

If you, your Doctor, or provider disagree with our determination; you, your Doctor, or provider may appeal our decision by following the steps described below.

IF WE NOTIFY YOU THAT CONTINUATION OF SERVICES OR CARE IS NOT CERTIFIED, AND YOU ELECT TO CONTINUE CARE, BENEFITS WILL END 24 HOURS AFTER NOTIFICATION.

Appeals

If we do not certify services or care; and you, your Doctor or provider disagree with our determination; you, your Doctor or provider may appeal our decision by writing to us within 60 days of the date of our decision. Your case will be reviewed by a different Blue Shield physician consultant than the one who made the original determination. We will notify you of our decision within 30 days of receiving your appeal information.

If a penalty was imposed because you failed to seek pre-certification for non-emergency care or you failed to notify us of an emergency admission within one business day as required by above, you may appeal that decision by writing to us within 60 days of the date of our decision and providing for our consideration any extenuating circumstances which may have prevented you from complying with the requirements of the Managed Benefits Program. We will notify you of our decision within 30 days after we receive your appeal information.

When You Are Out of Our Operating Area

If you live, work or are traveling outside of Our Operating Area, all of the requirements and procedures set forth in this Section still apply.

SECTION V

INPATIENT HOSPITAL CARE

Subject to your compliance with the requirements of the Managed Benefits Program described in Section Four, we will pay for the services listed below when you receive acute hospital care as an inpatient in the kinds of hospitals described below:

Short Term Acute Care General Hospital

A Short Term Acute Care General Hospital is a hospital which is a licensed institution primarily engaged in providing inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians with twenty-four hour nursing services by or under the supervision of registered nurses. None of the following are considered Short Term Acute Care General Hospitals:

Hospitals for treatment of mental illness.

Places primarily for nursing care; skilled nursing facilities; convalescent homes or similar institutions; institutions primarily for custodial care, rest or as domiciles.

Health resorts or spas.

Hospitals for the treatment of tuberculosis. Infirmaries at schools, colleges or camps.

Places for the treatment of alcoholism or drug abuse, hospice care or rehabilitation.

Acute Hospital Care Defined

We will pay only for care, which in our sole judgment, is acute hospital care. Acute hospital care is care or treatment, given or ordered by licensed professionals, for an illness or injury of a severity that can only be treated in an inpatient hospital setting. The services must be of an intensity that they can only be provided in an acute care hospital setting.

The following are not considered acute hospital care:

A hospital stay or a portion of a hospital stay in connection with physical check-ups; convalescent or custodial care; rest cures or sanitarium type care; alcoholism or drug addiction rehabilitation; behavior modification; or while awaiting placement in a different level of care, such as a skilled nursing facility or home health care, whether or not such placement is available to you.

Custodial Care is considered custodial when it is primarily for the purpose of meeting personal needs and can be provided by persons without professional skills or training. For example, custodial care includes activities of daily living such as help in walking; getting in and out of bed; bathing; dressing; eating; assistance with toileting and taking medicine.

A hospital stay or portion of a hospital stay which is primarily for diagnostic x-rays, laboratory

tests, or other types of diagnostic studies, even if it would be more convenient for you or your doctor to have the diagnostic service performed during a hospital stay.

A hospital stay or a portion of a hospital stay which is primarily for physical rehabilitation. (However, we will pay, for certain physical therapy services as described below.)

In a Participating Hospital In Our Operating Area

A Participating Hospital is any hospital which has an agreement with us to provide hospital services to persons covered by our contracts at an agreed upon rate. If you are a registered bed patient in a Participating Hospital and receive acute hospital care (as defined above), we will pay for the following services, if the service is given to you or arranged by an employee of the hospital, if the hospital bills for the service, and if the hospital retains the money collected for the service:

Bed, board and general nursing service in a semi-private room. A semi-private room is a room which the hospital considers to be semi-private. If you occupy a private room in a Participating Hospital, you have to pay the difference between what we pay and the hospital's charge for the private room.

Special diets.

Use of operating, recovery and endoscopic rooms and equipment:

Use of intensive care or special care units and equipment.

Diagnostic and therapeutic items for use in the hospital. such as drugs; medications; sera; biologicals and vaccines; intravenous preparations; dyes; and the administration of such items; however, we will not pay for those items which are not commercially available for purchase and readily obtainable by the hospital.

Dressings and plaster casts.

Professional services and use of equipment in connection with:

oxygen;

Physiotherapy;

Laboratory and pathological examinations. Use of equipment in connection with:

Anesthesia;

Electrocardiograms; Electroencephalograms X-ray examinations; Diagnostic Imaging; Radiation therapy; Chemotherapy.

We will also pay for supplies furnished by the hospital in connection with these services.

Whole Blood or blood products, except when participation in a volunteer blood replacement program is available to you. We will also pay for autologous blood collection and storage services provided by the hospital and included in their charge for the hospital stay.

Any additional medical services and supplies which are customarily provided by hospitals and which are provided while you are a registered bed patient. The services and supplies must be billed by the hospital in which you are a registered bed patient.

Services of a doctor if the doctor is employed by the hospital and charges for the services are billed by and retained by the hospital.

We will not pay for: Private duty nurses.

Medications, supplies, and equipment which you take home from the hospital.

Non-medical items, such as television rental or telephone services.

In a Participating Hospital of Another Blue Cross and/or Blue Shield Plan

A Participating Hospital of another Blue Cross and/or Blue Shield Plan is a hospital which has an agreement with another Blue Cross and/or Blue Shield Plan to accept that other Blue Cross and/or Blue Shield Plan's payment for covered services and that other Blue Cross and/or Blue Shield Plan and that hospital participate in the Blue Cross Blue Shield Association reciprocal arrangement. If you are a registered bed patient in a Participating Hospital of another Blue Cross and/or Blue Shield Plan as defined above and that hospital is also a Short Term Acute Care General Hospital, we will pay for the same hospital services which are generally provided to persons covered by the other Blue Cross and/or Blue Shield Plan. However, all of the limitations and exclusions of this Plan still apply.

In a Non-Participating Hospital Outside Our Operating Area

A Non-Participating Hospital outside our operating area is any hospital which does not have an agreement with us or another local Blue Cross Plan regarding our payment for covered services and which is located outside our operating area (as defined in Section One. We will not make any payment for your hospital stay in a Non-Participating Hospital in our operating area unless such hospital is a short term acute care general hospital. We will pay for the same services in a Non-Participating Hospital located outside our operating area we would pay for in a Participating Hospital.

Number of Days of Hospital Care

We will pay for the first 365 days of hospital care in each "single hospital confinement". (See below for limitations on the payment for care for mental and nervous disorders, physical rehabilitation therapy and nursery care.) A "single hospital confinement" means one or more inpatient admissions to one or more Participating Hospitals, Non-Participating Hospitals, or Participating Hospitals of other Blue Cross and/or Blue Shield Plans. When you are admitted to one of these hospitals after at least 90 days during which you have not been confined in any hospital, skilled nursing facility or similar institution, the admission will begin "a new single

hospital confinement".

However, a hospital stay because of an accidental injury is not counted as part of any other "single hospital confinement" if the stay is not related to any other injury or illness. In other words, you are entitled to 365 days of hospital care for each "single hospital confinement" related to the same accidental injury.

In determining how many days of hospital care you have used, the day you are admitted to a hospital will be counted as one day but the day that you are discharged will not be counted. However, if you are admitted and discharged in the same day, one day will be counted. You cannot choose which days of hospital care you want us to pay for. In other words, we will pay for consecutive days of hospital care from the date of your admission to the hospital.

Limitations on Number of Days of Care for Mental and Nervous Disorders

We will only pay for a maximum of 60 days per person in each calendar year for hospital care in connection with mental or nervous disorders.

Admissions for Physical Rehabilitation

A hospital stay or a portion of a hospital stay which is primarily for physical rehabilitation, is not acute hospital care within the meaning of this Contract. However, we will pay for a maximum of 45 days of a hospital stay or portion of a hospital stay in a calendar year in a Short Term Acute Care General Hospital which is primarily for restorative physical rehabilitation if we, in our sole judgment, determine that your condition is subject to significant clinical improvement.

Nursery Care For Newborns

We will pay for the ordinary nursery care of your newborn child while you are confined in the Hospital and after delivery for up to a maximum of seven days.

Chemotherapy

The services you receive must be:

Related to or necessary for the diagnosis and treatment of a malignant disease;

The services must be ordered by a doctor;

Treatment must be of the parenteral (excluding out-patient subcutaneous and intramuscular), infusion, perfusion or intracavitary type; or

Out-patient oral chemotherapy.

In no event will any payment be made for:

Chemotherapy which is experimental or use of investigative anti-neoplastic drugs.

SECTION VI

OUTPATIENT HOSPITAL CARE

We will pay for the care described below when it is provided in an outpatient department of a hospital.

Type of Outpatient Hospital Care

The hospital must be a hospital which meets the requirements of Section Five of this Plan. As in the case of inpatient care, the service must be given by an employee of the hospital, the hospital must bill for the service and the hospital must retain the money collected for service.

Covered Services

- Emergency, Surgical and Pre-Admission Testing Services

Emergency Care for Accidents, Injury or Sudden Onset of Illness. The emergency care must be given within 72 hours of the accident, injury or 12 hours of sudden onset of illness. Payment will only be made when all of the following conditions are met:

There is a sudden, unexpected onset of the medical condition. Immediate medical care is necessary.

The symptoms were so severe that the lack of immediate medical care could reasonably be expected to result in a life threatening condition or cause serious bodily impairment.

We will not make any additional payments for follow-up care such as removal of sutures or check-up visits.

We will determine, in our sole judgment, whether your medical condition required emergency care. We will not consider emergency care medically necessary because it is more convenient for you, your doctor or other provider. The fact that your doctor told you to go to the Emergency Room of a Hospital does not automatically mean that care qualifies for coverage as an emergency.

Penalty for Non-Emergency Care. If you receive care in the Emergency Room of a Hospital which we, in our sole judgment, determine is not emergency care, in addition to the coinsurance payment required under Section Three, you must pay the Hospital \$50.00 for the service for each such emergency room visit.

- Outpatient Surgery

We will pay for hospital services for outpatient surgery if we determine, in our sole judgment, it is medically necessary for such surgery to be performed in the outpatient department of a hospital and cannot be performed in a doctor's office, clinic or less intensive setting. However, we will not make any additional payments for care such as removal of sutures or check-up visits. (Certain outpatient surgeries are subject to Managed Benefits. Please see Section IV.)

- Pre-Admission Testing

We will pay for tests ordered by a physician which are given to you as a preliminary to your admission to the hospital as a registered bed patient for outpatient or inpatient surgery if the following conditions are met:

They are related to, necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed.

You have a reservation for the hospital bed and for the operating room before the tests are given.

You are physically present at the hospital when the tests are given.

Admission to the hospital actually takes place within 14 days after the tests are given.

- Chemotherapy

The services you receive must be:

Related to or necessary for the diagnosis and treatment of a malignant disease;

The services must be ordered by a doctor;

Treatment must be of the parenteral (excluding out-patient subcutaneous and intramuscular), infusion, perfusion or intracavitary type; or

Out-patient oral chemotherapy.

In no event will any payment be made for:

Chemotherapy which is experimental or use of investigative anti-neoplastic drugs.

- Mammography Screenings

We will pay for the hospital costs related to mammography screenings for occult breast cancer performed in a hospital. However, our benefits for mammography screening under this Section and Section Thirteen shall be subject to the following aggregate limitations:

Women at Risk. We will pay for mammograms for women of any age who have a prior history of breast cancer or whose mother or sister has a prior history of breast cancer if the mammogram is recommended by a physician.

Women 35 Through 39 Years of Age. We will pay for one baseline mammogram for women 35 through 39 years of age.

Women 40 Through 49 Years of Age. We will pay for mammograms up to once every two years, or more frequently upon the recommendation of a physician, for women 40 through 49 years of age.

Women 50 Years of Age and Older. We will pay for one mammogram in each calendar year for women 50 years of age and older.

Mammography screening shall mean an x-ray examination of the breast using dedicated equipment, including x-ray tube; filter; compression device; screens; films and cassettes; with an average glandular radiation dose less than 0.5 ram per view per breast.

- Cervical Cytology Screening (Pap Smears)

We will pay for one screening for cervical cancer and its precursor states each calendar year for women 18 years of age or older. The screening may be provided in the Outpatient Department of a Hospital under this Section or in a Doctor's office pursuant to Section Thirteen. Cervical cytology screening shall mean an annual pelvic examination collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

- Diagnostic X-Ray and Laboratory Services

We will pay the hospital costs incurred in the outpatient department of a hospital for diagnostic x-ray and laboratory tests when such tests are ordered by a doctor.

- Radiation Therapy

We will cover radiation therapy when ordered by your doctor for the treatment of a condition illness or injury by x-ray, radium or radioactive isotopes.

- Out-patient Therapy Services

We will pay for physical, occupational, inhalation, and speech therapy under the following conditions:

The therapy must be prescribed by your doctor;

The therapy must be skilled therapy furnished by skilled medical personnel, licensed or authorized

to provide such therapy and

The therapy must be intended to improve or restore your bodily functions within a reasonable and generally predictable period of time. We will not pay for therapy which is designed only to maintain your present condition.

SECTION VII

FREE STANDING AMBULATORY SURGERY CENTER CARE

Type of Free Standing Ambulatory Surgery Center Care

We will pay for ambulatory surgical care rendered in a free standing ambulatory surgery center certified under the Public Health Law of the State of New York. If the facility is located outside of New York State, the facility must have the approval of a comparable state authority as a free standing ambulatory surgery center.

Conditions for Free Standing Ambulatory Surgery Center Care

We will pay for ambulatory surgical care rendered in the type of facility indicated above if it is, in our sole judgment, medically necessary for such surgery to be performed in an ambulatory surgery center and cannot be performed in a doctor's office, clinic or less intensive setting. However, we will not make any additional payment for follow-up care such as removal of sutures in check-up visits.

SECTION VIII

HOME CARE

Pursuant to the provisions of the Managed Benefits Program described in Section Four, you must receive prior certification from us for any home care services you receive from a home care agency.

Type of Home Care Agency

We will pay for home care visits given by a Home Care Agency licensed or certified under Article 36 of the New York State Public Health Law. If you receive home care outside of New York State, the care must be provided by a Home Care Agency or hospital and the agency or hospital must have Medicare approval and have an appropriate operating certificate or license to provide home care issued by the appropriate state agency.

Conditions for Home Care

We will pay for Home Care visits only if the following conditions are met:

If you did not receive Home Care visits you would have to be hospitalized and receive acute hospital care or cared for in a skilled nursing facility and receive skilled nursing or skilled rehabilitative care. In other words, the Home Care visits are a substitution for, or prevent the need for, acute hospital care or skilled nursing or rehabilitative care.

A plan for your Home Care is established and approved in writing by a physician.

Home Care Services Covered

We will pay for the following Home Care services provided by and billed by the Home Care Agency or hospital, if you meet the conditions above:

Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (RN).

Physical, occupational or speech therapy if the Home Care Agency or hospital provides these services.

Part-time or intermittent home health aide services which consist primarily of caring for the patient.

Medical supplies, drugs and medications prescribed by a doctor, but only if we would have paid for these items if you were in a hospital or confined in a skilled nursing facility.

Laboratory services provided by or on behalf of the Home Care Agency or hospital, but only if we would have paid for these items if you were in a hospital or confined in a skilled nursing facility.

Number of Home Care Visits

We will pay for Home Care visits and for the other services listed above only for as long as you

would otherwise have had to be hospitalized in a hospital or confined in a skilled nursing facility. Each visit by a member of a Home Care team is counted as one Home Care visit. Four hours of home health aide service are counted as one Home Care Visit.

Out-of-Network Benefits

When Home Care services are rendered out-of-network, the number of home care visits are reduced to 40 visits per member per calendar year.

SECTION IX

INFUSION THERAPY

Pursuant to the provisions of the Managed Benefits Program described in Section Four, you must receive prior certification from us for any Infusion therapy services you receive from a Home Care Agency.

Type of Provider

We will pay for Infusion Therapy provided to you in your home by a Home Care Agency licensed or certified under Article 36 of the New York State Public Health Law. Infusion Therapy is the administration of drugs or nutrients using specialized delivery systems which otherwise would have required you to be hospitalized. For example, drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs or nutrients taken by mouth or self-administered by injection into the muscle are not. If you receive Infusion Therapy in your home, outside of New York State, it must be provided by a Home Care Agency and the agency must be licensed to provide home infusion therapy by the appropriate state agency.

Number of Visits and Conditions for Infusion Therapy

We will pay for Infusion Therapy visits in your home, but only if the following conditions are met:

We determine, in our sole judgment, that if you did not receive Infusion Therapy at home, you would have to receive such services in a hospital or skilled nursing facility.

The services must be ordered by a doctor and be provided by an agency licensed or certified to provide such services.

SECTION X

HOSPICE CARE

Pursuant to the provisions of the Managed Benefits Program described in Section Four, you must receive prior certification from us for any Hospice care you receive from a Hospice Organization.

Type of Provider

Hospice Care is care provided to terminally ill patients at home or home-like facilities. We will pay for hospice care provided by a Hospice organization which has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the Hospice organization must have an operating certificate issued by a state agency in the state where the hospice care is provided under standards, which in our sole judgment, are similar to those used in New York.

Eligibility for Benefits

To obtain benefits for Hospice Care under this Plan, you must meet all of the following conditions:

You must experience an illness for which the attending physician's prognosis for life expectancy is estimated to be six months or less.

Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.

Hospice Care Benefits

We will pay for the following services when provided by the Hospice organization:

Bed patient care either in a designated hospice unit or in a regular hospital bed.

Day care services provided by the Hospice organization.

Home care and outpatient services which are provided by the Hospice and for which the Hospice charges you. The services may include the following:

intermittent nursing care by an RN, LPN or Home Health Aides;

physical therapy;

speech therapy;

occupational therapy; respiratory therapy; social services; nutritional services;

laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms;

medical supplies;

drugs and medications prescribed by a physician and which are considered approved under the US Pharmacopoeia and/or National Formulary. We will not pay when we determine, in our sole judgment, that the drug or medication is of an experimental nature;

durable medical equipment;

medical care provided by the Hospice physician;

bereavement services provided to your family during illness, and until one year after death.

The services must be medically necessary and appropriate for the care of the patient and provided or arranged by the Hospice organization. All services must be billed for by the Hospice organization.

Number of Visits

We will pay for coverage beginning with the first day on which care is provided. We will also pay for up to five visits for bereavement counseling services, either before or after the insured's death, provided to your family.

SECTION XI

TREATMENT FOR ALCOHOLISM AND SUBSTANCE ABUSE

During any Calendar Year we will pay for:

Inpatient rehabilitation: not more than 30 days. Inpatient rehabilitation is a twenty-four hour program of services for the active treatment of AASS provided by a professional.

Outpatient care: up to a total of 120 outpatient visits during a calendar year. Care must be provided in a facility as described below. When outpatient benefits are provided, coverage is limited to one visit per day. As many as 20 of these visits may be for family therapy. Family therapy is treatment or counseling of family members which takes place when a covered person is receiving treatment for AASS. However, these 20 family therapy visits may be utilized even if the covered person in need of treatment has not or is not receiving treatment for AASS. The total number of these visits combined with those of the covered person in need of treatment, cannot exceed 120 outpatient visits in any calendar year. Coverage for family members includes visits for remediation, through counseling and education, of the adverse effects on the physical and mental health of family members resulting from a close relationship with the covered person receiving or in need of treatment.

Treatment Plan And Services We Cover

A treatment plan must be received by us within 10 days after you first begin the treatment. This treatment plan must be approved by us in order for benefits to continue beyond the tenth day. Subject to these rules, we will pay for treatment programs for AASS which consist of any of the following:

inpatient detoxification; inpatient rehabilitation; outpatient care.

The services must be provided by an employee of the facility. We will not make payment to persons providing covered services. We will not make payments if the facility turns the payments over to the person who provided the service.

Facilities Where We Will Pay For Treatment

We will pay for the care for alcoholism and alcohol abuse described above. If you have a primary diagnosis of alcohol abuse or alcoholism, you must receive care in New York State only in programs or facilities certified by the Division of Alcoholism and Alcohol Abuse; and in other states, in those which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism treatment programs or facilities. Coverage is provided for services rendered in and billed by these programs or facilities notwithstanding the exclusion for treatment in a government hospital unless no charges would have been made in the absence of insurance.

We will pay for the care for substance abuse and substance dependence described above. If you have a primary diagnosis of substance abuse or substance dependence you must receive care in New York State only in programs or facilities certified by the Division of Substance Abuse Services as medically supervised ambulatory substance abuse programs; and in other states, in those programs or facilities which are accredited by the Joint Commission on Accreditation of Hospitals as substance

abuse treatment programs. Coverage is provided for services rendered in and billed by these programs or facilities notwithstanding the exclusion for treatment in a government hospital unless no charges would have been made in the absence of insurance.

To Whom Payment Will Be Made For Treatment Of AASS

If the treatment facility has an agreement with us, we will make our payments directly to the facility. If the treatment facility has no agreement with us, we will pay you, or the facility, at our option.

Unnecessary Care

We will not pay for any service which we determine, in our judgement, was not necessary for the treatment of AASS.

Out-of-Network Benefits

When care for Alcoholism and Substance Abuse is received out-of-network, benefits are reduced to 60 outpatient visits only.

SECTION XII

SKILLED NURSING FACILITY SERVICES

Pursuant to the provisions of the Managed Benefits Program described in Section Four, you must receive prior certification from us for any care you receive in a Skilled Nursing Facility.

Care in a Skilled Nursing Facility

We will pay for your care in a Skilled Nursing Facility when your physician refers you to the Skilled Nursing Facility prior to the time you enter the facility. We will provide for up to 180 days of Skilled Nursing care per calendar year. Care must be at a level that we determine, in our sole judgment, requires that you receive skilled nursing care on a daily basis and that hospitalization would otherwise be medically necessary. We will not pay for any days of care in a Skilled Nursing Facility when, in our sole judgment, your condition did not require skilled nursing care on a continuing basis. The fact that Medicare has paid or would pay for your stay in a Skilled Nursing Facility does not mean we will make payment if your condition or the care you receive does not meet our criteria for payment. If you have any questions as to your eligibility for this benefit, we encourage you to call us.

Benefits provided will be for a semiprivate room and skilled nursing care, including physical therapy. Benefits also include the costs of incidental services and materials furnished directly by and billed for by the Skilled Nursing Facility. However, we will not provide benefits for any day of care in a Skilled Nursing Facility which we determine is designed primarily for the provision of custodial care.

You must be admitted to the Skilled Nursing Facility within 7 days after your discharge from a hospital for treatment of the same disease, ailment, or condition for which you were treated in the hospital.

Custodial Care

We will not pay for custodial care; that is, care which is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes, but is not limited to, activities of daily living such as help in walking; getting in and out of bed; bathing; dressing; eating; toileting and taking medicine.

Out-of-Network Benefits

When Skilled Nursing facility care is received out-of-network, benefits are reduced to 60 days per member per calendar year.

SECTION XIII

COVERED MEDICAL SERVICES

Conditions of Coverage

We will pay for the services listed below only if all of the following conditions are met:

Other than laboratory tests by an independent laboratory, the services are performed by a Doctor. Under this Plan, a Doctor is a licensed physician; osteopath; dentist or podiatrist. Except where it is specified that a service must be provided by a Doctor the service may also be provided by other Medical Professionals. Under this Plan, Other Medical Professionals are a licensed physical therapist; occupational therapist; speech therapist; chiropractor; certified and registered psychologist; psychiatric social worker who is certified under New York State Law (Article 154 of the Education Law) and who has completed at least six years of post-degree experience in psychotherapy that meets the requirements of the New York State Board for Social Work which maintains in Albany a list of all the certified social workers who meet these qualifications; a certified nurse-midwife, a certified nurse anesthetist, a physician's assistant or a nurse practitioner, as defined in the New York Education or Public Health Laws. If you receive care covered by this Plan from Other Medical Professionals outside of New York State, such Other Medical Professionals must be licensed or certified under standards, in our sole judgment, similar to those used in New York State by a state agency in the state where the care is provided. All of the Other Medical Professionals must practice only within the scope of their license or certification. A certified nurse-midwife, a certified nurse anesthetist, a physician's assistant or a nurse practitioner must practice under qualified medical direction, and must be employed by and practice with a Doctor, as defined above.

The Doctor or Other Medical Professional (as defined above) regularly bills for his services and bills for the services performed.

The bill is payable to the Doctor or Other Medical Professional (as defined above) who performs the services. In other words, the payment of the bill is not made to, or turned over to, a Hospital or other institution. The Doctor or Other Medical Professional keeps the payment. To be entitled to payment for some of the services described below, you must either be a registered bed patient in a Hospital or receive the services in the outpatient department of a Hospital. The Hospital must be a Short Term Acute Care General Hospital, as defined in Section Five.

The services of the Doctor or Other Medical Professional must be performed in connection with the diagnosis or treatment of your condition, disease or ailment and, in our sole judgment, be necessary for such diagnosis and treatment.

As stated in Section III, if services are rendered by a PCP or a PCP refers you to a specialist, the services will be reimbursed as in-network benefits. The following providers are considered PCPs:

1. General Practitioner
2. Family Practitioner
3. Internist
4. Pediatrician

Services For Which We Will Not Make Payment

We will not make separate payment for services that we determine, in our sole judgment, are ordinarily paid as part of another covered service. In determining whether multiple services billed are to be paid as a single covered service, we will use national standards and local guidelines. For example, our surgical allowance includes payment for visits, surgery or other medical procedures during the pre and post-operative period relative to the condition for which surgery was performed. We will not make any separate payments for visits, surgery, or other medical services provided relative to the same condition during the follow-up period. The follow-up period is the number of days essential to the recovery from a surgical procedure. We will also not make payment if the service billed is not properly represented in supporting documentation, such as your medical records.

Benefits Provided

• **Visits in a Hospital**

We will pay for visits to you by a Doctor or Other Medical Professional (as defined above), but not both on any one day of hospitalization covered under Section Five. However, separate payments for visits in connection with surgery or maternity care will not be made, regardless of whether the visits are made by a Doctor or Other Medical Professional, because the amount of payment for surgery or maternity care includes payment for such visits.

However, if you are admitted to a Hospital not knowing whether surgery will be performed, we will pay for visits to you prior to the determination that surgery will be performed, but we will not pay for more than one visit per day, regardless of whether such visits are by a Doctor or Other Medical Professional. If one Doctor or Other Medical Professional is treating you for a particular condition and another Doctor or Other Medical Professional is treating you for a separate and distinct condition, we will pay for one visit per day by each.

Payment will be made for only one visit per day unless you are entitled to payment for Prolonged Bedside Care described below.

• **Prolonged Bedside Care in a Hospital**

We will pay for care only by a Doctor (as defined above) while you are a registered bed patient in a Hospital during a period of illness which is so serious or critical that it requires constant bedside attendance by the Doctor. We will determine, in our sole judgment, if such constant bedside attendance was necessary. We will pay for this care on any day you would be entitled to payment for a visit in the Hospital as described above. However, we will not also pay for a regular visit on that day. We will pay one inclusive amount for prolonged bedside care which includes payment for all necessary care provided by the Doctor related to your constant bedside care.

- **Consultations in a Hospital**

We will pay for a consultation only by a Doctor (as defined above) who was called in by your Doctor if:

The consultation was, in our sole judgment, required by your illness.

The consultation took place while you were a registered bed patient in a Hospital.

The consultant did not give you care or treat you after he or she consulted with your Doctor.

The consultant entered a written report in your hospital record.

If in our sole judgment, because of the serious or critical nature of your illness, additional consultations were necessary, we will pay for as many additional consultations as we determine, in our sole judgment, were necessary for your care.

- **Mental Health Services**

You are covered for in-network benefits up to 26 visits per member, per calendar year for psychiatric care given in the out-patient department of a hospital or Doctor's office.

A copayment applies for each visit:

Visit 1 through 5 - \$10 copayment

Visit 6 through 20 - \$25 copayment

Visit 21 through 26 - \$45 copayment

If services are received out-of-network, the 26 visit limitation is removed but a \$2,000 maximum per year/\$3000 maximum per lifetime applies and benefits are reimbursed at 50%.

- **Radiology and Other Imagery**

We will pay for diagnostic x-ray, other imagery or for radiation or radioactive material. **However, you must receive prior certification for MRI under the Managed Benefits Program described in Section Four.** Payment will also be limited or excluded under the circumstances described below:

When Payment Will Be Made. We will only make payment for radiology and other imagery procedure if we determine, in our sole judgment, that the procedure you receive is the most appropriate kind of procedure for the diagnosis or treatment of your condition. For example, we will not pay for Magnetic Resonance Imaging (MRI) when we determine that an x-ray or clinical examination could have been used to diagnose your condition. The fact that your Doctor ordered the particular procedure does not mean that the procedure qualifies for payment under this Plan.

When Payment Will Not Be Made. We will not pay for diagnostic x-rays for: routine chest films in connection with physical examination; tuberculosis survey films; routine hospital admission film; comparative x-rays of your extremities unless both parts are diseased or traumatized; fluoroscopy; dental pathology (except we will pay for x-rays in connection with accidental injury to sound natural teeth if rendered within 12 months of the accident, if you are covered under this Plan at the time this service is rendered); or in connection with any procedures or care not covered under this Plan.

- **Maternity Care**

We will pay for services for the termination of a pregnancy by a delivery of a baby, by abortion or by miscarriage. We will pay one inclusive amount for maternity care which includes payment for all the necessary care provided by the Doctor or Other Medical Professional which is related to the pregnancy including pre-natal, delivery and postpartum care.

No referral is needed for OB/GYN related services.

- **Surgery**

We will pay for the surgical services of a Doctor. Surgery includes closed reduction of fractures, dislocation of bones, endoscopic procedures and any incision or puncture of the skin or other tissue except for inoculation, vaccination, collection of blood, drug administration or injection.

Payment for surgery is subject to the following limitations:

When multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same operative session, we will pay for the major procedure and, in addition, we will pay one-half of the payment otherwise payable for the lesser procedures.

When an incidental procedure, such as incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst, etc., is performed with another surgical procedure, we will pay for the major procedure only.

When a surgical procedure is performed in two or more steps or stages, the total payment for the combination of steps or stages which make up the entire procedure will be limited to the amount which we would pay for such surgical procedure if it were not performed in steps or stages.

- **Assistance at Surgery in a Hospital**

We will pay for the services of another Doctor assisting the Doctor who performs the operation if all of the following conditions are met:

The operation takes place in a Hospital or approved Ambulatory Surgery Center where there is no house staff or there is no hospital resident in the specialty involved.

The complexity of the procedure is such that only a doctor could assist.

The assistance is in connection with a surgical operation or procedure which is covered under this Plan.

The other Doctor is in the private practice of medicine and meets the conditions listed above.

- **Second Surgical Opinion**

We will pay for a second opinion with respect to proposed surgery upon the following conditions:

The second surgical option is rendered following a recommendation by your surgeon that surgery

be performed. We will not pay for a second surgical opinion when the recommendation for surgery is made by your family physician or internist. The recommendation must be made by your surgeon.

The second surgical opinion is rendered by a physician who is a board certified specialist and who by reason of his or her specialty is an appropriate physician to consider the surgical procedure being proposed.

The second surgical opinion is rendered with respect to an inpatient hospital or outpatient hospital surgical procedure of a non-emergency nature which is covered under this Plan.

The board certified specialist who renders the second surgical opinion does not also perform the surgery for which the second surgical opinion was obtained.

Second surgical opinions rendered by a par provider are subject to a \$10 copay.

- **Anesthesia**

We will pay for the administration of anesthesia in connection with surgery or maternity care covered under this Plan if, in our sole judgment, the nature of the procedure requires anesthesia. If the Doctor who administers the anesthesia also performs the surgery or gives the maternity care or also assists the Doctor who performs the surgery or gives the maternity care, no payment will be made for anesthesia. Except as provided below, we will pay for anesthesia related to dental procedures only if an underlying medical condition requires that you be hospitalized and have anesthesia. We will not pay for charges related to local anesthesia.

- **Ultrasound**

We will pay for ultrasound services provided by a Doctor which are related to an injury or illness only when, in our sole judgment, the service was medically necessary to diagnose your injury or illness. Routine screening for determination of pregnancy will not be considered medically necessary.

- **Outpatient Laboratory Tests**

We will pay for diagnostic laboratory tests when rendered in an outpatient department of a Hospital or in a Doctor's office. We will also pay for laboratory tests performed by an independent licensed laboratory when ordered by your Doctor. The tests must be directly related to your illness or injury. We will not, however, pay for any diagnostic laboratory test when performed in conjunction with routine or periodic physical examinations, premarital or similar examinations.

- **Mammography Screenings**

We will pay for mammography screenings for occult breast cancer. However, our benefits for mammography screening under this Section and Section Six shall be subject to the following aggregate limitations:

Women at Risk. We will pay for mammograms for women of any age who have a prior history of breast cancer or whose mother or sister has a prior history of breast cancer if the mammogram is recommended by a physician.

Women 35 Through 39 Years of Age. We will pay for one baseline mammogram for women 35 through 39 years of age.

Women 40 Through 49 Years of Age. We will pay for mammograms up to once every two years, or more frequently upon the recommendation of a physician, for women 40 through 49 years of age.

Women 50 Years of Age and Older. We will pay for one mammogram in each calendar year for women 50 years of age and older.

Mammography screening shall mean an x-ray examination of the breast using dedicated equipment, including x-ray tube; filter; compression device; screens; films and cassettes; with an average glandular radiation dose less than 0.5 rem per view per breast.

Mammography screenings rendered by a par provider are subject to a \$10 copay.

• **Cervical Cytology Screening (Pap Smears)**

We will pay for one screening for cervical cancer and its precursor states each calendar year for women 18 years of age or older. The screening may be provided in the Doctor's office under this Section or in the outpatient department of a Hospital pursuant to Section Six. Cervical cytology screening shall mean an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

Cervical cytology screenings rendered by a par provider are subject to a \$10 copay.

• **Dental Care For Accidental Injury**

If you suffer an accidental injury to your sound natural teeth, we will pay the services otherwise covered under this Plan, but only if performed by a Doctor while you are covered under this Plan and within 12 months of the accident. Damage to your teeth resulting from routine use, aging, decay or disease are not considered accidental injuries for the purpose of this provision.

Injuries caused to your teeth by chewing and biting are not considered accidental for the purpose of this provision.

• **Well Child Care and Initial Newborn Exam**

We will pay for Well Child visits for covered children under the age of 19 by a Doctor or Other Medical Professional as defined in your Contract or Group Plan acting within the scope of their license or certification as follows:

An initial newborn check-up and well-child visits including laboratory tests ordered at the time of the visit in accordance with standards of a national association of pediatric physicians to be designated by the New York State Commissioner of Health.

Routine and necessary immunizations as determined by the New York Superintendent of Insurance.

These benefits are paid in full, not subject to deductible and coinsurance when services are rendered by a participating provider and in-network.

- **Therapy Services**

We will pay for therapy services as described under the outpatient hospital Section of the Contract no matter where they are performed. There is no limit on the number of visits per year.

- **Office Visits**

Except as otherwise limited or excluded by the other provisions of this Plan, we will pay for medically necessary visits to the office of a Doctor or Other Medical Professional. In-network office visits are subject to a \$10 copay.

- **Routine Physical Examination**

We will pay for one annual routine physical examination by a Doctor during each twelve month period, provided the services are rendered in-network. There is no coverage for routine physical benefits provided out-of-network. This benefit does not include coverage for lab tests associated with a routine physical examination. Routine physical exams rendered by a par provider are subject to a \$10 copay.

- **Diabetes Benefits**

We will provide the following benefits for the treatment of diabetes:

Equipment and Supplies. We will provide benefits for the following equipment and supplies for the treatment of diabetes, when they are prescribed by a Doctor or Other Medical Professional and we determine they are medically necessary:

blood glucose monitors

blood glucose monitors for the legally blind

test strips for glucose monitors, visual reading and urine testing

data management systems insulin

injection aids

cartridges for the legally blind syringes

insulin pumps and appurtenances

insulin infusion devices oral agents for controlling blood sugar.

Additional Equipment and Supplies. We will also provide benefits, under the same conditions listed above, for such additional diabetes equipment and supplies as the New York State Commissioner of Health shall designate by regulation as medically necessary and appropriate for the treatment of diabetes.

Diabetes Education. We will provide benefits for necessary diabetes self-management education, which is education designated to ensure that individuals with diabetes are trained as to the proper self-management and treatment of their diabetic condition. Education will be limited to education provided to you upon your diagnosis as a diabetic, upon a physician's diagnosis of a

significant change in your condition or symptoms requiring changes in self-management, and where, we determine, in our sole judgment, that re-education or refresher education is necessary.

We will cover such education provided by a physician or certified nurse practitioner or their staff during an office visit. However, in the case of a physician office visit, no separate payment will be provided for the education because our payment for the office visit will constitute payment for the entire office visit, including the education.

We will also cover such education when it is provided by a certified diabetes nurse-educator, certified nutritionist, certified dietician or registered dietician upon the referral of a physician or certified nurse practitioner, but only when it is rendered in a group setting, unless we determine, in our sole judgment, that group education is not available in your area. Please contact us if you need assistance arranging for group education.

We will also cover education provided in your home but only if we determine, in our sole judgment, that it is medically necessary for you to receive such education at home.

Diabetes education rendered by a par provider is subject to a \$10 copay.

- **Chiropractic Care**

We will pay up to 25 visits, for the professional services of a licensed Chiropractor in connection with the detection and correction (by manual or mechanical means) of:

structural imbalance; or distortion; or subluxation;

in the human body for the purpose of removing nerve interference and the effects thereof. This includes cases when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. Chiropractic services are reimbursed at 90%. No referral is needed for chiropractic services.

- **Vision Care**

Benefits include a comprehensive eye examination and the choice of eyeglasses or contact lenses.

Services will be available on a biennial basis (once every 24 months) for examinations and lenses and frames; and include:

A comprehensive eye examination

Single vision, bifocal, or trifocal lenses with the choice of glass or plastic in all ranges of prescriptions.

The choice of eyeglass frames from the uniform selection in each provider's office (Designer Collection).

Contact lenses (soft standard daily wear) with a \$25 copayment, in lieu of eyeglasses.

Vision benefits will be administered by Davis Vision. Davis Vision will issue authorizations to subscribers for benefit utilization. Authorizations are valid for forty-five (45) days and may be used at a panel or non-panel provider. The authorization may not be used at more than one provider

or at more than one time period.

The plan frame collection is available at each participating provider's office. If you wish to receive a non-plan frame or non-plan lenses at a panel office, an allowance will be given (Allowance Schedule follows). You will be required to pay the difference. Services received from a non-panel provider will be reimbursed according to an Indemnity Schedule which follows.

Indemnity Reimbursement Schedule

Professional Fees

Examination	\$16.00
Materials	
Single vision lenses only	\$14.00
Bifocal lenses only	23.00
Trifocal lenses only	32.00
Frames only	14.00
Contact lenses (excluding exam)	\$45.00

The following items are "optional" and may be selected by the beneficiary at the time of use and at the appropriate copayment.

Premier frames - \$25 copayment

Invisible bifocals - \$20 copayment

Photochromic lenses:

Single Vision \$15

Multifocal \$25

• **Hearing Exams**

We will pay for the examination and testing of your ears for the purpose of hearing loss determination administered by a Physician or other licensed provider.

An allowance of \$150 is provided every five years toward the purchase of a Hearing Aid to correct auditory damage resulting from a Medical Condition.

Out-of-Network Benefits

There are no hearing benefits when services are rendered out-of-network.

• **Acupuncture**

We will pay for acupuncture administered by a Physician who is either an M.D. or D.O.

- **Durable Medical Equipment**

We will pay for durable medical equipment when the equipment is prescribed by your Doctor, and it is directly related to the treatment of your condition. Durable medical equipment is equipment which is intended for repeated use and which is not generally useful to a person in the absence of illness or injury. The equipment must be the kind that is generally used for a medicinal purpose, as opposed to a comfort purpose. We will determine whether the item should be purchased or rented. If the equipment is purchased, we will also pay for repairs and necessary maintenance. If the equipment is rented, we will only pay for the rental up to the purchase price.

The items we will pay for include, but are not limited to, oxygen and oxygen equipment, a non-motor driven wheelchair or hospital bed, and braces or crutches. Repair, replacement, fitting and adjustments are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered. Items we will not pay for include, but are not limited to, deluxe equipment (such as motor-driven wheelchair) when standard equipment is available; items not medical in nature; comfort and convenience items; disposable supplies; exercise and hygiene equipment; sauna, bath; air conditioners; humidifiers and dehumidifiers; wigs; hair prosthesis; experimental or research equipment; electronic communication devices; exercise equipment and contraceptive devices.

- **Prosthetic and Orthotic Appliances**

We will pay for prosthetic appliances and orthotic devices which are prescribed by your Doctor and which are directly related to the treatment of your condition. A prosthetic appliance aids body functioning or replaces a limb or body part after surgical or accidental loss. An orthotic appliance is used to correct a defect of body form or function. The items we will pay for include artificial limbs or eyes, post-mastectomy care including a prosthesis, and post laryngectomy care. Items we will not pay for, include but are not limited to, arch supports; removable shoe inserts; corrective shoes; orthotics used solely for sports; eyeglasses or contact lenses except for corrective lenses following cataract surgery; hearing aids; wigs; hair prosthesis; experimental or research appliances or devices; electronic communication devices and dental prosthetics except for dental prosthetics required as a result of accidental injury to sound natural teeth if provided within 12 months of the accident.

- **Sterile Medical Supplies**

We will pay for sterile medical supplies which we, in our sole judgment, determine are medically necessary, and which are directly related to the treatment of your condition. Items we will not pay for include, but are not limited to, undergarments; hygiene products; non-sterile supplies; comfort items and diapers.

- **Blood**

We will pay for blood or blood plasma if you are not eligible to receive blood under a community, employee or other form of blood program.

- **Ambulance Service**

We will pay for professional ground ambulance service when you are transported locally to or from a hospital or skilled care facility in an ambulance and, in our sole judgment, use of the ambulance was medically necessary. We will not, however, pay for elective or convenience ambulance transport, volunteer ambulance service, wheelchair vans or any other forms of non-emergency transportation. There is a \$10 copay for professional ambulance service.

Individual Case Management

• Alternative Benefits

In addition to the benefits specified in this Plan, if you voluntarily participate in individual case management we may provide benefits for services furnished pursuant to an alternative treatment plan. We may provide such alternative benefits if, and only for so long as, we determine that the alternative services are medically necessary, cost-effective and feasible, and that the total benefits paid for such services do not exceed the total benefits to which you would otherwise be entitled under this Plan in the absence of alternative benefits. If we elect to provide alternative benefits for a subscriber in one instance, it shall not obligate us to provide the same or similar benefits for any subscriber in any other instance where the alternative treatment is not medically necessary, cost-effective and feasible, nor shall it be construed as a waiver of our right to administer this Plan thereafter in strict accordance with its express terms.

• Appeals of Individual Case Management

If we deny a request for Individual Case Management, you or your Doctor may appeal by requesting a review within thirty (30) days of the original decision. The request shall be made in writing to:

Blue Shield of Northeastern New York
Attn: Utilization Management Department
PO Box 15013
Albany, New York 12212-5013

All available pertinent information from the physician regarding medical necessity, appropriateness of setting and feasibility of the proposed alternative treatment plan will be reviewed by a physician different from the one who originally reviewed your request for Individual Case Management. A decision on your appeal will be made within thirty (30) days of receipt of all information necessary to complete the review. A notice of the decision will be sent to you and your Doctor.

If the benefits under an Individual Case Management Plan are to be terminated we will provide at least ten (10) days written notice of the termination. You or your Doctor may appeal the termination by requesting a review within thirty (30) days of the decision to terminate benefits. The request shall be made in writing to the Utilization Management Department. All pertinent information from the Doctor regarding the medical necessity, appropriateness of setting and the reasons as to why termination of benefits is not appropriate will be reviewed by a physician different from the one who originally reviewed your request for Individual Case Management. A decision on your appeal will be made within thirty (30) days of receipt of all information necessary to complete the review. A notice of the decision will be sent to you and your Doctor.

SECTION XIV

EXCLUSIONS

In addition to certain exclusions and limitations already described in this Plan, we will not pay under this Plan when any of the following apply to you:

Admission to a Hospital Before You Become Covered Under This Plan

If you are admitted to a hospital as a registered bed patient before the date you become covered under this Plan, we will only pay for covered services provided during that stay after the effective date of coverage and only to the extent those services are not covered under any other HMO or health insurance policy.

Government Hospital

Except as otherwise provided in this Plan or required by law, we will not pay for hospital care or services rendered by a Doctor or Other Medical Professional in any hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government. However, we will pay for care covered under this Plan in a government hospital which is a Participating hospital or a Participating hospital of another Blue Cross and/or Blue Shield Plan. Also, we will pay for care in a government hospital which is a Non-Participating hospital if, because of serious injury or sudden illness, you are taken to one of these hospitals for emergency care because it is close to the place where you were injured or became ill. In this type of emergency situation, we will continue to make payments only for as long as emergency care, in our sole judgement, is necessary and it is not possible for you to be transferred to another hospital.

Workers' Compensation

We will not pay for any care for any injury, condition, or disease if payment is available to you under a Workers' Compensation Law or similar legislation. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law. Also, we will not make any payments even if you bring a lawsuit against the person who caused your injury or condition and even if you receive money from that lawsuit and you have repaid the hospital and other medical expenses you received payment for under the Workers' Compensation Law or similar legislation.

Free Care And Discounted Fees

We will not pay for any services if they are furnished to you without charge or would usually be furnished to you without charge in the absence of insurance. If the services would have been furnished to you at a lower charge except for the coverage provided to you under this Plan or any other Insurance, we will not pay more than that lower charge for such services. In no event will we pay for any professional services rendered to you by a relative. A relative is considered a spouse; parent; sibling; or child related by blood; adoption; or marriage.

Government Programs

We will reduce our payments under this Plan by the amount you are eligible to receive for the same services under Medicare or under any other federal, state, or local government program, except that we will pay for services covered under this Plan even though you are eligible for Medicaid. However, we will not reduce our payments under this Plan if the following provisions apply to you:

- **Eligibility for Medicare By Reason of Age.**

If you are eligible for coverage under Medicare by reason of age, our payments under this Plan will not be reduced if the following conditions are met:

If the person to whom this booklet is issued is an active employee of the group contract holder. Also, the benefits of an active employee's spouse will not be reduced if the spouse is eligible for coverage under Medicare by reason of age.

This special provision does not apply to anyone if the person to whom this booklet is issued is a retired employee of the group contract holder.

The group contract holder must be an employer which is subject to the provisions of the Tax, Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended.

This special provision applies only to persons at least age 65.

- **Eligibility for Medicare By Reason of Disability**

If you were eligible for coverage under Medicare by reason of disability, our payments under this Plan will not be reduced if the following conditions are met

If the person to whom this booklet is issued is an active employee of the group contract holder.

This special provision applies to the person to whom this booklet is issued if disabled and eligible for Medicare, and to that person's spouse if disabled and eligible for Medicare, and to any other covered dependent of that person if disabled and eligible for Medicare.

This special provision does not apply to anyone if the person to whom this booklet is issued is a retired employee of the group contract holder.

The group contract holder must be a “large group health plan” as defined in the Omnibus Budget Reconciliation Act of 1986 (OBRA). Generally, a large group health plan is a plan that covers employees of an employer with at least 100 employees.

This special provision does not apply to a person who is eligible for Medicare by reason of end-stage renal disease.

This special provision shall only be effective until September 30, 1998 unless extended by the terms of federal legislation.

- **Eligibility for Medicare By Reason of End-Stage Renal Disease**

If you are eligible for Medicare by reason of end-stage renal disease, our payment under this Plan will not be reduced during the period of time set forth in the Medicare Law that Medicare is the secondary payor.

Non-Acute Hospital or Medically Unnecessary Care

We will not pay for a hospital stay or portion of a hospital stay during which you do not receive acute hospital care or services (see Section Five) which are medically necessary (see Section One). This includes, but is not limited to: a hospital stay or a portion of a hospital stay in connection with physical check-ups; convalescent or custodial care; rest cures; sanitarium-type care; or alcoholism or drug addiction rehabilitation.

Diagnostic Studies

We will not pay for any hospital stay, or any portion of a hospital stay, which is primarily for diagnostic purposes. This exclusion applies to a hospital stay or a portion of a hospital stay during which the services you receive are primarily for diagnostic x-rays, laboratory tests or other types of diagnostic studies.

Blood

We will not pay for blood or blood products furnished to you or charges associated with donating or processing blood, including but not limited to autologous blood collection and storage, unless it is included by the hospital as part of its charges for your inpatient or outpatient stay.

Loss Subject To Mandatory No-Fault Automobile Insurance

We will not pay for any loss which is covered by mandatory automobile no-fault benefits.

Cosmetic Surgery

We will not pay for any services in connection with elective cosmetic surgery which is primarily intended to improve your appearance. Such services include, but are not limited to, breast reduction or enlargement, rhinoplasty and hair transplants. We will, however, provide benefits for services in connection with reconstructive surgery when such service is incidental to or follows: surgery resulting from trauma, infection, or other diseases of the part of the body involved. We will also provide benefits for reconstructive surgery because of congenital disease or anomaly of a child covered under this Plan which has resulted in a functional defect.

Routine Care of Feet

We will not pay for any services in connection with routine conditions of the feet, including but not limited to corns; calluses; flat feet; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet or supportive devices for the foot.

Services Maintained By an Employer or School

We will not pay for any service or care furnished by a medical department, clinic, or other similar service maintained by your employer or school.

Experimental, Investigational, or Obsolete Services

Unless otherwise required by law, we will not pay for any treatment, procedure, drug, biological product or medical device (hereinafter "services") or any hospitalization in connection with such services if, in our sole judgement, such services are experimental, investigational or obsolete. We will also not pay for any services required because of complications resulting from such experimental, investigational or obsolete services. Experimental or investigational means that the service is:

Not of proven benefit for the particular diagnosis or treatment of your particular condition; or

Not generally recognized by the medical community, as reflected in the published peer-review medical literature, as effective or appropriate for this particular diagnosis or treatment of your particular condition.

Obsolete means that the service is not generally used or recognized by the medical community as effective for the particular diagnosis or treatment of your condition. Governmental certification of a service will be considered, but is not necessarily sufficient to render a service of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition.

Custodial Care

We will not pay for custodial care. Care is considered custodial when we determine, in our sole judgment, it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes activities of daily living such as help in walking; getting in and out of bed; bathing; dressing; eating; assistance in toileting and taking medicine.

Dental Care

Except as provided in Section Thirteen, we will not pay for treatment for cavities and extractions; care of

the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; dental restorative procedures, such as crowns, caps, bridges and dentures; or any other dental services you may receive.

Weight Reduction

We will not pay for services in connection with weight reduction and dietary control, including but not limited to stomach stapling and weight loss programs. We will, however, pay for covered services related to the treatment of morbid obesity. Morbid obesity is defined as weighing more than twice your recommended body weight for your height and sex.

Sex Change

We will not pay for services or supplies for or related to sex transformations.

Organ Transplant Searches, Screenings or Donations

We will not pay costs relating to searches or screenings for donors of organs to be transplanted. We will pay for covered services directly related to the removal of an organ for transplantation in a person covered under this Plan. We will not pay for any services if you are donating an organ for transplantation to a person not covered by this Plan.

We will not pay for transplant services funded by a governmental agency or by charitable contributions; for the purchase price of organs sold; for donor organs other than human donors; for transportation of the donor, the organ or the recipient; for family living expenses; or experimental or investigative transplants.

Evaluation and accreditation of a hospital and/or other health care facility to provide organ transplants shall be under the Public Health Law of the State of New York or similar statutory or regulatory authority of another state.

Artificial Means To Induce Pregnancy

We will not pay for services or supplies for or related to artificial means to induce pregnancy, including but not limited to invitro fertilization, embryo transfer or artificial insemination.

Charges for Standby Services

We will not pay for charges related to a Doctor or Other Medical Professional on standby in case their services are needed. We will only pay for charges related to covered services actually performed.

Wigs or Hair Prosthetics

We will not pay for wigs, hair prosthetics, or cranial prostheses.

Non-Covered Benefits

We will not pay for any services not specifically described in this Plan as a covered service.

Services Furnished Pursuant to a Referral Prohibited by State Law

We will not pay for pharmacy, clinical laboratory, x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a of the New York State Public Health Law. Section 238-a generally prohibits a health care practitioner from making a referral for these services to a health care provider in which the practitioner or a member of the practitioner's immediate family has a financial interest or relationship.

Reversal of Voluntary Sterilizations

We will not pay for services or supplies related to the reversal of voluntary sterilizations.

SECTION XV

PRESCRIPTION DRUG BENEFITS

How To File A Claim For Prescription Drug Benefits

Blue Shield's Prescription Drug Program is administered by Pro-Serv. Most pharmacies in the 18 county area have a participating agreement with Pro-Serv. A list of Participating Pharmacies is available from Blue Shield.

Participating Pharmacies

When having a prescription filled, or obtaining insulin at a Participating Pharmacy, present your Pro-Serv Card and prescription to the pharmacist. You pay only the co-pay amount. Pro-Serv will pay the pharmacy directly for the remaining cost of the drug.

Non-Participating Pharmacies

When filling a prescription or obtaining insulin at a Non-Participating Pharmacy, you must pay for the drug first, then submit a claim. When you are reimbursed for a drug purchased at a Non-Participating Pharmacy, you are paid the same amount a Participating Pharmacy would be paid for the cost of that drug minus the amount of your co-payment. This may be less than the price you paid to the Non-Participating Pharmacy.

How To Submit A Claim

It may be necessary, at times, to use a Pro-Serv Subscriber Reimbursement Form. You should use this form:

- During the period between the effective date of your Prescription Drug Contract and the receipt of your Pro-Serv Card; and
- When purchasing prescriptions at a Non-Participating Pharmacy.

Pro-Serv Subscriber Reimbursement Forms can be obtained from your employer or by writing to:

Blue Shield of Northeastern New York
P.O. Box 15013
Albany, New York 12212
Attention: Special Benefits Department

or by calling Blue Shield at:

(518) 438-5500
1-800-888-1238 (Toll Free - Nationwide)

To submit a claim you should:

- Complete the subscriber information portion of the form, indicating the numbers from your Pro-Serv Card, the subscriber's name, address and the patient's name and date of birth. The form must be signed by the subscriber.

NOTE: A separate claim form must be completed for each family member and for each pharmacy patronized.

- Have the pharmacist complete the pharmacist information portion of the form.
- Attach the pharmacy receipts to the claim form and mail to the above address.
- Payment for covered prescriptions will be sent directly to you.

To avoid filing a Subscriber Reimbursement Form in the future, use your Card when purchasing a prescription at a pharmacy which displays the Pro-Serv emblem.

PRESCRIPTION DRUG BENEFITS

BLUE SHIELD'S PRESCRIPTION DRUG PLAN

IS ADMINISTERED BY PRO-SERV

We will pay for medically necessary prescription drugs. The following items are covered:

- **Legend Drugs.** Drugs or compounds which require a written prescription order and which are required by law to bear the legend "Caution - Federal Law Prohibits Dispensing Without A Prescription."
- **Prescription Orders.** Drugs which are not legend drugs, but which require a written prescription order under New York State Law.
- **Other Prescriptions.** Prescriptions which consist of two or more ingredients or drugs at least one of which is a drug defined as a legend drug or another prescription drug.
- **Insulin, diabetic needles and syringes.** We will pay for insulin even though it does not, by law, require a prescription. We will also pay for diabetic needles and syringes
- **Contraceptive Drugs.** This plan provides benefits for contraceptive drugs prescribed for all females, even if prescribed for other than contraceptive reasons.

In order for payment to be made these drugs, except for insulin, must be sold to you under the written prescription order of a licensed doctor, dentist, osteopath or podiatrist who is legally authorized to issue the prescription order. These drugs must be sold to you for use outside of a hospital, skilled nursing facility or other institution by a licensed pharmacist in a retail pharmacy which is registered by either the New York State Board of Pharmacy or by a similar board of another state.

Subject to the following quantity limitations we will pay for:

- Up to a 34 day supply of drugs under each written prescription order;
- A maximum of 100 unit doses or up to a 34 day supply of drugs, whichever is greater, as designated by us for treatment of chronic conditions.

We will pay for refills if they are ordered by your doctor. Refills are subject to the stated quantity limitations and can be obtained up to one year from the date of the original written order unless otherwise prohibited by law.

A pharmacy need not sell any drug which, in the pharmacist's professional judgement, should not be sold.

Co-Payment Provision

These benefits are subject to a "Co-Payment Provision." This co-payment is separate from any other co-payments that apply to the Group Contract. We will not pay the full cost of the prescription. You must pay the first \$1.00 for prescriptions filled generically and \$3.00 for prescriptions filled with a brand name drug for each prescription purchased. If the cost of the prescription is an amount which is less than the co-payment, it is not covered by this plan.

If you purchase a brand name drug for which we have determined, in our sole judgement, there is a generic equivalent, we will pay you 100% of the reasonable charge for the generic drug minus the copayment. You must pay the difference between our payment and the pharmacy's charge for the brand name drug.

You must pay the co-payment amount for each new prescription and each refill prescription that you purchase.

For Example: If your co-payment is \$1.00 and you must purchase two prescriptions, you must pay a total of \$2.00 and then we will pay the balance of the cost to a participating pharmacy.

This Prescription Drug Program assists you in paying the cost of prescription drugs which your doctor orders and which the pharmacist fills at your request. We are not responsible for your doctor's selection of a particular prescription, the manner in which the pharmacist fills your order, the defects of any drug which is issued to you, or the effect of the drug on you.

Maintenance Prescription Drug Program

Blue Shield's Maintenance Prescription Drug Program allows you to order most covered prescription drugs, which you are required to take on a continuing, long-term basis for chronic conditions or illnesses, by mail. We will pay for covered maintenance drugs which you obtain through Prescription Drug Service, Inc. (PDS). The maintenance drug must require a prescription in order to be dispensed and it must be prescribed by your doctor. An example of a maintenance drug is a drug which is: an antiarthritic; an anticoagulant; a cardiac drug; and any other drug which is usually considered a maintenance drug.

How to Use The Program

- First, discuss the program with your doctor and determine if a maintenance drug is appropriate for you.
- If it is, have your doctor prescribe the correct quantity of the maintenance drug to be dispensed. For example. for a three month period: 1 pill per day, or 90 pills; 2 pills per day, or 180 pills; etc.
- Next, regardless of where you live, to obtain your maintenance drugs you should send PDS the following:

The Appropriate Copay, \$3 for Brand or \$1 for Generic, and the Prescription Form.

If you do not have a claim form available when you visit your doctor, PDS will also accept your doctor's regular prescription form. Please make sure all the above information is included before mailing to PDS.

These should be sent to the following location:

Prescription Drug Service, Inc.
P.O. Box 707
Smithtown, NY 11787-9948
Telephone: 1-800-899-3784

Also, please be certain to allow at least 10 to 14 working days for the delivery of your medication. Your medication will be sent to you, prepaid, by United Parcel Service (UPS).

If you wish to use PDS and have questions about the program or whether or not a certain drug is available under this program, you may telephone POS at the number given.

EXCLUSIONS

- Non-Prescription Drugs.
- Administration or injection of drugs.
- Vitamins except those which, by law, require a prescription.
- Drugs dispensed to in-patients.
- Prescriptions covered by Workers' Compensation or similar laws.
- Drugs for the treatment of disorders resulting from war.
- Prescriptions dispensed by your employer.
- Prescriptions covered by government programs (except Medicaid).

- Free prescription drugs.
- Unreasonable or unnecessary drugs.
- Experimental or obsolete prescription drugs.

SECTION XVI

COORDINATION OF BENEFITS

This Section applies to you only if you have other group health benefits coverage.

When You Have Other Health Benefits

It is not unusual to find yourself covered by two health insurance contracts, plans, or policies (hereinafter collectively referred to as "policies") providing similar benefits both issued through or to group. When that is the case and you receive an item or service which would be covered by both policies, we will coordinate benefit payments with any payment made under the other policy. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:

Any group or blanket insurance policy, including HMO and other prepaid group coverage; except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance policy.

Any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization; or employee benefit organization.

Any Blue Cross, Blue Shield, or other service type group plan or group remittance subscriber contracts.

Any coverage under governmental programs; or any coverage required or provided by a statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies.

Medical benefits coverage in group and individual mandatory automobile traditional "fault" type contracts.

Rules to Determine Payment

In order to determine which policy is primary certain rules have been established. The first of the rules listed below which applies shall determine which policy shall be primary:

If the other policy does not have a provision similar to this one, then it will be primary. . . .

If you are covered under one policy as an employee or member of a group and you are only covered as a dependent under the other policy the policy which covers you as an employee will be primary.

Subject to the provisions below, if you are covered as a child under both policies, the policy of the parent whose birthday (month and day) falls earlier in the year is primary. If both parents have the same birthday, the policy which covered the parent longer is primary.

If the other policy does not have the rule described above, but instead has a rule based on gender of a parent and, as a result, the policies do not agree on which shall be primary, the policy under which you are the dependent of a male will be primary.

There are special rules for a child of separated or divorced parents:

If the terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the policy of that parent has actual knowledge of the court decree, that policy shall be primary.

If no such court decree exists or if the entity obligated to pay or provide the benefits under such a court decree does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

First, the policy of the parent with custody of the child.

Then, the policy of the spouse of the parent with custody of the child.

Finally the policy of the parent not having custody of the child.

If you are covered under one of the policies as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other policy, the policy covering you as an active employee or as a dependent of the active employee will be Primary. However, if the other policy does not have this rule, and as a result the policies do not agree on which shall be primary, this rule shall be ignored.

If none of the above applies, then the policy which has covered you for the longest time will be primary. The above rules apply whether or not you actually make a claim under both policies.

Payment of the Benefits When This Plan is Secondary

When this Plan is secondary, the benefits of the Plan will be reduced so that the total benefits payable under the other policy and this Plan do not exceed the charge for the service. However, we will not pay more than we would have paid if we were primary.

Right To Receive and Release Necessary Information

We have the right to release or obtain information which we believe necessary to carry out the purpose of this section. We will not notify you or get your consent before releasing or obtaining information except as required by Article 25 of the New York General Business Law. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not furnish the information to us, we have the right to deny payments.

Payments to Others

We may repay to any other person, insurance company, or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid and they satisfy our obligation to you under this Plan.

Our Right to Recover Overpayment

In some cases we may have made payment even though you had coverage under another policy. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits program if we have not already received payment from that other program. You must sign any document which we feel is needed to help us recover any overpayment.

SECTION XVII

TERMINATION OF YOUR COVERAGE

Described below are reasons why this Plan may terminate, or your coverage under this Plan may terminate.

Termination of This Plan

This Plan is provided under the terms of a group health insurance contract between us and the group contract holder, whose number is listed on your Identification Card. When the group contract is terminated for any reason whatsoever, including a default in the payment of premiums, we will no longer provide any of the benefits of this Plan. (See Section Eighteen, as to how you can continue Blue Shield coverage on an individual direct payment basis.)

If You Are No Longer a Member of the Group

If your employment or membership in the group terminates, your coverage and the coverage of your dependents under this Plan will automatically terminate on the date to which the premium for you has been paid. (See Section Eighteen as to how you can continue Blue Shield coverage on an individual direct payment basis.)

On Your Death

Your coverage under this Plan will automatically terminate on the day following your death. However, if you have other than individual coverage, this Plan will terminate on the date to which the premium has been paid. (See Section Eighteen as to how your husband or wife can continue Blue Shield coverage on an individual direct payment basis.)

Termination of Your Marriage

If you become divorced or your marriage is annulled, the coverage of your wife or husband under this Plan will automatically terminate on the date of the divorce or annulment. (See Section Eighteen as to how your former wife or former husband can continue Blue Shield coverage on an individual direct payment basis.)

Termination of Coverage of a Child

The coverage of your child under this Plan will automatically terminate on the date the child marries; or on the date the child becomes 19 years of age; or if the child is over 19 years of age and covered under this Plan, on the date the child is no longer incapable of self-support; or when the child is no longer an unmarried full-time student meeting the requirements of Section Two.

APPENDIX A-2

Traditional Blue PPO 898
 Prepared for: City of Troy



A Division of HealthCare Plans, Inc. An Equal Opportunity Employer of the BlueShield Family of Companies

What makes the Traditional Blue PPO 898 Plan stand out? How about:

The freedom to use any provider

\$20 office visit co-pays

100% coverage for inpatient hospital services at participating providers

No claim forms when using participating providers

Coast-to-Coast coverage through the BlueCard Program

Dependents covered to age 19.
 Students covered to age 25.

Out of Network features

Upfront Deductible:
 \$200 individual
 \$400 family

Coinsurance: 20%
 (50% for OP mental health, durable medical equipment & external prosthetics/orthotics)

Out of Pocket Maximum:
 \$2,000 individual
 \$4,000 other than individual

Maximum Benefit:
 Unlimited lifetime max per contract

In-Network

Doctor's office visits

- Office visits • pediatrics • internal medicine • family practice • specialists\$20 co-pay
- Routine physical – 1 per year (*no coverage out of network*)\$20 co-pay
- PCP office visits for children under age 19.....Covered in full
- Well child visits and immunizations (up to age 19)Covered in full

Women's services

- Routine Ob/Gyn- up to 2 visits per year\$20 co-pay
- MammogramsCovered in full
- Maternity care (Prenatal & post-natal care)Covered in full
 after \$20 co-pay for initial visit

Medical care

- Physical, speech & occupational therapy (120 visits aggregate).....\$20 co-pay
- Chiropractic care\$20 co-pay
- Diagnostic x-rays, lab services & MRIsCovered in full

Outpatient hospital care

- Outpatient surgery (facility) • ambulatory facility.....\$20 co-pay
- Cardiac rehabilitation (24 visits per year)\$20 co-pay
- Chemotherapy • radiation therapy • hemodialysis.....Covered in full
- Preadmission testing (within 7 days of admission)Covered in full

Inpatient hospital care

- Semi-private room (unlimited days).....Covered in full
- Physical rehabilitation (45 days)Covered in full
- Skilled nursing facility- non custodial (365 days)Covered in full
- Maternity admissionsCovered in full

Emergency care

- Emergency room visit\$35 co-pay
- Emergency ambulance service.....Covered in full

Mental health care

- Inpatient care (60 days).....Covered in full
- Outpatient care (20 visits).....\$20 co-pay

Substance abuse treatment

- Inpatient detoxification for chemical dependency (7 days).....Covered in full
- Outpatient treatment (60 visits).....\$20 co-pay

Other services

- Hospice (Unlimited days)\$20 co-pay
- Home health care (200 visits)\$20 co-pay
- Diabetic supplies, equipment, education, insulin\$20 co-pay
- Infusion therapy (200 visits aggregate with Home Care)\$20 co-pay
- Urgent careCovered in full
- External prosthetics/orthoticsCovered in full
- Durable medical equipmentCovered in full
- Post-mastectomy prosthetics.....Covered in full

Covered Benefits • This is a summary of covered benefits and exclusions and is not intended as a contract. It does not detail all benefits, limitations, and exclusions that may apply. A complete contract will be issued upon enrollment. Please check the contract for final information on your benefits and exclusions. In addition, please note the following benefit information:

› Both In-Network and Out of Network providers are reimbursed at Fee Schedule for eligible Hospital and Medical services. For Out of Network services, in addition to any applicable deductible and coinsurance, the patient is responsible for any amounts that exceed the Fee Schedule allowance.

› In-Network and Out of Network day limits and visit limits are aggregate. Out of Network benefits are not in addition to the benefits provided In-Network.

› Emergency ambulance service includes medically necessary, pre-hospital airborne ambulance from the site of the accident or illness to a hospital for emergency treatment.

Potential Restrictions- All indicated benefits assume an In-Network provider renders services. Maximum benefits are obtained when rendered by an In-Network provider. Pre-certification is recommended for all inpatient admissions. In addition, prior authorization is required for all MRIs, MRAs, and Pet Scans.

We Keep Your Information Confidential • BlueShield of Northeastern New York is committed to maintaining the confidentiality of patient information in all situations, such as in your doctor's office, the hospital, with our employees and everyone we contract with to provide and manage your health care. We will only release such information *in* accordance with state and federal law and the guidelines established by BlueShield of Northeastern New York. Here's a summary of some of the guidelines we follow to keep your personal information confidential:

• Routine Consent: When you joined BlueShield of Northeastern New York, you agreed to let us access your personal health information for the purpose of ensuring that you receive the quality health care and services you need. Examples of situations in which we use personal information for your benefit include:

- ✓ the coordination of care between your providers and BlueShield of Northeastern New York.
- ✓ healthcare quality improvement programs such as disease management, case management, preventive care and quality improvement and measurement activities.
- ✓ billing, payment of claims and coordination of benefits.

• Special Consent: We will contact you for approval before releasing Information that is not covered by our general guidelines. Those situations could include worker's compensation or auto insurance claims, as well as data used for research studies.

• Obtaining Consent from Members who are Unable to Give Consent: BlueShield of Northeastern New York has guidelines describing the people who *may* authorize release or have access to personal health information of any of our members who are unable to give consent (i.e. legal guardian). If the member lacks the capacity to consent, the person authorized by law to consent on the member's behalf must sign the authorization.

• Access to Medical Records: BlueShield of Northeastern New York does not generate or modify, nor do we maintain complete copies of your medical records. We receive copies of your medical records in order to process claims *and* perform other routine functions in the normal course of business. If you desire to obtain copies of your medical records, you should contact the practitioner or facility considered to be the source of these documents.

• Providing Information to Employers: We do not share personal health information, including identifiable claims information, with our employer groups. However, we have contracts that require the release of certain claims information. In these limited circumstances, it is our policy to only provide information with certain restrictions about how the information will be used so confidentiality will be maintained.

Exclusions:

- Admission to a hospital before you become covered under this contract.
- Government hospital.
- No fault automobile insurance.
- Workers' Compensation.
- Free care.
- Government programs.
- Custodial Care.
- Unauthorized services.
- Experimental, investigational, or obsolete services.
- Cosmetic Surgery
- Dental care.
- Military service connected disabilities.
- Routine care of feet.
- Weight reduction.

Non-covered benefits,

- Sex change.
- GIFT (gamete intrafallopian transfer), ZIFT (zygote intrafallopian transfer), in vitro fertilization, and cloning.
- Organ transplant searches, screening, or donation.
- Methadone maintenance.
- Reversal of elective sterilization.
- Non-acute hospital or medically unnecessary care.
- Court ordered services.
- Diagnostic studies in an inpatient hospital setting.
- Services maintained by an employer or school.
- Hearing aids.
- Charges for standby service.
- Prescription drugs.

Traditional Blue

BlueShield of
Northeastern New York

Traditional Blue PPO 898 City of Troy

	Benefit	Co-Payment	Limits
Eye exam	Routine vision exam through Davis Vision provider.	\$20 co-pay	One exam every calendar year.
Lenses	We will pay for single vision, bifocal, trifocal or lenticular lenses. (Additional lens options, such as progressive no-line bifocals and photochromic lenses are available at discounted prices and can be purchased by you at the time of service.)	\$0 co-pay	Coverage available once every calendar year. Please contact Davis Vision for the location of Designated Providers in your area: 1-800-999-5431.
Frames	Davis Designer Collection.	\$0 co-pay	Coverage available once every calendar year. Please contact Davis Vision for the location of Designated Providers in your area: 1-800-999-5431.
Contacts	Hard, soft, gas permeable daily wear or disposable contact lenses. (Available in lieu of spectacles.)	\$0 co-pay (\$105 maximum allowance)	Coverage available once every calendar year. Please contact Davis Vision for the location of Designated Providers in your area: 1-800-999-5431.
Providers	For maximum benefits, please utilize the participating Davis Vision providers listed in your Participating PPO Provider Directory.		

- o For services by Non-Participating Providers, you are responsible for submitting a claim directly to Davis Vision using the appropriate Non-Participating Provider claim form. In addition, you are responsible for any charges that exceed the allowed amount for covered services.

No benefits shall be provided for:

Frames from a Designated Provider that are not included in the Davis Designer Collection. However, the Davis Premier Frame is available at a discounted price through your Davis Vision provider and can be purchased by you at the time of service.

Vision Services received or prescribed before the effective date of coverage, or ordered after termination of coverage.

Examinations; frames; or lenses which are not necessary according to accepted standards of ophthalmic practice or which are not ordered or prescribed by the attending physician or by the optometrist.

Replacement of lost; stolen; broken; or damaged lenses, contact lenses or frames, unless at the time of replacement the Subscriber is otherwise entitled to benefits for the lenses or frames.

Industrial safety glasses; safety goggles; or sunglasses; whether or not they require a prescription.

Examinations; frames; or lenses required by the Subscriber's employment.

Examinations; lenses; or frames for which benefits are afforded in whole or in part, under a Workers' Compensation Act or like laws; whether or not the Subscriber claims or receives benefits thereunder, and regardless of whether the Subscriber recovers any damages against a third person.

Duplication of services: The benefits covered under this amendment are reduced by any benefits received under your contract or group plan.