ORANGE-ULSTER
SCHOOL DISTRICTS HEALTH PLAN

PLAN AND SUMMARY PLAN DESCRIPTION

NOTICE: THIS MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN IS NOT A LICENSED INSURER. IT OPERATES UNDER A MORE LIMITED CERTIFICATE OF AUTHORITY GRANTED BY THE SUPERINTENDENT OF INSURANCE. MUNICIPAL CORPORATIONS PARTICIPATING IN THE MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN ARE SUBJECT TO CONTINGENT ASSESSMENT LIABILITY.

NOTICE: This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

SECTION 1
INTRODUCTION

Your Employer is providing health benefits to you through the self-funded Orange-Ulster School Districts Health Plan (the OU Plan). This booklet is your plan document and summary plan description, and it provides information on your Plan benefits and your responsibilities to provide information to the Plan for proper administration of your medical claims. Any apparent conflict between this document and any other publication or presentation involving this Plan will be resolved by reference to this Plan document.

School Districts Participating in the Plan:

- Chester Union Free School District
- Eldred Central School District
- Goshen Central School District
- Highland Falls Central School District
- Marlboro Central School District
- Minisink Valley Central School District
- Orange-Ulster BOCES
- Port Jervis City School District
- Valley Central School District
- Washingtonville School District
- Cornwall Central School District
- Florida Union Free School District
- Greenwood Lake Union Free School District
- Kiryas Joel Village School District
- Middletown City School District
- Monroe-Woodbury Central School District
- Pine Bush Central School District
- Tuxedo Union Free School District
- Warwick Valley School District

Board of Directors – The Board of Directors, which is the governing committee of the OU Plan, consists of the Superintendent (or his designee) from each of the participating Employer School Districts.

Executive Director/Plan Administrator – The Plan Administrator and the Executive Director is Ike Lovelass, with offices at 163 Harriman Heights Road, Monroe, New York 10950. Phone: 845-781-4890; fax: 845-781-8174.

PPO Networks and Other Service Vendors – See Appendix "A."

Privacy/Security Official – The Plan's Privacy and Security Official is the Executive Director of the Plan (see above).

Plan Effective Date – This Restated Plan's Effective date was January 1, 2007.

Plan Year – Jan 1 through Dec 31**.**

Fiscal Year; Calendar Year – The Fiscal and Calendar year each end on December 31st.

Agent for Service of Process – Service of process may be made upon the Chairman of the Board of Directors, and/or the Plan Administrator or Executive Director, Orange-Ulster School Districts Health Plan, 163 Harriman Heights Road, Monroe, New York 10950.

Coverage Under the Group Plan – The OU Plan provides the benefits described in this document to eligible Employees and Retirees, as well as their eligible Dependents. Many of these benefits are currently mandated by New York State Insurance Law and Regulation. If State law or regulations change in the future, certain benefits described herein may be increased, reduced or even eliminated by way of plan amendments adopted by the OU Plan's Board of Directors, and approved by the State Insurance Department.

Gender and Number - All singular terms used in the document are meant to be interchangeable with the plural and vice versa, and terms representing the masculine gender are meant to be interchangeable with the feminine gender, unless the context or usage clearly requires that only the specific terminology used should apply.

SECTION 2
DEFINITIONS

Throughout this document, certain words and phrases that are capitalized are defined in this section.

BIOLOGICALLY BASED MENTAL ILLNESS – means a mental, nervous or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under Timothy's Law, only the following disorders satisfy the definition of "biologically based mental illness": schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders; anorexia and bulimia.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES – as the definition applies to the mandates of Timothy's Law, means those persons under the age of 18 years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders <u>*and*</u> one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that place the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that place the child at substantial risk of removal from the household.

CONFINEMENT – means admission to a Facility as an inpatient due to injury or illness. Successive periods of Confinement for the illness or injury will be considered as one continuous period of Confinement unless separated by a period of 90 days or more during which the Covered Person has not been confined to a Facility.

COSMETIC SURGERY – means surgery to improve an individual's appearance, which is not considered Reconstructive Surgery. Cosmetic surgery usually includes procedures like breast enlargement or reduction, liposuction, rhinoplasty, ear pinning and facial lifts, or other surgery not considered Medically Necessary.

COVERED CHARGE – means the amount of Covered Expenses, after any applicable deductible or co-payment that will be paid by the Plan not exceeding *the lesser* of the Usual and Customary charges, or the Professional Provider's actual charges, or any discounted rates negotiated with the Professional Provider by the Plan or its representative. (The Covered Person is responsible for any expenses that are not considered Covered Charges.)

COVERED EXPENSES – means those Covered Charges incurred for Covered Services, treatments, or supplies which are reimbursable under the Plan. The fact that a provider may prescribe, order, recommend or approve a service or supply does not necessarily make it a Covered Expense. Even though it may not specifically be identified as an exclusion, an expense may be non-reimbursable under this Plan.

COVERED PERSON – means an Employee, Retiree, or Dependent who is covered for benefits under this Plan.

COVERED SERVICES – means those Medically Necessary services described in this Plan, as well as those services that may not be Medically Necessary but are specifically covered such as mammograms, cervical cytology screening and well child care.

CUSTODIAL CARE – means any service or supply that is given principally for personal hygiene or assistance in daily activities and can, according to generally accepted medical standards be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication that could normally be self-

administered. The Plan may review medical and progress periodically to determine whether care is or has become Custodial Care. Custodial Care is not covered by the Plan.

DEPENDENT – means an Employee's (or Retiree's) spouse or a child who meets the eligibility requirements for coverage in Section 3.

EMERGENCY CONDITION/EMERGENCY – means a sudden onset of a medical or behavioral condition, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent person, possessing an average knowledge of medicine and health, could reasonably expect to result (in the absence of immediate medical attention) in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or (b) serious impairment of the person's bodily functions; or (c) serious dysfunction of any bodily organ or part of the person; or (d) serious disfigurement of such person.

EMPLOYEE – means, at a minimum, a person who is directly employed in a regular business of an Employer member of this Plan, who receives W-2 compensation from the Employer, and who meets the Employer's requirements for eligibility for health coverage under the Plan. Eligibility requirements may vary among participating Employers. See Section 3 for additional eligibility information.

EMPLOYER – means one of the school or BOCES districts participating in the Plan.

EXPERIMENTAL and/or INVESTIGATIONAL – means those treatments, procedures, drugs, biological products, or medical devices ("Services"), which are not generally covered by this Plan. See Section 11 for additional information and an explanation of Experimental and Investigational exclusions.

FACILITY – means a Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; Skilled Nursing Facility; hospice; home health agency or home health care services agency certified or licensed under Article 36 of the New York Public Health Law; an institutional provider of mental health or chemical dependence and abuse treatment, operating under Article 31 of the Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or any other provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable).

HOSPITAL – means any short-term acute general hospital facility that

1. is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, those diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick patients;
2. has organized departments of medicine and major surgery;
3. has a requirement that every patient must be under the care of a physician or dentist;
4. provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
5. if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395x[k]);
6. is duly licensed by the agency responsible for licensing such hospitals; and
7. is **not**, other than incidentally, a place of rest; a place primarily for the treatment of tuberculosis; a place for the aged; a place primarily dedicated to the treatment of chemical dependence or alcohol abuse; a free-standing ambulatory surgery center; a Skilled Nursing Facility; a place for convalescent, custodial, educational, or rehabilitative care.

MAINTENANCE CARE – means continuing care where there is no evidence of improvement of the condition being treated, and the schedule of visits for care is not consistent with an acute pattern of treatment. Unless otherwise stated, the Plan does not pay for Maintenance Care.

MEDICALLY NECESSARY – means those treatments, procedures, drugs or supplies (Services) required to diagnose or treat a Covered Person's medical condition, as determined in accordance with accepted medical practices and standards. The fact that a provider has furnished, prescribed, ordered, recommended or approved the Service does not make it Medically Necessary or mean that the Plan will provide coverage for it. The Plan will determine whether care was Medically Necessary. We will base our decision in part on a review of your medical records. We will also evaluate medical opinions we receive. This could include the medical opinion of a professional society, peer review committee, or other groups of physicians.

In determining if a Service is Medically Necessary, we will also consider the following:

- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of the attending Professional Providers (which have credence but do not overrule contrary opinions); and
- Any other relevant information brought to our attention.

Services will be deemed Medically Necessary only when:

- They are appropriate and consistent with the diagnosis and treatment of your medical condition;
- They are required for the direct care and treatment or management of that condition;
- If not provided, your condition would be adversely affected;
- They are provided in accordance with community standards of good medical practice;
- They are not primarily for the convenience of you, your family, the Professional Provider or another provider;
- They are the most appropriate services rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you; and
- When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office or at home).

Service or care must be approved standard treatment. Except as otherwise required by law, or as provided in the Plan, no service or care rendered to you will be considered Medically Necessary unless we determine that the service or care is consistent with diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative.

PRE-HOSPITAL EMERGENCY MEDICAL TREATMENT – means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital; provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this subsection, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

PROFESSIONAL PROVIDER – means a certified and licensed physician, osteopath, dentist, optometrist, chiropractor, registered psychologist, psychiatrist, social worker, clinical social worker, podiatrist, physical therapist, occupational therapist, licensed midwife, speech-language pathologist, audiologist or any other licensed health care provider that the New York State Insurance Law requires to be recognized who charges and bills patients for his or her services. To qualify for reimbursement under

this plan, a clinical social worker involved in the diagnosis and treatment of mental, nervous or emotional disorders must be licensed pursuant to Article 154 of the New York State Education law, and have at least six years post-degree experience in psychotherapy under the terms outlined in Section 4303 of the New York State Insurance Law. Any Professional Provider's services must be rendered within the lawful scope of his practice in order to be covered under this Plan.

RECONSTRUCTIVE SURGERY – means surgery limited to improving or restoring bodily function or correcting a deformity that has resulted in a functional impairment caused by disease or trauma. It may also mean surgery to correct a congenital or developmental abnormality of a covered Dependent child. If a Covered Person is receiving benefits in connection with a mastectomy, reconstruction of the breast on which the mastectomy has been performed, as well as surgery and reconstruction of the other breast to produce a symmetrical appearance, will be considered Reconstructive Surgery and will be a Covered Expense.

RETIREE - means a former Employee of a member school district who qualifies for a retirement benefit from a New York State Retirement System offered by their Employer.

SKILLED CARE – means a service which we determine is furnished by or under the direct supervision of licensed medical personnel to assure the safety of the patient and achieve the medically desired results as defined by Medicare guidelines. A service is not considered Skilled Care merely because it is performed or supervised by licensed medical personnel. However, it is a service that cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.

SKILLED NURSING FACILITY – means a Facility accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or qualified as a Skilled Nursing Facility under Medicare. We will provide coverage in a Skilled Nursing Facility only if care is determined by us to be Skilled Care (see above).

SPOUSE – means a person to whom you are legally married under the laws of the State or country in which the marriage took place. Neither a "common law" marriage partner, a "domestic partner," nor a partner in a "civil union" will be considered a "spouse" for purposes of dependent eligibility under the Plan. Proof of marriage acceptable to the Plan will be required for enrollment of a spouse.

TIMOTHY'S LAW – means the New York State law that mandates the provision of certain mental health benefits for persons enrolled in this Plan.

TOTALLY DISABLED – means, when referring to an Employee, that the Employee is unable to perform the substantial and material duties of his occupation or employment or the duties of any other employment for which he is reasonably qualified by training and experience and at comparable wages. During unemployment, a Covered Person will be considered Totally Disabled if he is unable, because of illness or injury, to perform the duties of any employment for which he is reasonably qualified by training and experience. A Dependent Spouse will be considered Totally Disabled if he is completely unable, as a result of injury or illness, to engage in the usual, customary, substantial and material activities engaged in prior to the onset of disability. A Dependent child will be considered Totally Disabled if he is completely unable, as a result of injury or illness, to engage in normal activities of children of similar age.

USUAL AND CUSTOMARY CHARGES (U&C) – means the normal and necessary charges made for similar services by 90% of the providers of medical service with like experience, education and training, who are practicing in the same geographic area. Determination whether or not a charge is U&C shall be made by the Claims Administrator based on nationally obtained and recognized survey data or on data received from a nationally recognized insurer or consulting service which, as a major portion of its business, is involved in the adjudication of health care claims.

SECTION 3
ELIGIBILITY AND ENROLLMENT

Who is Eligible? Employees, Retirees, and their Dependents may be eligible for coverage under this Plan. However, eligibility, participation, and contributions to the Plan are variable and depend upon the policy or your particular school district, their personnel policies and contractual agreements. For information on the specific eligibility requirements of your Employer, contact your school's insurance clerk.

Demonstrating Your Eligibility. The Plan requires that Employees submit appropriate official documentation of eligibility when enrolling themselves or their family members in the Plan. Coverage will not begin until documentation of eligibility (such as marriage or birth certificates, tax returns, etc.) has been submitted as requested by the Plan.

Employees. An Employee is eligible for Plan benefits if he meets the following *minimum requirements*. He must be hired by a participating Employer for an anticipated period of at least 3 months; he must be working a regularly scheduled work week of at least 20 hours; and he must be paid an annual salary of at least $5,000.00. (Individual Employers may increase the anticipated employment eligibility requirement for up to six months. They may also require a work week of more than 20 hours to qualify for coverage, and they may set a higher minimum annual salary rate for eligibility. In addition, certain classes or categories of Employees may not be eligible for coverage. Check with your Employer to determine specific eligibility requirements.)

Transfer of Employment between Participating Employers. If you transfer employment from one Employer participating in the Plan to another Employer participating in the Plan, you must re-enroll with the new Employer within 30 days of the transfer, and there will be no lapses in your coverage. In addition, credit will be transferred from the old to the new Employer for any deductibles previously satisfied.

Employment by Two or More Employers. If an individual is employed by two or more Employers who each participate in the Plan, the individual may elect coverage as an Employee with only one of them.

Husband and Wife Employees. If both husband and wife each qualify as an Employee of a participating Employer, each may choose to be covered as an Employee under the Plan of their respective Employers, and each may elect family coverage, if desired. Some participating districts, however, may have limited eligibility for dual coverage through their collective bargaining agreement with employee unions. Please see your local school district's insurance clerk for details on your school district's policy.

Employees on Active Military Duty. Employees going into or returning from active military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act and Article 4305(g) of the New York State Insurance Law. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for service. Employees have 60 days from being ordered to active duty to elect continued coverage under this section or coverage will be suspended during the period of active duty. An Employee who elects to continue coverage during a period of active duty must pay the required group premium payment once monthly in advance.

If the Employee suspends coverage while on active duty, coverage under this Plan will continue when he or she returns to employment and will be retroactive to the date of termination of the period of active duty. The Employee must request continuation of this Plan's coverage within 31 days of termination from active duty, or from discharge from hospital incident to such active duty (as long as the hospitalization continues for no longer than 12 months after discharge from active duty).

No exclusionary or waiting period will be imposed in connection with the reinstatement of coverage under reemployment unless the condition arose during a period of active duty that has been determined by the secretary of veterans' affairs to have been incurred in the line of duty.

Employees on Approved Leaves of Absence. If an Employee goes on an approved leave of absence (without pay) for other than medical reasons, coverage for the Employee and his covered Dependent(s) may be continued for the duration of the approved leave, provided all required contributions are made by the Employee when due. (This provision applies only if approved as general policy for the Employee's particular participating Employer.) If an Employee goes on an approved leave of absence (without pay) due to Total Disability for more than three months, coverage for the Employee and his covered Dependent(s) will be continued for the duration of the approved leave of absence, not to exceed one year. All required contributions must be made by the Employee when due.

Employees Involuntarily Terminated from Employment. If an Employee is terminated because of a service-connected disability retirement, coverage for the Employee and his covered Dependent(s) may be continued indefinitely, provided the Employee has completed the number of years of service required before the disability retirement, and provided he pays all required contributions when they are due.

If an Employee dies, and his death was due either to a work-related accident, or his death occurred after he completed at least 10 years of service, coverage for his covered Dependent(s) may be continued, provided that his former Employer continues to participate in the Plan. For the first three months after the Employee's death, there will be no cost for continued coverage. Coverage will continue as long as the Dependent is eligible as long as the required contributions are made. Benefits will end if the Dependent ceases to qualify as an eligible Dependent for any reason other than lack of the deceased Employee's principal support. (Once the Dependent becomes enrolled in the Plan as a result of survivorship, he or she may not add Dependents other than those who were eligible when the survivor first qualified for coverage.)

Retirees. To be eligible for Plan enrollment, retired Employees of a participating school district must have satisfied all requirements to collect an allowance/benefit from the applicable New York State Employee's or Teacher's Retirement System, and they must pay any required contributions. In addition:

- A retired Employee (who was enrolled in the Plan immediately prior to retirement) may continue, at the option of the Employer, to be covered under the Plan as if an active Employee, until he becomes eligible for Medicare. If an Employer provides retiree coverage, the Employer may establish service requirements for its retired Employee's eligibility.
- An Employee who does not maintain coverage under the OU Plan upon retirement may not re-enroll in the Orange-Ulster Health Plan later.
- Retirees who are prohibited from participating in the Orange-Ulster School District's Health Plan because of a non-duplication of coverage clause in their contractual agreement may enroll or re-enroll if they lose coverage later under the plan that prevented them from participating in the OU Plan at retirement. In that case, the Retiree must enroll within 30 days of the loss of the other coverage. If there are reasonable circumstances that prevented the Retiree from enrolling within 30 days after losing his other coverage, the time for enrollment may be extended for up to one year, but no longer. In cases of legal incompetence, the one-year maximum time period for enrollment will begin after the incompetence ends.

Vested Employees. A vested Employee is an ex-Employee who does not qualify as a Retiree, but was employed for a sufficient length of time to have satisfied the minimum requirements for vesting of retirement allowance/benefits. A vested Employee shall be considered to be a Retiree for the purpose of establishing eligibility to participate in the Plan, provided the Employee was covered under the Plan during the entire time he was in a vested status, and provided the Employee makes all required

contributions during the period of vesting. (The Employer may require that the Employee be within five (5) years of retirement at the time he becomes vested.)

Dependents. If an Employee has family coverage, the following members of his family may also be covered as Dependents:

(1) An Employee's legal Spouse.

(2) An Employee's children, step-children, adopted or pre-adoptive children, and eligible foster children (those who are placed with the employee by an authorized agency or order of a court of competent jurisdiction). Eligibility ends when the child reaches his or her 26th birthday. Until 2014, this option is only available if the dependent is not eligible for other employer-sponsored health plan coverage.

(3) Other children supported by the Employee or Spouse of the Employee who live in the Employee's home may also be eligible under some circumstances; however, in the case of children who do not meet the definition of "child" under IRS152 (f)(1), and where no blood or legal relationship to the Employee or Spouse of the Employee exists, the support must be at least 50% to be eligible for coverage, and they are eligible only until the age of 19 (or 25 if they are full-time students).

(4) An unmarried Dependent child, regardless of age, who is incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, and who is eligible to be claimed as a dependent ("qualifying relative") under IRS rules and regulations (which means the employee must provide more than half the dependent's support). The condition must have occurred before the child reached the age at which coverage under the Plan would otherwise have terminated. The child's disability must be certified by a physician within 31 days after he reaches the age at which coverage would have terminated in order for coverage to continue under the Plan. The Plan has the right to check whether a child is and continues to qualify under this paragraph.

To qualify for student coverage after a child's 19th birthday, a child who does not meet the definition of child under IRS 152(f)(1), must be dependent on his parent(s) for support, and be enrolled as a full time student as determined by the institution, at an accredited institution of higher learning (post-secondary education). Proof of enrollment during each semester must be submitted to the Claims Administrator as requested in order to ensure continued coverage; otherwise benefits may be reduced or denied. Coverage will be continued during school vacation periods provided the child intends to resume full-time student status at the end of the vacation period. If a dependent student is granted a medical leave from school, coverage will continue for a maximum of 12 calendar months following the month in which the child withdraws from school, plus the time between the end of that period and the beginning of the next regular semester.

Time spent in military service, not to exceed four years, may be deducted from the Dependent's age for the purpose of establishing eligibility for coverage.

A child who lives with an Employee on a temporary basis, such as an exchange student is not eligible for benefits. We have the right to request and be furnished with any proof we need to determine eligibility status of prospective Dependents as they pertain to eligibility under this Plan.

Young Adult Coverage to Age 30.

If an Employee has a child under the age of 30 who wishes to continue coverage under this plan with single coverage, this plan offers the Young Adult Option explained below. In order to qualify for this option, the Employee must be covered under this plan. In addition:

Requirements for the Young Adult to Enroll:

1. Be unmarried;
2. Be 29 years of age or under (up to 30th birthday);

3. Not be insured by or eligible for comprehensive (i.e. medical and hospital) health insurance through his or her own employer;
4. Live, work or reside in New York State or the Plan's service area; and
5. Not be covered under Medicare.

Note: The young adult is not required to live with the employee, be financially dependent on the employee, nor be a student to be eligible for this coverage.

Enrollment Dates for Coverage:

1. Loss of Coverage under the Plan. If the person is currently covered under the employee's policy, he may enroll within 60 days of the date that coverage would otherwise end due to reaching the maximum age for dependent coverage. Coverage will be retroactive to the date that coverage would otherwise have terminated (similar to COBRA election period).
Note: Coverage will be retroactive only if elected within 60 days of the date the young adult would otherwise age off a parent's policy. In all other cases, coverage will be prospective and will start no more than 30 days from the date that the Plan receives notice of election and premium payment.

2. Changes in Circumstances. The person may enroll within 60 days of newly meeting the eligibility requirements because of a change in circumstance. Coverage will be prospective and will start within 30 days of when the Plan receives notice of the election and premium payment. Examples of changes in circumstances would be a young adult moving back to New York State after living outside the state or losing health insurance coverage sponsored by his own employer.

3. During an Annual 30-Day Open Enrollment Period. The Plan has an open enrollment period each year, during which the person can elect coverage if eligibility requirements are met. Coverage will be prospective and will start within 30 days of when the Plan receives notice of the election and premium payment.

4. During the Initial 12-Month Open Enrollment Period. There is an initial 12-month open enrollment period, which will begin July 31, 2010 during which adults can enroll if they meet the eligibility requirements. Coverage will be prospective and will start within 30 days of when the Plan receives notice of the election and premium payment.

Cost of Coverage. The young adult or his or her parent will be responsible for a separate premium for the young adult option (over and above what the parent pays for the group coverage). However, the cost will not exceed that which is charged for other single coverage.

Loss of Eligibility if Employee Loses Coverage. If the employee separates from his or her employer or group and is no longer eligible for health insurance, the young adult would also lose coverage. HOWEVER, if the employee elects COBRA, the adult remains eligible until COBRA is exhausted.

Dropping Coverage and Re-enrolling Later. If a young adult drops the coverage (perhaps because he obtains a job that has employer-sponsored coverage) and then loses that coverage (perhaps because he loses the job), he can sign up again as long as he meets the eligibility requirements.

When Does Coverage End? Coverage will end when one of the following occurs:

1. Coverage is terminated pursuant to the terms of the policy.
2. The employee is no longer enrolled in the Plan or receiving COBRA.
3. The young adult no longer meets the eligibility requirements.
4. The premium for coverage in not paid within a 30-day grace period.
5. The group insurance policy is terminated and not replaced.

Extended Plan Benefits. Plan benefits will be extended during a period of Total Disability caused by injury, sickness or pregnancy, or for hospital confinements beginning (or surgery performed) during 31 days following termination of coverage. This extension of benefits is provided without cost to the disabled Covered Person only for treatment of the injury, sickness or pregnancy that that caused the disability. This extension of benefits for the specific cause of disability will be provided for up to 12 months subsequent to termination of coverage, unless coverage is available for the total disability under another group plan.

When Coverage Begins.

Employees. A new Employee's effective date of coverage is established by his Employer. Coverage may begin on the first day of employment or at a later date. Check with your Employer for his policy regarding effective dates of coverage under the Plan.

An Employee who waives coverage for himself and/or his Dependents when he is first eligible, or loses coverage for failure to pay required contributions, may elect coverage as a late enrollee. His benefits will begin on the first day of the month following enrollment, or on the first day of the month following the Employer's waiting period, whichever is later. If the late enrollee is covered within 30 days prior to the late enrollment by another group health plan, coverage under *this* Plan will begin immediately.

Dependents (other than newborns). Employees may elect family (Dependent) coverage when (1) they acquire a Spouse or child who meets the definition of Dependent, or (2) they wish to enroll a previously eligible but un-enrolled Spouse or child who meets the definition of Dependent.

An Employee must apply for family coverage within 30 days after his coverage becomes effective, or the date he acquires a Dependent, in order for coverage to become effective on the first day of the month following application. Otherwise, family coverage will not begin until the first day of the third month following application. (In some cases, coverage may begin on the date of marriage, or the date the Employee acquires a Dependent child. Application for first day coverage must be made in advance).

An unborn child will not be eligible for coverage as a Dependent until the date of the child's birth. However, medical and/or surgical intervention of the unborn child to prevent or correct a congenital defect will be considered a maternity expense, as long as the maternity expenses related to that child are Covered Expenses under the Plan, and the treatment is not Experimental or Investigational as defined in the Plan.

Newborn Coverage. If an Employee has family coverage, his newborn Dependent child will automatically become covered as a Dependent on the date of his birth. However, the newborn's eligibility for coverage will terminate 30 days after birth unless the Claims Administrator has received enrollment materials by that date.

If the Employee does *not* have family coverage at the time of the infant's birth, the infant will still be covered if the Employee elects Dependent medical coverage, effective as of the first day of the month in which the child was born, and he submits enrollment materials to your school district's health plan representative, not later than 30 days after the birth. The contribution payment must be received by the Employer on or before the 30th day of the month following the month in which the birth occurs.

Newborn coverage will be provided to the same extent as it is for other covered Dependent children. The Plan pays Covered Expenses for Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, as well as Hospital charges for routine nursery care.

A newborn adopted child is covered from birth provided that the Employee takes physical custody of the child as soon as he is released from the Hospital after birth, and that the Employee files a petition for adoption (pursuant to the New York State Domestic Relations Law, Section 115-C) within 60 days of the infant's birth. In addition, coverage will be provided only if no notice of revocation of the adoption has been filed and only if consent to the adoption has not been revoked. In no instance will the Plan pay for the adopted infant's Hospital stay if either of the biological parents has medical coverage available for the infant.

When Coverage Ends.

Employees. Coverage as an Employee under this Plan ends on the date the Plan terminates, or at 11:59:59 p.m. on the last day of the month in which the first of the following events occurs (except as provided in any extension of coverage provision):

(1) The day of the month in which your employment ceases; or
(2) The day your status as an eligible Employee ends; or
(3) The last day of the month immediately preceding the month in which you, or your Employer on your behalf, made any required contribution*; or
(4) The day your Employer stops participating in the Plan or otherwise terminates your coverage; or
(5) The day you enter the armed forces of any country, except as otherwise required by Section 4317 of the Uniformed Services Employment and Reemployment Rights Act (USERRA) (membership in the reserves is not deemed entry into the armed forces).

*For example, if your employer's contribution is due July 15, and the employer fails to make the July payment, your insurance is cancelled retroactive to June 30th.

Dependents. Coverage as a Dependent ends on the day the Plan terminates or at 11:59:59 p.m. on the last day of the month in which the first of the following events occurs (except as provided in any extension of coverage provision):

(1) The day the Employee's coverage under the Plan ends; or
(2) The day the Employee ceases to be in a class of Employees eligible for Dependent coverage; or
(3) The last day of the month immediately preceding the month in which the Employee, or the Employer on behalf of the Employee and covered Dependent, made any required contribution*; or
(4) The day Dependent coverage is canceled; or
(5) The day you no longer qualify as a Dependent (or student Dependent) under the Plan; or
(6) The day you enter the armed forces of any country, except as otherwise required by Section 4317 of the Uniformed Services Employment and Reemployment Rights Act (USERRA) (membership in the reserves is not deemed entry into the armed forces); or
(6) The date of the Employee's death.

*For example, if your employer's contribution is due July 15, and the employer fails to make the July payment, your insurance is cancelled retroactive to June 30th.

Retirees. Coverage for Retirees and their Dependents ends when the first of the following events occurs (except as provided in any extension of coverage provision):

(1) The Retiree or the former Employer fails to timely pay the applicable cost of the Retiree's coverage; or
(2) The Plan terminates; or

(3) The Dependent coverage terminates under the Plan; or
(4) The Retiree dies.

Enrollment in the OU Plan. Enrollment in the OU Plan is not automatic. You are required to enroll yourself and your Dependents, and advise the Plan when you have changes that affect enrollment. You may enroll for individual or for family coverage if you have eligible Dependents. If certain changes occur that affect your current enrollment, it's **your** responsibility to notify the Plan of enrollment changes; for example, you must notify the Plan of the following:

1. Adding a newly acquired Spouse or Dependent child;
2. Adding an existing Spouse previously enrolled as an Employee or Retiree;
3. Adding a previously eligible but unenrolled Spouse or Dependent child;
4. Changing from individual to family coverage any time you acquire or elect to enroll a previously eligible Spouse or Dependent child;
5. Changing from family to individual coverage when you no longer have or wish to cover eligible Dependents;
6. Changing, adding, or removing a Dependent from family coverage; or
7. Reporting other group plan(s) and Medicare coverage information and changes.

Open Enrollment Period. You and your eligible Dependents may also enroll in the Plan during the Plan's "open enrollment" period that takes place each year between October 1st and December 31st. If you enter during the open enrollment period, you will not be considered late enrollees, and your coverage will begin the following January 1st.

SECTION 4
COBRA CONTINUATION COVERAGE

Federal and state laws require the Plan to offer special health benefit continuation rights to certain Covered Persons, if coverage is lost due to certain specified occurrences. This law is commonly known as COBRA. The events that will give the Covered Person the option to choose this COBRA continuation coverage are known as "qualifying events." A "qualified beneficiary" is the Covered Person who is eligible for coverage due to a qualifying event.

Qualifying Events. If you are an Employee, you will become a qualified beneficiary under the Plan if you lose coverage because any of the following events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason.

If you are the Spouse of an Employee, you become a qualified beneficiary if you lose coverage because any of the following events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends;
(4) Your spouse becomes entitled to Medicare benefits (Part A or B or both); or
(5) You become divorced or (in some cases) legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage because any of the following events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends;
(4) The parent-employee becomes entitled to Medicare Part A or B, or both;

(5) The parents become divorced or legally separated; or
(6) The child no longer meets the definition of Dependent under the Plan.

When is COBRA Coverage Available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Claims Administrator has been notified that the qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee's becoming entitled to Medicare benefits under Part A, Part B or both, the *Employer* must notify the Claims Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events. For other qualifying events (divorce or legal separation of the Employee and spouse, or a Dependent child's losing eligibility for coverage as a dependent child), *you must notify your Employer* within 60 days after the qualifying event occurs, and your Employer will notify the Claims Administrator.

How is COBRA Coverage Provided? Once the Claims Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Length of Continuation of Coverage. COBRA continuation coverage is a temporary continuation of coverage. Under federal COBRA or state continuation of coverage laws, you may be entitled to up to 36 months of COBRA coverage, unless your right to continue coverage terminates earlier for one of the reasons described below.

Early Termination of COBRA Coverage. The maximum period of COBRA coverage may be shortened, and coverage terminated early for any of the following reasons:

(1) the Employer ceases to provide any group health coverage to any Employee (including successor plans);
(2) the qualified beneficiary fails to make timely payment of his required contribution for coverage;
(3) the qualified beneficiary becomes entitled to Medicare (after the date of his COBRA election); or
(4) the qualified beneficiary becomes covered, after the date of COBRA election, under another group health plan maintained by another Employer that does not exclude or limit coverage for a qualified beneficiary's pre-existing medical condition.

Cost of COBRA Coverage. Employees and other Covered Persons who elect to continue benefits through COBRA will pay 102% of the combined Employee/Employer contribution. The initial payment must be received by the 45th day after the COBRA election.

If You Have Questions. Questions concerning COBRA continuation coverage rights under this Plan should be addressed to the Claims Administrator. For general information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

SECTION 5
CHOOSING A PROFESSIONAL PROVIDER

As a participant in the OU Plan, you will have the opportunity to choose which Professional Providers you want to provide your care. Some providers you may choose will be part of a network of providers who have agreements with the Plan to accept certain payment for services. These are called ***in-network*** providers. Those Professional Providers who do *not* have agreements with the Plan to accept certain payment for services are referred to as ***out-of-network*** providers. You or your dependents may choose either for your medical care. However, *your out-of-pocket costs will differ depending upon which provider you choose.*

Choosing an In-Network Provider. If you choose to obtain care from one of the Plan's participating (in-network) providers, the allowance that the Plan pays to the provider, along with any required patient deductibles, co-pay or co-insurance, is usually considered payment in full.

Choosing an Out-of-Network Provider. However, if you choose or for some reason are required to obtain care or services from a non-participating provider, you are responsible for any deductibles, co-payments and out-of-pocket maximums, as well as any charges that exceed the U&C allowances. Please keep in mind that the Plan offers as large a network as possible; however, it cannot guarantee that all hospitals, providers and pharmacies that you use will be "in-network"; nor can it guarantee that all geographic locations in which you may choose to live or to which you may travel will have in-network providers for you to utilize. If you are concerned about whether the provider you choose has an agreement with the Plan for payment, you should inquire before you see the provider.

SECTION 6
THE ORANGE ULSTER MANAGED BENEFITS PROGRAM

Some of the benefits provided to you through the OU Health Plan are coordinated by managed benefit coordinators that encourage the efficient and effective use of hospital, surgical, physical medicine, mental health and substance abuse services. This section is meant to inform you about the managed benefits program and alert you to the instances in which you are required to contact a managed benefits coordinator so that your plan benefits are not reduced or disallowed. Make sure to review Sections 9 and 10 for additional information on the Managed Benefits Program.

Your Responsibilities Under the Managed Benefits Program. It is important for you to remember that this Plan contains a managed benefits component that requires you to notify the appropriate managed benefits coordinator prior to hospital admission or utilization of certain services. ***If you fail to notify the managed benefits coordinator when required, your plan benefits may be reduced or even disallowed.*** Names and contact information for managed benefit coordinators are found in Appendix A of this document. If you are going to receive any of the services described below, *you must call* the appropriate coordinator for pre-approval of care. Those services that require a phone call to the appropriate managed benefits coordinator are listed below:

1. **Hospital Admissions**: If you intend to be hospitalized for an *elective* inpatient admission, you must receive approval at least five working days *prior to* admission. (Emergency, urgent, and maternity admissions do not require pre-approval; however, notification of such admission must be made within 48 hours after admission, or as soon as reasonably possible.)

If you fail to notify the managed benefits coordinator of your hospitalization, your benefits may be significantly reduced or even disallowed.

2. **Skilled Nursing Facility Admissions, Home Health Care Visits, Hospice Care Programs.** If a patient is not currently hospitalized, he (or someone on his behalf) must notify the appropriate coordinator at least five working days prior to admission to a Skilled Nursing Facility or of the beginning of home care or hospice visits.

If you fail to notify the managed benefits coordinator of your admission or the beginning of home care or hospice visits, your benefits may be significantly reduced or even disallowed.

3. **Mental/Nervous Disorders and Substance Abuse Treatment:** All inpatient admissions for treatment of mental and nervous disorders or substance abuse require pre-approval five (5) working days prior to a scheduled admission, or within two (2) working days after an emergency admission, or as soon as reasonably possible. (For outpatient treatment, authorization for additional visits must be obtained from the coordinator prior to the fourth outpatient visit.)

If you fail to notify the managed benefits coordinator of your admission or treatments, your benefits may be significantly reduced or even disallowed.

4. **Chiropractic Care, Physical and/or Occupational Therapy, Physical Medicine Services.** If you are going to receive out-of-network chiropractic care, physical therapy, occupational therapy or other physical medicine services, please notify the appropriate managed benefits coordinator to be certain the services are covered. (If services are from in-network providers, the provider will contact the coordinator.)

If you fail to notify the managed benefits coordinator of your admission or treatments, your benefits may be significantly reduced or even disallowed .

5. **Mandatory Second Surgical Opinion Program.** Prior to having certain elective surgical procedures performed, you *must* obtain a second opinion in order to receive full benefits under this Plan. To find out if the procedure you have planned requires a second opinion, call the coordinator at least 14 days prior to the scheduled procedure. Some examples of non-emergency surgeries that always require a second opinion include but are not limited to the following: gastric bypass; hysterectomy; joint replacement; laminectomy; spinal fusion.

If you fail to notify the managed benefits coordinator or if you do not obtain a required second opinion, your benefits may be significantly reduced or even disallowed.

Large Case Management Program. Sometimes a medical situation is identified that may result in unusually large claims to the health plan (for example, multiple or premature births, brain injury, chronic neurological diseases, eating disorders, etc.). If such a catastrophic disease or injury occurs, the managed benefits coordinator may work with the patient's attending physician to provide a long-term plan of care. In addition, and if approved by the appropriate managed benefits coordinator, the patient may be eligible for alternative health benefits that might otherwise not be available under the Plan.

SECTION 7
SUMMARY OF MEDICAL BENEFITS

Medical benefits offered by the OU Health Plan are categorized as either “Hospital and/or Hospital Alternative Benefits” or as “Medical Expense Benefits.” Those benefits are summarized in this section.

Hospital and Hospital-Alternative Benefits

The schedule of benefits found on this and the next page is a brief outline of the amounts the Plan will pay for Medically Necessary charges for inpatient Hospital and hospital-alternative care covered under the Plan. (For purposes of this section, hospital alternatives include birthing centers, Skilled Nursing Facilities, rehabilitation facilities, home health care and hospice care.) **To fully understand the benefits provided under this Plan, and to confirm that they qualify as Covered Expenses, please refer to Section 9.**

Both in- and out-of-network *benefits* for inpatient Hospital and hospital-alternative services *are the same*. However, your *cost* for these services depends upon whether you choose an in-or an out-of-network provider.

If you choose an **in-network provider** for Hospital or hospital-alternative benefits, the benefits are paid at 100% of Covered Charges, unless otherwise specified. To determine whether the Facility you have chosen to be admitted to is an *in-network* provider, please refer to network directories found at www.ousdhp.com

If you choose an **out-of-network** provider, you will be responsible for the following charges:

(1) A $500.00 per admission deductible, and
(2) Any charges that we determine to be in excess of Usual and Customary Charges.

(Note: The out-of-network deductible may be waived, after review, if the admission was the result of an Emergency as defined in this Plan, or if there is no in-network provider within a 50-mile radius of the place in which a Confinement occurs.)

Important: if you will be receiving ANY of the services described in this section, you must notify the appropriate managed benefits coordinator in advance (see Appendix A). Otherwise, you may be responsible to pay up to $500.00 of Covered Expenses, in addition to any other deductible or other payment requirements.

HOSPITAL AND HOSPITAL-ALTERNATIVE BENEFITS	
Type of Service:	**This Plan Pays (In-Network)**:
INPATIENT CARE IN A HOSPITAL Covers room and board (semi-private room) and Medically Necessary services and supplies. **Call the managed benefits coordinator prior to elective Hospital admissions or, for an emergency, notify the coordinator as soon as reasonably possible or 48 hours after the emergency admission, whichever is longer.**	The Covered Charges for 365 days of inpatient care per Confinement. Another 365 days becomes available after you have been out of the Facility for 90 consecutive days. ***Inpatient care in a Hospital for a mental or nervous condition is limited to 100 days of coverage per calendar year, unless the admission is for treatment of a “biologically based mental illness” as defined in this Plan, or the patient is a “child[ren] with serious emotional disturbances” as defined in this plan, in which case the benefit will be the same as for any Hospital admission for a medical problem.*** See Sec. 9 for additional details.

BIRTHING CENTER **Call the managed benefits coordinator prior to admission.**	The Covered Charges.
INPATIENT CARE IN A SKILLED NURSING FACILITY Covers room and board (semi-private room) and Medically Necessary services and supplies. **Call the managed benefits coordinator prior to admission to a Skilled Nursing Facility.**	The Covered Charges for up to 180 days of Confinement per calendar year. See Sec. 9 for additional information and limitations.
INPATIENT CARE IN A REHABILITATION FACILITY **Call the managed benefits coordinator prior to admission to a rehabilitation facility.**	The Covered Charges for up to 100 days of Confinement per calendar year. See Sec. 9 for additional information.
HOME HEALTH CARE **Call the managed benefits coordinator prior to beginning home health care services.**	The Covered Charges for up to 180 visits per calendar year. See Sec. 9 for requirements for coverage.
HOSPICE **Call the managed benefits coordinator prior to beginning hospice services.**	The Hospice's Covered Charges. See Sec. 9 for additional information and requirements for coverage.

Hospital Outpatient Benefits. In addition to the benefits described in the preceding schedule, the following Hospital outpatient services are also covered under the Plan. If services are received **in-network**, you may be responsible to pay up to a **$50 per day deductible**, depending on the service. However, if these same services are provided ***out*-of-network**, your deductible will be **$70 per day**. The out-patient deductible may be reduced if you are forced to utilize an out-of-network provider due to an Emergency (as defined in this Plan), or if there is no in-network Hospital within a 50-mile radius of the Hospital in which you are treated.

HOSPITAL OUTPATIENT BENEFITS	
Type of Service:	**The Plan Pays:**
EMERGENCY MEDICAL TREATMENT	The Covered Charges, following a $50 in-network or $70 out-of-network deductible, per day. (Deductible may be waived if the patient is admitted directly to the Hospital.) See Sec. 9 for more information.
DIAGNOSTIC X-RAYS AND LABORATORY TESTING, INCLUDING CERVICAL CYTOLOGY SCREENING	The Covered Charges, following a $35 in-network or $70 out-of-network deductible, per day. See Sec. 9 for more information.
PRE-ADMISSION TESTING	The Covered Charges. See Sec. 9 for more information
PHYSICAL THERAPY	The Covered Charges, following a $35 in-network or $70 out-of-network deductible, per day. See Sec. 9 for more information.
HEMODIALYSIS **CHEMOTHERAPY** **RADIATION THERAPY**	The Covered Charges.
ROUTINE (SCREENING) MAMMOGRAMS	The Covered Charges.

Medical Expense Benefits

If you have a medical expense that is not covered as a Hospital or hospital-alternative benefit, it may be covered as a Medical Expense Benefit. Examples of medical expense benefits would be office visits to your Professional Provider for care and treatment. See Section 9 for a detailed description of your medical expense benefits under the Plan.

In-Network Medical Expense Benefits. Like Hospital Expense Benefits, your choice of an in- or out-of-network Professional Provider determines your cost for medical services or supplies. If you choose to go to an in-network Professional Provider for primary or specialized care, your co-pay will be $15 per visit/service. To determine whether the Professional Provider you have chosen is an in-network provider, please refer to the network directories found at www.ousdhp.com.

Out-of-Network Medical Expense Benefits. If you use an *out*-of-network (OON) provider, rather than in-network provider, you will be responsible for the $15.00 co-pay for visits to the provider, ***as well as***

annual deductibles and co-insurance payments explained below (up to a yearly out-of-pocket maximum payment.) OON co-pays do not accumulate toward the out-of-pocket maximum.

Out-of-Network Deductibles, Co-insurance and Out-of-Pocket Maximums. If you receive care from an out-of-network provider, you are responsible for a deductible payment each calendar year before the Plan will pay any benefits at all on your behalf. The calendar year deductible is $300.00 per person if you have individual coverage or $800.00 per year if you have family coverage. Any expenses incurred in the last three months of a calendar year will be carried over into the next year, and applied toward your deductible obligation for the following year.

After you have satisfied the yearly deductible, you and the Plan share the cost of Covered Services, up to a specified out-of-pocket maximum. Your co-insurance obligation is payment of 20% of the first $5,000.00 of Covered Expenses (or $1,000.00 maximum) in a calendar year if you have individual coverage. If you have family coverage, you will pay 20% of the first $9,000.00 of Covered Expenses up to a maximum payment of $1,800.00 in a calendar year. Once you reach the maximum out-of-pocket payment, the Plan will pay 100% of any additional Covered Charges for that calendar year.

Remember, deductibles and co-insurance obligations are in addition to the $15 co-pay per visit or service for out-of-network providers. Also, charges incurred for outpatient mental health services and treatment, deductibles & penalties resulting from failure to comply with the Managed Benefits Program requirements, as well as out-of-network co-pays are separate and not included in the co-insurance maximum.

The maximum the Plan will pay for your medical expense benefits in a calendar year is $500,000.00 per person, except for mental health and/or substance abuse treatment and/or Qualified Infertility Procedures, which have separate maximum benefits (See Section 9). However, your lifetime benefits are unlimited.

In-Network Providers to whom Out-of-Network Charges Apply. A few benefits provided under this Plan do require that you pay deductibles, etc., even though the Professional Provider may actually be part of a network of providers listed in Appendix A. The table below shows those benefits that are subject to out-of-network deductibles, co-insurance and out-of-pocket maximums, even though the provider is part of a network.

In-Network Providers to Whom Out-of-Network Charges Apply.	• Home Infusion or Intravenous Services • Durable Medical Equipment and Supplies • Non-hospital Occupational Therapy • Speech Therapy • All providers eligible under the Plan not specifically identified above as in-network providers of service.	You are responsible for all out-of-network deductibles, as well as co-insurance, co-pay per visit or service, and other limits, even though these providers may be in-network.

SECTION 8
PRESCRIPTION DRUG BENEFITS

What is Covered? The OU Plan covers drugs, biologicals and compounded prescriptions that can be dispensed only pursuant to a prescription and that are required by law to bear the legend: "Caution – Federal Law prohibits dispensing without a prescription." The drug or medication must be prescribed by a Professional Provider, and approved by the FDA for the treatment or for specific diagnosis or condition. The drug must also be Medically Necessary treatment of the condition for which the drug is prescribed, and not Experimental and Investigational as defined in this Plan, unless otherwise required pursuant to an external appeal. Insulin and oral agents for controlling blood sugar are provided through the prescription drug program, as are other diabetic supplies. (Please see Section 9 for additional details on diabetic supplies furnished through the prescription drug program.)

Prescription Drugs include contraceptive drugs and devices as well as Medically Necessary enteral formulas for which a provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death. The Plan also pays for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to a written order. However, our coverage for modified solid food products is limited to $2,500 in a calendar year.

Generic equivalents of prescribed drugs will be provided unless specifically prohibited by the prescribing physician. If you choose to obtain a brand name drug when a generic equivalent is available, you will be responsible to pay the excess charges.

What is Not Covered? In addition to any exclusions found elsewhere in this Plan, benefits are not provided for the following:

- Drugs not requiring a written prescription (except insulin);
- Drugs that have over-the-counter equivalents (i.e., the same drug), except as otherwise provided;
- Artificial appliances, therapeutic devices, hypodermic needles and similar devices (except for insulin injection, bone density devices and contraceptive devices);
- Administration of injection drugs;
- Appetite suppressants, unless they are determined to be Medically Necessary to diagnose or treat a Covered Person's medical condition (in no case will over-the-counter appetite suppressants be a covered benefit);
- Vitamins or any herbal products (other than those *requiring* a prescription);
- Drugs that are prescribed or dispensed for cosmetic purposes and that are not required to diagnose or treat a Covered Person's documented medical condition. A drug that may be used both for cosmetic purposes, and for medical purposes, such as Botox, will not be excluded if used for a medical purpose; however, it will not be covered if used solely to, for example, improve one's appearance. Contact the case management consultant if you have any questions concerning the coverage of drugs used for cosmetic purposes. Examples of drugs that we often determine not to be Medically Necessary include those prescribed or dispensed for hair growth stimulants or removing wrinkles;
- Immunization agents, biological sera, blood or blood plasma;
- Drugs or devices used to improve sexual performance or stimulation, unless they are determined to be Medically Necessary to diagnose or treat a Covered Person's medical condition.
- Drugs dispensed to patients in Facilities, unless the institution does not include services for drugs;
- Drugs for which payment is made under Federal or State law, such as Workers' Compensation or no-fault insurance;
- Drugs that are determined to be Experimental or Investigational (unless otherwise required to be covered pursuant to external review).

How the Program Works. If you purchase drugs at a participating (in-network) pharmacy or through the mail order pharmacy, your co-payments depend upon the category of the drug purchased. Generic drugs cost the least, while preferred drugs and non-preferred drugs are more expensive. For a list of preferred drugs (PDL), see the pharmacy benefit manager's web site listed in Appendix A.

Using the Mail Order Pharmacy. If you choose, you may order a 90-day supply of long term or maintenance drugs through the mail order pharmacy. Three refills of mail order drugs may be obtained under each prescription order. Your co-pays will be less for mail order drugs than for drugs you refill monthly at the drug store. Once you have had a prescription filled for three months, you are eligible to order additional refills through the mail order pharmacy. Drugs purchased in this manner will be sent directly to your home, postage paid. Forms for the mail order pharmacy are available from your Employer's health plan administrator.

The table below shows your co-pay for drugs, depending on the type of drug (generic, preferred or non-preferred) and whether you obtain the drug at a retail drug store or through the mail order pharmacy.

Where Drug Purchased	***Your Co-Payment Amount***	
Purchased at Participating Pharmacy	For Generic Drugs	$5 co-payment per prescription (34 day maximum supply)
	For Preferred Drugs (PDL)	$20 co-payment per prescription (34 day maximum supply)
	For Non-PDL Brands (As designated by the Plan's PBM-PDL Formulary)	$40 co-payment per prescription (34 day maximum supply)
Purchased through Mail Order Pharmacy Program	For Generic Drugs	$7.50 co-payment per prescription (90 day maximum supply)
	For Preferred Drugs (PDL)	$30 co-payment per prescription (90 day maximum supply)
	For Non-PDL Brands (As designated by the Plan's PBM-PDL Formulary)	$60 co-payment per prescription (90 day maximum supply)

Using Non-Participating Pharmacies. If you fill your prescription at a non-participating (out-of-network) pharmacy, you will have to pay the retail price of the drug and then file a claim for reimbursement with the pharmacy benefit manager (PBM). You will be reimbursed the in-network pharmacy discount rate, minus the applicable in-network co-payment, and your cost will probably be higher than it would be if you went to a participating pharmacy. You may obtain claim forms from your Employer or Claims Administrator.

Drugs that Require Prior Authorization. Certain drugs that may be prescribed by your doctor require that the pharmacist contact the pharmacy benefit manager for verification of coverage. These drugs include those used to treat migraines, obesity, ADD, narcolepsy and arthritis. The pharmacist will let your physician know if there are any authorization or limitation requirements on the prescribed drugs.

SECTION 9
HOSPITAL AND MEDICAL EXPENSE BENEFITS

The Plan will pay the benefits described in this section on behalf of Covered Persons, provided the benefits are Medically Necessary and not excluded elsewhere in this document. They may be subject to co-payments, deductibles, and/or co-insurance depending on whether the care is provided by an in- or out-of-network provider (See Section 7).

Inpatient Care in a Hospital. The Plan provides coverage for 365 days of care for each Confinement in a Hospital for treatment of medical conditions other than mental health or nervous disorders.

(If your Hospital admission is for treatment of a mental or nervous disorder, the Plan provides coverage for 100 days of care in a Hospital each calendar year. If you are admitted to a mental health Facility *instead of a Hospital*, please refer to the mental health managed benefit described later in this section.)

A single Hospital confinement means one or more inpatient admissions to a Hospital. When you are admitted to a Hospital after at least 90 days during which you have not been confined in any Hospital, Skilled Nursing Facility or similar Facility, the admission will begin a new period of Confinement. During your hospitalization, the Plan pays Covered Charges for a semi-private Hospital room and for Medically Necessary services and supplies. The services must be provided by an employee of the Hospital. The Hospital must bill for the services and it must retain the money collected for the service.

Some examples of non-covered services include the following:

- Private duty nurses;
- Private room, unless Medically Necessary (if not Medically Necessary, you will have to pay the difference between the cost of the private room and the semi-private room);
- Non-medical items, such as television and telephone;
- Medications, supplies, and equipment you take home from the hospital; and
- Custodial care.

Remember to contact the managed benefits coordinator
prior to planned Hospital admissions
or immediately following Emergency admissions.

Inpatient Care in a Skilled Nursing Facility (SNF). The Plan pays for inpatient care in a Skilled Nursing Facility in a semi-private room. It also pays for nursing care, drugs, physical, speech and occupational therapy provided by the SNF, and any service that would be covered if the patient was an inpatient in a Hospital.

To be considered a Covered Expense, the Confinement in an SNF must be recommended by a physician who certifies that 24-hour skilled nursing care is Medically Necessary as an alternative to hospitalization. Coverage will be provided for a maximum of 180 days in a calendar year. In order to determine whether the care is Medically Necessary, the guidelines used by the Federal Government's Medicare program will be applied. The Managed Benefits Program Coordinator, in conference with the patient's Physician, will verify medical necessity and establish when SNF care is appropriate and eligible for benefits. In addition, to qualify for benefits, you must have been confined to a Hospital for at least three days, and enter the SNF within 14 days following your discharge from a Hospital. No benefits will be paid for care that is determined to be Custodial Care.

Remember to contact the managed benefits coordinator
prior to your admission to a Skilled Nursing Facility.

Inpatient Care in a Rehabilitation Facility. The Plan pays for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) for up to 100 days per calendar year for a condition that in the judgment of the managed benefits coordinator can reasonably be expected to result in improvement within a relatively short period of time.

Remember to contact the managed benefits coordinator
prior to your admission to a rehabilitation Facility.

Home Health Care. The Plan will provide coverage for up to 180 home health care visits per calendar year if it is provided by a certified Home Health Care Agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. If you receive home health care outside of New

York State, a Home Health Care Agency must have Medicare approval as well as an appropriate operating certificate to provide home care issued by the appropriate state agency.

Coverage for home care requires that (a) a home care treatment plan is established and approved in writing by a Professional Provider; (b) the care is provided by a certified or licensed agency; (c) you apply through your Professional Provider to the agency with supporting evidence of your need and eligibility for home care, and (d) the home care is related to the illness or injury for which you have been hospitalized or confined in a Skilled Nursing Facility. This home care must be Medically Necessary at a skilled or acute level of care. Each visit by a member of a home health care team is considered a separate home health care visit, and four hours of home health aide services are considered as one home health care visit.

Home health care consists of one or more of the following:

- part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- part-time or intermittent home health aide services that consist of primarily rendering direct care to you;
- physical, occupational or speech therapy if provided by the agency;
- medical supplies, drugs and medication prescribed by a physician and laboratory services by or on behalf of the agency to the extent such items would have been covered if the person had been confined in a Hospital or Skilled Nursing Facility.

Remember to contact the managed benefits coordinator prior to beginning Home Health Care services.

Hospice Care. The Plan pays for Hospice care during a terminal illness if a person has been certified by their primary care physician as having a life expectancy of six months or less, and if care is provided by a hospice organization that has an operating certificate issued by the New York State Department of Health. If provided in another State, the agency must be approved for hospice services in that State or by Medicare.

The Plan pays Covered Charges for medical care provided by a physician, and bed patient care provided by the hospice organization either in a designated hospice unit or in a regular hospital bed for as long as the care is necessary, as well as day care services provided by the hospice organization, and five days of bereavement counseling services. Home care and outpatient services must be billed through the hospice organization.

Services and care may include intermittent nursing care by nurses or home health aides; physical, speech, occupational and respiratory therapy; social services; nutritional services; laboratory and diagnostic testing; chemotherapy and radiation therapy (for control of symptoms); medical supplies and non-experimental drugs.

Remember to contact the managed benefits coordinator prior to beginning Hospice Care services.

Outpatient Care in a Hospital. Charges for the following outpatient Hospital services are covered in full following the per day deductible explained in Section 7, as long as the patient is physically present; they are for the diagnosis and/or treatment of an illness or injury; they are ordered by a Physician; and they are billed by the Hospital.

(1) **Emergency Medical Treatment**. The Plan pays for outpatient (or emergency room) Hospital charges (excluding physician charges) related to the treatment of an Emergency condition. (See Definition of Emergency Medical Treatment in Section 2.)

(2) **Surgery, Chemotherapy and Radiation Therapy**. The Plan pays for outpatient hospital charges (excluding Physician charges) related to the performance of a surgical operation, chemotherapy or radiation therapy.

(3) **Pre-admission Testing.** The Plan pays in full for pre-admission testing in the outpatient department of a Hospital when:

a. The testing is ordered by a physician as a planned preliminary to the patient's admission as a registered bed patient for surgery in the same hospital;
b. The testing is necessary for, and consistent with, the diagnosis and treatment of the condition for which the surgery is to be performed.
c. The reservations for a hospital bed and an operating room have been made before the tests are performed;
d. The patient is physically present at the hospital for the tests; and
e. The surgery is performed within 7 days of the tests.

(4) **Diagnostic X-rays and Laboratory Charges**. The Plan pays for outpatient Hospital charges (excluding physician charges) for diagnostic X-ray examination and laboratory tests, including such examinations and tests performed as part of pre-admission testing for a proposed covered hospitalization.

(5) **Physical Therapy**. The Plan pays for physical therapy treatment performed in the outpatient department of a Hospital and billed by the Hospital, provided that the therapy is in connection with a condition which necessitated hospitalization or surgery; treatment begins within six months from the date of the hospital discharge or surgery; and treatment is received within one year of the hospital discharge or surgery.

(6) **Hemodialysis Treatment**. The Plan pays for hemodialysis treatment performed in the outpatient department of a Hospital and billed by the Hospital.

Ambulance Service and Pre-Hospital Emergency Services. The Plan provides coverage for pre-hospital emergency services (as defined in Sec. 2) and ambulance services so long as such services are provided by an ambulance service certified under the New York State Public Health Law. We will also provide coverage for land ambulance transportation to a Hospital by such an ambulance service in cases where a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect the absence of such transportation to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious dysfunction of any bodily organ or part of such person, or (d) serious disfigurement of such person.

In addition to the services described above, we will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:

A. Ground or air ambulance service for an urgent condition. When you have an urgent condition the need for care is less than the need for care in an emergency condition, but the condition requires immediate attention. An urgent condition is one that may become an emergency condition in the absence of treatment.
B. Air ambulance service for an emergency condition, and
C. Transportation between facilities.

Air ambulance transportation requires approval from the case management consultant before you receive the transportation, or the payment may be denied retrospectively because it is not considered Medically Necessary.

The first $50.00 in Covered Expenses will be paid in full by the Plan. The balance of the payment will be subject to deductible and co-insurance requirements. Payment to an ambulance organization for which

the Covered Person has no financial obligation (such as a volunteer ambulance) is limited to $50 per calendar year for each Covered Person.

Second Medical Opinions for Cancer. The Plan pays for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, when there is a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation for a course of treatment of cancer. If you are referred to an out-of-network physician for a second opinion, you will not be subject to deductibles or co-insurance.

Routine Screening and Examinations.

- **Breast Cancer (Mammography).** The Plan pays for annual mammography screening for Covered Persons age 40 and older, as well as a single baseline mammogram those persons age 35 to 39 years old. Also covered are screening mammograms at any age for those at risk who have a prior history of breast cancer or a first degree relative with a prior history of breast cancer. The screening may be provided in the outpatient department of a Facility or in a Professional Provider's office and no deductible or co-insurance will be applied.

- **Cervical Cancer (Pap Smears).** The Plan pays for one annual screening for cervical cancer and its precursor states for women who are covered under the Plan. Cervical cytology screening includes pelvic examination, collection and preparation of a pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the pap smear. Benefits for pap smears will be paid whether the screening is done in- or out-of network.

- **Routine Gynecological Examinations.** The Plan pays for up to two primary or preventive obstetrical or gynecological examinations per year for women who are covered by the Plan. The patient will not be subject to deductible or co-insurance for these examinations, even if they are performed by an out-of-network provider. (Office co-payments, however, will apply.)

- **Osteoporosis (Bone Mineral Density Measurement and Testing).** The Plan pays for bone mineral density testing, as well as drugs and devices to treat the osteoporosis. To qualify for this benefit, the person must meet either the eligibility criteria under the Medicare program or those set by the National Institute for Health (NIH) for the detection of osteoporosis. The law provides that individuals qualifying for coverage shall, at a minimum, include individuals having any of the following conditions:

  A previous diagnosis of or a family history of osteoporosis; or
  Symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
  A prescribed drug regimen posing a significant risk of osteoporosis; or
  Lifestyle factors posing a significant risk of osteoporosis; or
  Age, gender, and/or physiological characteristics which pose a significant risk of osteoporosis.

- **Prostate Cancer (PSA Testing).** The Plan pays in-network benefits for annual screening for prostate cancer for. A standard diagnostic exam (screening) includes, but is not limited to, a digital rectal exam and prostate-specific antigen (PSA) test. Prostate cancer screening asymptomatic men age 50 and older as part of the Adult Wellness Benefit. Benefits for an annual screening are also provided to men age 40 and over who have a family history of prostate cancer, or at any age for men with a previous history of prostate cancer or other prostate cancer risk factors performed as part of routine physical exams is paid in-network only. There is no benefit payable to an out-of-network provider.

- **Colon Cancer (Colonoscopy).** The Plan pays (**in-network only**) for one routine colon cancer screening (colonoscopy) per Covered Person age 50 or older every five years, or when the only reason given for the procedure is "family history." For purposes of this section, "family" is defined as mother, father, child, brother, sister, aunt, uncle, or grandparent. Colonoscopies are only paid

by the Plan when you go to an in-network provider. There is no benefit payable to an out-of-network provider.

Adult Wellness Benefits. In addition to the benefits described above, the Plan pays for adult well care exams and immunizations consistent with the clinical standards of the American Academy of Family Physicians (including shingles vaccine where appropriate). Routine annual physical exams are paid as an ***in-network benefit only*** for Employees, Retirees, and their spouses age 19 and older, subject to $15 patient co-pay. The exam may include urinalysis, hematocrit and hemoglobin, lipid panel, occult blood, PSA testing, and electrocardiograpy. If you are over 40 and have a prior or family history of colon cancer, your physician may order sigmoidoscopy and it will be paid as an in-network adult wellness benefit (up to one exam each calendar year.

Well Child Care. The Plan pays for well child visits and childhood immunizations in accordance with the prevailing standards of the Advisory Committee on Immunization Practices (ACIP), and as required by the New York State Insurance Department. No deductible or co-insurance obligations will be required if you go to an out-of-network provider. However, you may be responsible to pay any amount over the Usual and Customary charges of the provider.

Services covered as part of a well child visit include taking complete medical histories; performing a complete physical exam; performing developmental assessments; providing anticipatory guidance; performing laboratory tests; giving appropriate immunizations; and/or providing other services ordered at the time of the well child visit. The Plan pays for periodic visits to a pediatrician for children up to age 19, in accordance with the visitation schedule established by the American Academy of Pediatrics as adopted by the New York State Insurance Department. From birth to age 2, the Plan pays for eight office visits to a provider. From ages 2 through 5, the Plan pays for annual examinations, and from ages 6 through 18, the Plan pays for a routine examination once every two years.

Maternity Care. The Plan pays for inpatient Hospital or hospital-alternative care for the mother and infant for at least 48 hours following a normal delivery and at least 96 hours following a caesarian delivery, regardless of whether such care is Medically Necessary. In the event the mother elects to leave the Facility before the end of the minimum stay, the Plan will pay for one home care visit at the mother's request. This visit does not count toward the home care limit explained elsewhere in this document, and will not be subject to a deductible or co-payment.

Care provided to a maternity patient in a Facility includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. The Plan also provides coverage for complications of pregnancy and for anesthesia during delivery.

"Complications of pregnancy" are conditions that require Hospital admission (not including terminations of pregnancy). The diagnosis must be one that is distinct from pregnancy but which is adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. Non-elective caesarian section, termination due to ectopic pregnancy, or early spontaneous termination of pregnancy are also considered "complications of pregnancy." The following conditions would *not* be considered "complications of pregnancy": false labor; occasional spotting; physician-prescribed rest during pregnancy; morning sickness; pernicious vomiting of pregnancy; toxemia; and similar conditions associated with the management of a difficult pregnancy.

The Plan pays Professional Provider charges for maternity care beginning with the first visit in which pregnancy is determined. It includes all prenatal and postpartum care, including services of a licensed midwife, practicing in a collaborative relationship with (a) a licensed physician who is board-certified as an obstetrician-gynecologist by a national certifying body, or (b) a licensed physician who practices obstetrics and has obstetrical privileges at a general hospital licensed

> under Article 28 of the Public Health Law, or (c) a hospital licensed under Article 28 of the Public Health Law that provides obstetrics through a licensed physician having obstetrical privileges at such institution, that provide for consultation, collaborative management and referral to address the health status and risks of his or her patients and that include plans for emergency medical gynecological and/or obstetrical coverage.

Sleep Disorder Testing. The Plan pays Covered Charges for diagnostic testing for sleep disorders provided that the Facility where such care is provided is accredited by the Association of Sleep Disorder Centers (or is in a contractual preceptor relationship with an accredited Facility) and is under the direction and control of a Professional Provider. The Covered Person must be referred by the attending Physician. The need for diagnostic sleep testing must be confirmed by medical evidence, and the Covered Person must have symptoms of either narcolepsy or severe upper airway apnea.

Physician Services for Medical and Surgical Care. The Plan pays for services of a physician for non-cosmetic surgical care and medical care and treatment in a Facility, a home, or a physician's office providing that the physician who performs the service bills for the service and the services are performed in connection with a Covered Person's illness or injury.

When more than one surgical procedure is performed during an operation, the Covered Charge for the secondary procedure will be paid at not more than 50% of the charge normally paid for the procedure. The Covered Charge for an assistant surgeon is limited to 20% of the primary surgeon's Covered Charge and 20% of the surgeon's Covered Charge for a physician assistant during surgery. There is no coverage for incidental procedures.

Podiatry. The Plan pays Covered Charges for services of a Professional Provider for treatment of illness, injury and malformation of the foot.

> It does not cover Routine Care of the feet, as defined in Section 2, nor does it cover the following: examination, diagnosis and treatment of flat feet or any instability or imbalance of the foot, or of any metatarsalgia or bunion (unless an open cutting operation is used); nor does it cover examination, diagnosis and treatment of corns, calluses or toenails, including their cutting or removal, unless the treatment is prescribed by a physician for a metabolic disease, such as diabetes mellitus or a peripheral vascular disease, such as arteriosclerosis, or is necessary surgical intervention for removal of a diseased toenail or treatment of an ingrown toenail requiring an open cutting operation.

Durable Medical Equipment. The Plan pays Covered Charges for rental, repair or maintenance of durable medical equipment, subject to payment of deductible and co-payment, when such equipment is determined to be Medically Necessary. The Plan may also purchase the equipment, if it determines purchase to be more practical or less expensive than rental. The equipment must be the kind that is generally used for a medical purpose, as opposed to a comfort or convenience purpose. Examples of durable medical equipment include crutches, standard wheelchairs, hospital beds, and home dialysis units. If the equipment is purchased and later sold, the proceeds must be paid to the Plan. The Plan will pay for replacement cost of equipment provided (1) the equipment remains Medically Necessary, with or without a change in the Covered Person's condition; and (2) the equipment has fulfilled its anticipated life span as defined by the manufacturer and was subject only to normal wear and tear. Repairs to DME are covered if the DME remains Medically Necessary and as long as the warranty has expired.

> The Plan *will not* pay for deluxe equipment (e.g., motor-driven wheelchairs or beds) if standard equipment is available *and* medically adequate; items such as air cleaners, air conditioners, dehumidifiers, heating pads and hot water bottles; installation charges or delivery and setup charges; materials purchased to construct equipment; or equipment which is available in a Facility where the patient is confined.

Prosthetics. The Plan pays Covered Charges for prosthetic devices and/or orthopedic appliances used to replace functioning natural parts of the body, and that are determined to be Medically Necessary to

relieve or correct a condition caused by an injury or illness. Repairs to and of these devices may also be covered.

A prosthetic device is an artificial organ or body part, including but not limited to artificial limbs and eyes used to replace functioning natural body parts. Prosthetic devices do not include, for example: eyeglasses, contacts, supportive devices for the feet, hearing aides, medical supplies, certain special articles of clothing or cosmetic devices, dental prosthesis, dentures or other devices used in connection with the teeth. However, the Plan will pay for necessary dental prostheses resulting from an accidental injury to sound natural teeth within 12 months of the accident, for a first pair of corrective lenses after cataract surgery, contacts for treatment of kerataconus and one appliance for mandibular repositioning due to TMJ. Delivery charges, service charges or extended warranties and sales tax are not covered.

Private Duty Nursing Services. The Plan pays Covered Charges for private duty registered nurses, other than a nurse who ordinarily resides in the Covered Person's home, or who is a member of the Covered Person's immediate family. Expenses incurred for a private licensed practical nurse will be paid on the same basis as for registered nurses if the attending physician certifies that the nursing care is necessary and a registered nurse is not available. Expenses will not be paid, however, for the first 48 hours of such service provided to the Covered Person in any calendar year. Expenses will also not be paid when the patient is confined to a Facility.

The nursing care must be provided by an R.N., an L.P.N. or L.V.N., all of whom must be state-licensed and registered. The services must be prescribed by a physician and consistent with the condition being treated. The Plan will not pay for private duty nursing rendered by a home health agency, unless the agency is licensed to provide that type of care in the state where it is operating.

Cardiac Rehabilitation. The Plan pays Covered Charges for cardiac rehabilitation programs when Medically Necessary and prescribed and performed by a Professional Provider. To be eligible for cardiac rehabilitation program, a Covered Person must have had either a documented diagnosis of acute myocardial infarction within the preceding 12 months, coronary bypass surgery, or a diagnosis of stable angina pectoris.

Diabetes Management, Supplies, and Treatment. The Plan pays Covered Charges for the following equipment and supplies for the treatment of diabetes either as a medical expense or *under the Prescription Drug Plan*, when they are Medically Necessary and are prescribed by a Professional Provider who is legally authorized to prescribe under Title 8 of the New York Education Law:

Lancelets and automatic lancing devices;
Glucose test strips;
Blood glucose monitors;
Blood glucose monitors for the visually impaired;
Control solutions used in blood glucose monitors;
Diabetes data management systems for management of blood glucose
Urine testing products for glucose and ketones;
Oral anti-diabetic agents used to reduce blood sugar levels;
Alcohol swabs;
Syringes;
Injection aids including drawing up devices or the visually impaired;
Cartridges for the visually impaired;
Disposal insulin cartridges and pen cartridges;
All insulin preparations;
Oral agents for treating hypoglycemia such as glucose tablets and gels
Glucagon for injection to increase blood glucose concentration; and
Insulin pumps and equipment for the use of the pump, including batteries; Insulin infusion devices; additional Medically Necessary equipment and supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of

diabetes, and which are available through retail pharmacies, are covered under the Medical Benefits provision, and cannot be purchased through the retail pharmacy.

The Plan will also pay (as a medical expense benefit) for diabetes self-management programs provided by a Professional Provider or his staff in connection with Medically Necessary visits when you have been diagnosed with diabetes, when there has been a significant change in your symptoms, when you experience the onset of a condition requiring changes in self-management, or when re-education is Medically Necessary. Education may be provided by a certified diabetes nurse educator, nutritionist, dietician or other provider as required by law. Education must be provided in a group setting, wherever possible, unless home visits are determined to be Medically Necessary.

Also available as medical expense benefits are repair, replacement or adjustment of covered diabetic equipment and supplies when necessitated by normal wear and tear. Repair and replacement of diabetic equipment and supplies necessitated because of loss, or damage caused by misuse or mistreatment are not covered.

Infertility Treatment. Infertility is defined as the inability to achieve a pregnancy according to guidelines and standards adopted by American Society for Reproductive Medicine (ASRM). ASRM defines infertility as the inability to achieve pregnancy after 12 or more months of unprotected intercourse, although earlier evaluation and treatment may be justified based on medical history and physical findings, and is warranted after six months for women age 35 and over.

By using in-network providers, you minimize your out-of-pocket costs. If you go to a Center of Excellence, you have no out-of-pocket costs. All infertility treatment must be pre-authorized by the Plan's Managed Benefits Program Coordinator.

Covered Services and Supplies: Include, but are not limited to: patient education program orientation; diagnostic testing; ovulation induction/hormonal therapy; artificial/intra-uterine insemination; and surgery to enhance reproduction capability. The Plan's Managed Benefits Program Coordinator (MBP) will not exclude coverage for Medically Necessary care for the diagnosis and treatment of correctable medical conditions otherwise covered by the Plan solely because the medical condition results in infertility.

Qualified Procedures: Certain procedures, called Qualified Procedures, are covered under the Plan only if you call the Plan's Managed Benefits Program Coordinator in advance and receive prior authorization. Qualified Procedures are specialized procedures that facilitate a pregnancy but do not treat the cause of the infertility. If the Plan's Managed Benefits Program Coordinator authorizes benefits, the following Qualified Procedures are covered:

A. Assisted Reproductive Technology (ART) Procedures including:

- In vitro fertilization and embryo placement
- Gamete Intra-Fallopian Transfer (GIFT)
- Zygote Intra-Fallopian Transfer (ZIFT)
- Intracytoplasmic Sperm Injection (ICIS) for the treatment of male factor infertility
- Assisted hatching
- Microsurgical sperm aspiration and extraction procedures, including:
  - Microsurgical Epididymal Sperm Aspiration (MESA), and
  - Testicular Sperm Extraction (TESE)

B. Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs. This includes expenses associated with cyropreservation (that is freezing and storage of sperm, eggs or embryos).

Maximum Lifetime Benefit: Benefits paid for Qualified Procedures under the Plan are subject to a lifetime maximum of $25,000.00 per Covered Person. This maximum applies to all covered prescription drugs, hospital, medical and other Covered Expenses that are associated with Qualified Procedures.

Infertility Centers of Excellence**:** Infertility Centers of Excellence are a select group of participating providers recognized by the Plan as leaders in reproductive medical technology and infertility procedures and contracted by the Plan's PPO Network. These Centers are available to provide the listed Covered Expense for Services and Supplies as well as Qualified Procedures. If the Managed Benefits Program Coordinator pre-authorizes infertility treatment at Infertility Centers of Excellence, benefits are payable in full. (Qualified Procedures are subject to the maximum $25,000.00 lifetime benefit.) No co-payments will be applied for services provided at the Centers of Excellence. Co-payments may apply for certain services required by the Center of Excellence and received outside the Center, such as laboratory or pathology tests.

Infertility Exclusions and Limitations**:** Charges for the following are not Covered Expenses:

- Experimental infertility procedures.
- Fertility drugs dispensed in conjunction with Assisted Reproductive Technology (ART) by the Fertility Center or physician are not covered under this benefit. Benefits for infertility-related drugs are payable on the same basis as for any other prescription drugs payable under the Plan's prescription drug benefit as administered by the Pharmacy Benefits Program Manager.
- Medical expenses or other charges related to genetic selection.
- Medical expenses or any other charges in connection with surrogacy (of a person not covered under the Plan).
- Any donor compensation or fees charged in facilitating pregnancy.
- Any charges for services provided to a donor facilitating pregnancy.
- Assisted Reproductive Technology services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant.
- Psychological evaluations and counseling.
- Other exclusions and limitations that apply to this benefit are included under Limitations and Exclusions section of the Plan.
- Any charges for services not pre-authorized as Covered Qualified Procedure Services by the Plan's Managed Benefits Program Coordinator.

Voluntary Sterilization. The Plan pays Covered Charges for voluntary sterilization, including Professional Provider and Hospital charges. It does not pay for reversal of voluntary sterilization.

Organ or Tissue Transplants. The Plan pays Covered Charges incurred with any organ or tissue transplant listed in this provision, **subject to referral and pre-authorization by the Plan's Managed Care and Utilization Review Coordinator.** Transplant coverage is offered under this Plan through a preferred provider network of specialized Professional Providers and Facilities. (Coverage is also provided for transplant services obtained out-of-network at a reduced benefit level.)

As soon as possible, but no longer than ten (10) days after a Covered Person's attending physician has indicated that the person is a potential candidate for a transplant, the Covered Person or his physician should contact the Plan's Managed Care and Utilization Review Coordinator for referral to the network's medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be developed for the Plan's review and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (name and address of the hospital), any secondary medical complications, a five-year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. *The Covered Person may*

provide a comprehensive treatment plan independent of the preferred provider network, but this will be subject to medical appropriateness review and may result in out-of-network charges.

Failure to pre-authorize a transplant procedure will mean that the Covered Person will be responsible for payment of a $1,000 deductible charge. **For authorization to receive Transplant Services call: (800) 764-3433.**

Organ Transplant Network**:** During the pre-authorization review, the Covered Person will be asked to consider obtaining transplant services at a participating transplant center; that is, a Facility that has entered into an agreement with the transplant network provider to provide services to the Plan. This is not an absolute requirement; however, benefits of the transplant and related expenses may vary depending on whether the services are provided in or out of the transplant network.

If services are provided out-of-network without approval from the Plan's Managed Care Coordinator, then out-of-network benefits will apply and you will be responsible for Plan deductible, co-payment and co-insurance requirements, *plus* an additional payment of $1,000.00.

If a transplant is performed out-of-network, but the Covered Person has received approval from the Plan's Managed Care Program Coordinator for the out-of-network services, then the network benefits will apply to the transplant and related expenses.

Transplant Benefit Period: Benefits for a covered transplant will accumulate during a Transplant Benefit Period and will be charged towards the transplant benefit period maximums. The term "Transplant Benefit Period" means the period that begins on the date of the initial evaluation and ends on the date that is twelve (12) consecutive months following the date of the transplant. (If the transplant is a Bone Marrow Transplant, then the date the marrow is reinfused is considered the date of the Transplant.)

Covered Transplant Expenses: The term "Covered Expenses" with respect to transplants includes the Usual and Customary expenses for the services and supplies that are covered under the Plan (or which are specifically identified as covered only under this provision) and which are Medically Necessary and appropriate to the Transplant. Covered Expenses also include the evaluation, screening and candidacy determination process; charges incurred for organ transplantation; charges for organ procurement, including donor expenses not covered under the donor's plan of benefits; charges incurred for follow-up care, including immunosuppressant therapy; and charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event the recipient or donor is a minor, two (2) other individuals.

If the transplant procedure is a bone marrow transplant, the Plan will pay for removal of the patient's bone marrow or for donated marrow. Coverage will also be provided for search charges to identify an unrelated match, treatment and storage of the marrow up to the time of reinfusion. Harvesting of marrow need not be performed within the Transplant Benefit Period.

If care is obtained at a Center of Excellence, all reasonable and necessary travel, lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period. Lodging accommodations and meal expenses must be pre-authorized by the Plan's Managed Care Program Coordinator.

Re-transplantation will be covered up to two re-transplants, for a total of three transplants per person, per lifetime.

Accumulation of Expenses: Expenses incurred during any one-transplant period for the recipient and donor will accumulate towards the recipient's benefit and will be included in the Plan's overall per person maximum Annual and Lifetime Benefit.

Mental Health and Substance Abuse. The Plan pays Covered Charges for treatment of mental health and substance abuse problems in an appropriate Facility as part of its Managed Benefits Program (see Section 7 for an explanation of the Managed Benefits Program). Utilizing a managed benefits program allows the Plan to provide quality treatment at a higher level of benefits than might otherwise be available to the patient. This provision is intended to encourage the efficient and effective use of mental heath/substance abuse services by providing enhanced benefit levels, or reduced out-of-pocket expenses to the patient through access to a Specialty Preferred Provider Organization (PPO). The benefits provided are limited to charges for services, which are Medically Necessary and appropriate for the care and treatment of the illness. The Managed Mental Health and Substance Abuse PPO Network consists of both local inpatient facilities and outpatient providers. All outpatient providers are licensed mental health professionals. A listing of network providers and facilities is available at www.ousdhp.com.

> ***Please note that if you are admitted to a general Hospital as opposed to a mental health Facility for treatment of mental or nervous disorders, your benefits are discussed above in the section entitled "Inpatient Care in a Hospital."***

Mental Health and Substance Abuse Pre-admission Requirements. To receive the Managed Care Benefits provided by this program, you must call the Managed Mental Health and Substance Abuse PPO Network Vendor in the following situations:

- **Elective Inpatient Admission or Partial Hospitalization:** You must call at least five (5) working days prior to a scheduled non-emergency, elective inpatient hospitalization. Many psychiatric and most substance abuse admissions are planned and, therefore, require authorization prior to the admission.
- **Emergency Hospital Admission:** You must call within two (2) working days after an Emergency hospitalization begins, or as soon as reasonably possible thereafter. Either yourself, a family member, your attending physician, or the Facility can provide notification to the coordinator.
- **Outpatient Care:** You must call prior to the fourth (4th) outpatient treatment to pre-certify a continued plan of outpatient treatment.

Failure to call the Managed Mental Health and Substance Abuse Utilization Review Vendor to pre-certify treatment means that the treatment will be processed as an "out-of-network" benefit until such time as a treatment plan is authorized by the Utilization Review Vendor. *Retrospective* pre-certification of outpatient treatment can only be approved for three outpatient visits. Failure to certify inpatient or outpatient substance abuse will result in the application of greater deductible and a higher patient co-insurance payment. The table on the next page shows the benefits available to you based upon whether you receive care at an in- or out-of-network Facility and whether or not your care is pre-certified as required by the Plan.

MANAGED MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS

Service/Benefit Provision	*In-Network*	*Out-of-Network*
Inpatient Mental Health Care Pre-Certified	100%, up to 100 days per calendar year (no deductible)	You pay 50%. The Plan pays 50% of U&C to 30 days per calendar year (after the $500 out-of-network hospital deductible).
Inpatient Mental Health Care Not Pre-Certified	Out-of-Network applies.	You pay 50%. The Plan pays 50% of U&C to 30 days per calendar year (after the $500 out-of-network hospital deductible).
Outpatient Mental Health Care Pre-Certified	100%, after $15 per visit co-pay, as indicated.	The Plan pays 50% of U&C, after $15 per visit co-pay, up to 30 visits per calendar year (after the $300 out-of-network deductible).
Outpatient Mental Health Care Not Pre-Certified	Out-of-Network applies.	The Plan pays 50% of U&C, after $15 per visit co-pay, up to 30 visits per calendar year (after the $300 out-of-network deductible).
Outpatient Mental Health Calendar Year Maximum Combined Counts (Network & Out-of-Network)	100 visits: Pre-Certified only.	30 visits
Lifetime Outpatient Mental Health Maximum Combined Counts (Network & Out-of-Network)	Unlimited: Pre-Certified only	60 visits
Inpatient Substance Abuse Pre-Certified	100% of Covered Charges (no deductible). Limit of 4 weeks per period of confinement and 6 weeks per calendar year.	50% of Covered Charges after the $500 out-of-network hospital deductible. Limit of 4 weeks per period of confinement and 6 weeks per calendar year.
Inpatient Substance Abuse Not Pre-Certified	100% of Covered Charges (no deductible). Limit of 4 weeks per period of confinement and 6 weeks per calendar year.	50% of Covered Charges after the $500 out-of-network hospital deductible. Limit of 4 weeks per period of confinement and 6 weeks per calendar year.
Outpatient Substance Abuse	100% of Covered Charges (no deductible). Maximum total of 60 visits per calendar year, including 20 visits for family members.	50% of Covered Charges. Maximum total of 60 visits per calendar year, including 20 visits for family members

Note: Timothy's Law requires that if a patient is suffering from a "biologically based mental illness" as defined in this document, or is a "child with serious emotional disturbances" as defined in this document, the inpatient mental health benefit will be the same as for any other illness. In addition, if a patient is suffering from a "biologically based mental illness" as defined in this document, or is a "child with serious emotional disturbances" as defined in this document, the outpatient mental health care benefit will be consistent with the benefit payable as an office visit to any other Professional Provider. However, any such claims will be subject at all times to review and/or retrospective denial by the plan's managed care consultant.

Physical Medicine Services (Chiropractic, Physical and Occupational Therapies). The Plan has arranged to provide "in-network" physical medicine benefits when treatment and services are provided through the Optum Health PPO Network and Utilization Review Vendor, a network of licensed providers of chiropractic services, physical therapy and occupational therapy.

Use of in-network providers will enable Covered Persons to receive "in-network benefits" (a per visit co-pay) for physical medicine services. Please note that physical therapy and occupational therapy services must be prescribed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.). In-network providers will work directly with the Optum Heath network to have services reviewed in order to obtain the highest available network.

You may also use out-of-network providers for physical medicine treatments (chiropractic, physical and occupational therapy services) but the Plan's "out-of-network" coverage will apply. You will be responsible for "out-of-pocket" costs, including the Plan's calendar year deductible, co-payment and co-insurance and you will be allowed reimbursement only up to the in-network allowance.

To receive the maximum out-of-network benefits available, the patient should contact the Managed Physical Medicine PPO Network Vendor any time that out-of-network physical medicine services will exceed 15 visits in a calendar year. Otherwise, the patient may be subject to a retrospective denial of benefit payment. We recommend notifying the Optum Health PPO Network and Utilization Review Vendor in advance in order to avoid benefit reductions, or denial of claims that are determined not to be Medically Necessary.

Pre-Certification Assistance. Pre-certification and authorization for Physical Medicine treatment is a contractual responsibility between Optum Health and the network providers. Members being treated by an Optum Health in-network provider do not need to arrange for pre-certification. Providers participating in the network will arrange for treatment pre-certifications without any requirement from the patient. However, **when receiving care from out-of-network providers, the Covered Person is responsible for pre-certification of benefits**. Otherwise, you risk that treatment will not be paid for when it is no longer Medically Necessary.

Failure to pre-certify physical medical treatment may result in a reduced payment by the Plan, increasing the patient's co-insurance. See the table below for details on charges that are the responsibility of the patient depending on where care is received.

MANAGED PHYSICAL MEDICINE BENEFITS

Service/Benefit Provision	*In-Network*	*Out-of-Network*
Chiropractic Services/ Physical and Occupational Therapies/Physical Medicine Services	**$15 patient co-pay** Per office visit (no deductible).	$15 patient co-pay, deductible and co-insurance per office visit apply.
Co-Insurance	**Not Applicable** (per visit co-pay only) Pre-Certification Performed. In-Network providers of Physical Medicine PPO will notify the Utilization Review Vendor directly without any requirement from you. (Please always verify that the provider you choose participates in the Physical Medicine PPO network.) The member/patient has no notification responsibility other than to notify the provider of service that their Health Plan participates in the Physical Medicine PPO Network. The Utilization Review Vendor will perform their utilization review, and furnish the treatment pre-certification directly to the in-network provider of service.	First 15 visits in any Calendar Year: Following the patient co-pay and the calendar year deductible, you pay 20%; the Plan pays 80% of the Optum Health PPO Network vendor's allowable charges for in-network PPO services, up to the out-of-pocket maximum expenses; then the Plan pays 100% following the $15 per visit patient co-pay. The co-insurance is the patient's responsibility, as is the difference between the doctor's charge and the "in-network" allowance. Pre-Certification of Benefits after 15 Visits: Your out-of-network provider should call the Optum Health Network Provider prior to the 16th visit to avoid retrospective benefit declinations when services are determined not to have been Medically Necessary. After the 15th physical medicine service visit, reimbursement is at 50% of the network allowance following the $15 per visit patient co-pay. The member's co-insurance of 50%, the patient co-pay and the charges by an out-of-network provider that are above the Plan's "in-network" allowance are entirely the member's responsibility, and do not apply towards the patient's out-of-pocket expense maximum.

Mandatory Second Surgical Opinions. The Plan pays for a mandatory second surgical opinion when you are planning to undergo certain surgical procedures such as those listed below. You must call the Managed Benefits Program (MBP) Coordinator at least 14 days before undergoing these non-emergency, inpatient or outpatient surgeries in order to determine whether a second opinion must be obtained. If you *do not* call the MBP Coordinator or *do not* obtain a second opinion when one is required, you may be responsible to pay up to $500.00 toward the cost of the care. If surgery is determined not to be Medically Necessary, surgical benefits may be disallowed altogether.

The Plan will pay 100% of the Usual and Customary (U&C) charges (or 100% of PPO allowances) for a second surgical consultation, subject to the following:

- Covered Charges for the second opinion surgeon are limited to the examination and consultation.
- The second opinion must be secured from a Board Certified Specialist in the field for which the patient is contemplating surgery.
- The second opinion surgeon must not be a part of the same medical or surgical group as the first opinion surgeon.
- The Employee and the Physician providing the second opinion must complete the appropriate claim forms required by the Plan.

When you call the Managed Benefits Program (MBP) Coordinator, they will determine whether a second opinion is required. In many cases, the MBP Coordinator may waive this requirement.

If the second opinion differs from the first opinion, a third opinion may be obtained following all of the guidelines outlined here. Regardless of the recommendation, the decision to have Medically Necessary surgery lies with the patient or patient's guardian. (A non-mandatory second and third surgical opinion is also a covered benefit.)

The following types of surgery require you to obtain a Mandatory Second Surgical Opinion:

- Bariatric Surgery
- Breast Surgery (non-diagnostic) (Note: breast reconstruction surgery after a mastectomy does not require a second opinion.)
- Heart Surgery (elective or non-emergency)
- Hysterectomy
- Intradiscal Electrothermal Annuloplasty (IDET)
- Joint Replacement Surgery
- Laminectomy
- Orthotryspy (Extracorporeal Shock Therapy of Plantar Fascitis)
- Nasal Surgery Panniculectomy (removal of excess external abdominal adipose tissue), and all other Plastic Surgery (cosmetic or reconstructive)
- Prostatectomy
- Spinal Fusion
- TMJ (Tempro-Mandibular Joint Disorder) Surgery

See Section 10 for information on how to appeal a managed care decision you may not agree with.

SECTION 10
HOW TO UTILIZE THE MANAGED BENEFITS PROGRAM AND APPEAL DECISIONS YOU MAY DISAGREE WITH

As soon as you are aware of a recommended hospitalization or outpatient treatment for any of the Plan's Managed Benefits Programs, you should telephone the Managed Benefits Coordinator (referred to hereafter as the Coordinator). Their contact information can be found in Appendix A. When you call, please have the following information available:

- Your name, address, and social security or alternate ID number;
- Patient's name, address, social security or alternate ID number, and age;
- Doctor's name, address, and phone number, if appropriate;
- Admitting hospital name and phone number, if appropriate;
- Employer's name and Claims Administrator's name;
- Medical condition and planned procedure, if known.

As soon as the Coordinator receives notice, the following actions happen:

1. Pre-Certification Process

a. All requests for pre-certification of Hospital admissions or other services are reviewed to determine Medical Necessity (including the appropriateness of the proposed level of care and/or provider) and to determine whether the care is Experimental and/or Investigational. The initial review is performed by a nurse. If the nurse determines that the proposed care is Medically Necessary and not Experimental and/or Investigational, she will authorize the care. (Authorized care is still subject to all Plan benefit provisions such as deductibles, co-insurance/co-payments and annual/lifetime maximums.)

If the nurse determines that the proposed care is not Medically Necessary or is Experimental and/or Investigational or that further evaluation is needed, she will refer the case to a clinical peer reviewer (defined as a physician who possesses a current and valid non-restricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification or registration or, where no provision for a license, certification or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition.). Failure to make a determination within the time periods required by Article 49 of the New York Insurance law will be deemed to be an adverse determination that is subject to an internal appeal.

b. Notice of an approval of proposed care or an adverse determination that proposed care is not Medically Necessary or is Experimental and/or Investigational will be provided to you and your authorized designee, and your provider, by telephone and in writing, within 3 business days following receipt of all information necessary to make the decision.

c. The notice of an adverse determination will include the reasons, including clinical rationale, for our determination. The notice will also advise you of your right to a review of the adverse determination, give instructions for initiating standard, expedited and external appeals, and specify that you may request a copy of the clinical review criteria used to make the adverse determination. The notice will also specify additional information or documentation, if any, needed for us to make a Level One internal appeal determination.

d. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within one (1) business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within three (3) business days from the date of reconsideration. All of the information described in paragraph 1.c. above will be included in this notice.

2. Concurrent review process.

a. When you are receiving services that are subject to concurrent review, a nurse will periodically assess the Medical Necessity, level of care, and Experimental and/or Investigational nature of services you receive throughout the course of treatment.

b. Once a case is assigned for concurrent review, a nurse will determine whether the services being received are Medically Necessary, at the appropriate level and not Experimental and/or Investigational. If so, the nurse will authorize the care. If the nurse determines that the care is not Medically Necessary or is Experimental and/or Investigational or that further evaluation is needed, the nurse will refer the case to a

clinical peer reviewer (defined in paragraph 1.a. above). Failure to make a determination within the time periods required by article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to Level One internal appeal (described in paragraph 4. below).

c. Your provider will be notified of the concurrent review decision, by telephone and in writing, within one (1) business day following our receipt of all information or documentation needed for the review.

d. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date services may begin, and the date of the next scheduled concurrent review of the case. If care is not authorized, the notice of any adverse determination will include the reasons, including clinical rationale, for our determination. The notice will advise you of your right to a review of the adverse determination, give instructions for initiating standard, expedited, and external appeals, and specify that you may request a copy of the clinical review criteria used to make the adverse determination. The notice will also specify additional information or documentation needed, if any, for us to make a Level One internal appeal determination.

e. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within one (1) business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within one (1) business day from the date of reconsideration. All of the information described in paragraph 2.d. above will be included in this notice.

3. Retrospective review process.

a. At the option of the Plan and the Utilization Review Manager, a nurse may review the Medical Necessity and the Experimental and/or Investigational nature of services, which are subject to utilization review after the care has been received. If the nurse determines that the care you received was Medically Necessary and not Experimental and/or Investigational, the nurse will authorize benefits. If the nurse determines that the care was not Medically Necessary or was Experimental and/or Investigational, the nurse will refer the case to a clinical peer reviewer (defined in paragraph 1.a. above). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to Level One internal appeal (described in paragraph 4. below).

b. You or your authorized designee and your provider will be notified of the retrospective review determination, in writing, within 30 calendar days from our review of all information or documentation needed for the review.

c. The notice of any adverse determinations will include the reasons, including clinical rationale, for our determination. The notice will advise you or your right to request a review of the adverse determination, give instructions for initiating standard, expedited, or external appeals, and specify that you or your authorized designee may request a copy of the clinical review criteria used by us to make the adverse determination. The notice will also specify additional information or documentation needed, if any, for us to make a Level One internal appeal determination.

d. The provider who rendered care for which benefits are denied may request a Level One internal appeal of the retrospective adverse determination on your behalf (even if not authorized in writing by you to act as you designee).

HOW DO I APPEAL A MANAGED DECISION I DISAGREE WITH?

Review of adverse determinations.

1. **Request for Level One Internal Appeal.**

   a. You, your authorized designee, and, in a retrospective review case, your health care provider may request a Level One internal appeal of an adverse determination, verbally or in writing, within 60 business days from the date that you receive notice of the adverse determination. To request a Level One Internal Appeal verbally, you may call 1-800-764-3433. To submit a written request for a Level One Internal Appeal, you may write to HealthCare Strategies, Inc., 9841 Broken Land Parkway, Suite 315, Columbia, Maryland 21046.

   b. Your case will differ, depending upon the urgency of the case. In most cases, a standard Level One Internal Appeal, described below, will be appropriate. In "urgent cases," an expedited Level One Internal Appeal is available; the expedited Level One Internal Appeal process is described after standard Level One Internal Appeal below.

2. **Standard Level One Internal Appeal.**

   a. We will acknowledge your Level One Internal Appeal in writing, within five (5) business days after receiving it.

   b. When one or more Level One Internal Appeals are received (for example, you submit an appeal, then your health care provider submits an appeal on your behalf), a single Level One internal Appeal will be conducted by a clinical peer reviewer (a physician who possesses a current and valid non-restricted license to practice medicine, or a heath care professional other than a licensed physician who, were applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition), who did not make the initial adverse determination.

   c. The clinical peer reviewer will render a determination within 30 calendar days after receipt of all necessary information. Written notice of the determination will be provided to you and any other qualified party who submitted a Level One Internal Appeal within two (2) business days after the determination is made, but in no event later than 30 calendar days after receiving all necessary information. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

   d. The notice will include detailed reasons and the clinical rational for the determination. If the determination is adverse, the notice will describe the procedure for filing an external appeal of the adverse determination. The external appeal process is described in paragraph "o" below. <u>Note – If you submit a Level Two Internal Appeal, the review appeal may take longer than the 45-day time frame for requesting an external appeal through New York State, which begins on the date you receive the final adverse determination notice upon completion of Level One Internal Appeal</u>.

3. Expedited Level One Appeal.

a. For cases involving a prospective or concurrent (but not retrospective) review decision (such as the review of continued or extended health care services; additional services rendered in the course of continued treatment; or any other issue with respect to which a provider requests an immediate review), you, your authorized designee, or a provider may request an expedited Level One Internal Appeal of the initial adverse determination.

b. When a request for expedited Level One Internal Appeal is received, the appeal will be conducted by a clinical peer reviewer who did not render the initial adverse determination. The Plan's Managed Benefits Program Coordinator will provide reasonable access to the clinical peer reviewer assigned to the appeal, within one (1) business day following receipt of notice of the request for appeal, to ensure that all relevant information is available to the clinical peer reviewer. You may ask that your provider and the clinical peer reviewer exchange information by telephone or fax.

c. Within 48 hours of review by us of all information needed for the appeal, the clinical peer reviewer will decide the expedited Level One Internal Appeal. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

d. Notice will be provided to you and the provider, by telephone and in writing, within 24 hours of the determination. The notice will include all of the information described and enclosed in a notice of standard Level One Internal Appeal determination (see above). <u>Note – If you request a Level Two Internal Appeal, the appeal may take longer than the 45-day time frame for requesting an external appeal through New York State, which begins on the date you receive the final adverse determination notice upon completion of Level One Internal Appeal.</u>

4. Level Two Internal Appeals.

a. After you receive notice of a Level One internal appeal determination, if you are still not satisfied, you or your authorized designee may submit a Level Two Appeal, verbally or in writing. (You also have an option to apply for an external appeal, see paragraph e. below). The Level Two internal appeal must be received by us within 60 business days from the date of the Level One Internal Appeal determination.

b. We will acknowledge your Level Two Internal Appeal, in writing, within 15 calendar days after receiving it. The acknowledgement will identify additional information, if any, needed for the Level Two Internal Appeal.

c. Your case will be reviewed by at least one clinical peer reviewer who did not make the prior determinations.

d. In "urgent cases" where a delay would significantly increase the risk to your health, we will make a Level Two Internal Appeal determination and call you within the lesser of two (2) business days or 72 hours after receiving all information needed for the review. Written notice of the Level Two Internal Appeal determination will also be provided within two (2) business days.

   In all other cases, we will make a Level Two Internal Appeal determination within 30 business days after receiving all information needed for the review. Written notice of the determination will be provided to you within two (2) business days after the determination is made, but no later than 30 business days after receiving all necessary information.

e. The notice you receive will include detailed reasons for the Level Two Internal Appeal determination and, if a clinical matter is involved, the clinical rationale for the determination. The notice will also advise you of the right to apply for an external appeal, if the time frame for applying has not expired by the date of receipt of notice of an adverse determination on Level Two Internal Appeal.

WHAT ARE "EXTERNAL" MANAGED CARE APPEALS?

New York State Law gives you the right to an external appeal when health care services are denied by one of the Plan's utilization Review Agencies, on the basis that the services are not Medically Necessary or that the services are Experimental or Investigational.

To request an external appeal you must complete a New York State External Appeal application form and send it to the New York State Insurance Department within 45 days of when you received a notice of final adverse determination from first level internal appeal process OR within 45 days of receiving written confirmation from the plan that the internal appeal has been waived. If all applicable items required by the State are not completed, your request will not be accepted.

1. **What is an External Appeal?**

   a. An external appeal is a request that you make to the State of New York for an independent review of a denial of services by your health plan.

   b. Reviews are conducted by external appeal agents that are certified by the state and have a network of medical experts to review your health plan's denial of services.

   c. You must complete the New York External Appeal Application which can be obtained from your Local School District Heath Plan Representative, any of the Plan's Managed Care vendors' utilization review firms or the Health Plan's claims administrator. Upon completion, submit the application to the New York State Insurance Department to request an external appeal.

2. **Eligibility for an External Appeal.**

   To be eligible for an external appeal:

   a. You must have received a final adverse determination as a result of your health plan's internal utilization review appeal process OR you and your health plan must have agreed to waive that appeal process. A final adverse determination is written notification from your health plan that your health care service has been denied through the Plan's internal appeal process. Because you are entitled to an internal appeal process through the Plan's utilization review agents, and then through the Health Plan's appeal committee, the External Appeal Application may be made at the same time you file your second level appeal to the Health Plan Committee through your Local School District Health Plan Representative.

   b. If both you and your health plan agree to waive the internal appeal process, the health plan will confirm the agreement in writing.

   c. You must submit a request for an external appeal to the State within 45 days from when you received a notice of final adverse determination from your health plan OR within 45 days of receiving written confirmation from your health plan that the internal appeal process has been waived.

   d. If you do not file a request for an external appeal with the State within this 45-day period, you will not be eligible for an external appeal. As indicated in the section "How do I

appeal a Managed Decision I disagree with?" you are entitled to an Internal Appeal by the Managed Care Vendor. If that Appeal results in a continued adverse decision, you must file a request for external appeal within 45 days of your receipt of the notice of final adverse determination from the plan's first level appeal process (through the Managed Care Coordinator) to be eligible for an external appeal.

e. If services are denied as Experimental or Investigational, you must have a life-threatening or disabling condition to be eligible for an external appeal and your attending physician must complete the Attending Physician Attestation form and send the form to the State Insurance Department. This form is also available from your Local School District, the Plan's Managed Care vendors or the Plan's claims administrator.

f. If the Covered Person's attending physician has certified that the patient has a life-threatening or disabling condition or disease for which (a) standard health services or procedures have been ineffective or would be medically inappropriate, or (b) there does not exist a more beneficial standard health services or procedure covered by the health care plan, or (c) there exists a clinical trial, and if the covered patient's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured's life-threatening or disabling condition or disease, has recommended either (1) a health service or procedure (including a pharmaceutical product) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the insured than any covered standard health service or procedure; or (2) a clinical trial for which the insured is eligible. Any physician certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and the specific health service or procedure recommended by the attending physician must otherwise be covered under the Plan except for the Plan's determination that the health service or procedure is Experimental or Investigational.

You may only appeal a service or procedure that is a covered benefit under your contract. The external appeal process may not be used to expand the coverage of your Health Plan.

The appeal cannot be for workers' compensation claims or for claims under no-fault auto coverage.

3. What About the Second Level of Internal Appeal to my Health Plan Appeal Committee?

a. You are not required to seek a second level of internal appeal with your health plan in order to request an external appeal, although you may file one simultaneously.

b. If you seek a second level of internal appeal with your health plan, you may not have time to request an external appeal. You must request an external appeal within 45 days of receiving the determination <u>from the health plan's first level of internal appeal</u>.

4. Am I Eligible for an External Appeal if I am Covered by Medicare or Medicaid?

a. You are not eligible for this external appeal process when Medicare is your only (or primary) source of health services. If you have coverage under Medicare, you must file a complaint with the federal government for denials of service.

b. If you have coverage under Medicare and Medicaid, this external appeal process may only be used to appeal denials of services or treatment covered by Medicaid.

c. If you have Medicaid coverage, you may also request a fair hearing. If you have requested an external appeal and a fair hearing, the determination in the fair hearing

process will be the one that applies. If you have questions about the fair hearing process, you should contract the New York State Department of Health at 1-800-206-8125.

5. Eligibility for an Expedited (Fast-Tracked) External Appeal.

a. If your attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to your health, you may request an expedited appeal. When requesting an expedited appeal, make sure you give the Attending Physician Attestation to your doctor to complete. Your appeal will not be forwarded to the external appeal agent until your physician sends this attestation to the Insurance Department.

6. How Long an External Appeal Will Take?

a. Expedited Appeals:

The external appeal agent must make a determination within three (3) days of receiving your request for an external review from the state.

b. Standard Appeals:

When your appeal is not expedited, the external appeal agent must make a determination within 30 days of receiving your request for an external review from the state. If additional information is requested, the external appeal agent has five (5) additional business days to make a determination.

7. The Cost to You for an External Appeal.

The Health Plan charges a fee of $50.00 for an external appeal.

a. If you have coverage under Medicaid Child Health Plus, or your health plan determines that the fee will pose a hardship, you will not be required to pay a fee.

b. You must submit the fee with your application for an external appeal. If you fax your application to the Insurance Department, you must send the fee within three (3) business days to the Insurance Department. If the fee is not sent to the Insurance Department within this time frame, the external appeal agent will suspend review of your appeal until payment is received.

c. Only checks or money orders, made payable to your health plan, will be accepted.

d. If the external appeal agent overturns your health plan's determination, the fee will be refunded to you.

6. **When Information May be Submitted to the External Appeal Agent.**

a. If your case is determined to be eligible for external review, you and the Health Plan will be notified of the certified external appeal agent assigned to review your case.

b. The Health Plan must send any medical and treatment record either it, or its UR vendors, have to the external appeal agent.

c. When the external appeal agent reviews your case, the agent may request additional information from you or your doctor. This information should be sent immediately to the external appeal agent.

d. You and your doctor can submit information even when the external appeal agent has not requested specific information. You must submit this information within 45 days from when your health plan made a final adverse determination or from when you and your health plan agreed to waive the internal appeal process.

**** It is important to send this information immediately. Once the external appeal agent makes a determination or once your 45-day time period ends, you will be unable to submit additional information.*

7. **What Happens When an External Appeal Agent Makes a Decision?**

a. Expedited Appeals:

If your appeal was expedited, you and your health plan will be notified immediately by telephone or fax of the external appeal agent's decision. Written notification will follow.

b. Standard Appeals:

If your appeal was not expedited, you and your health plan will be notified in writing within two (2) business days of the external appeal agent's decision.

c. Binding Decision:

The decision of the external appeal agent is binding on you and your health plan.

If you have any questions, please contact your Local School District Health Plan Administrator, the Health Plan's claims administrator or any of the Plan's Managed Care vendors whose toll-free telephone numbers are listed on your ID cards and in Appendix A of this document. You may also contact the New York State Insurance Department at 1-800-400-8882 or visit their web site at www.ins.state.ny.us.

SECTION 11
PLAN BENEFIT LIMITATIONS AND EXCLUSIONS

In addition to any benefit limitations and/or exclusions described elsewhere in this Plan, we will not provide coverage for any of the following:

Acupuncture/Hypnosis/Biofeedback. We will not provide coverage for any service or care related to acupuncture treatment and acupuncture therapy, hypnosis or biofeedback.

Blood Products. We will not provide coverage for blood donor services or for the cost of blood, blood plasma, other blood products, or blood processing or storage charges when they are available free of charge in the local area. When not free in the area, we will cover blood charges, even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center or a certified blood bank.

Cosmetic Services. We will not provide coverage for services in connection with elective cosmetic surgery that is primarily intended to improve your appearance and is not Medically Necessary. Examples of the kinds of services that we often determine not to be Medically Necessary include breast enlargement, rhinoplasty and hair transplants.

We will, however provide coverage for services in connection with reconstructive surgery when such service is incident to or follows surgery resulting from trauma, infection, or other disease of the part of the body involved. We will also provide coverage for reconstructive surgery due to congenital disease or anomaly of a child covered under this Plan that has resulted in a functional

physical defect. We will also provide coverage for services in connection with reconstructive surgery following a mastectomy.

Criminal Behavior. We will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The illegal act will be determined by the law of the state where the criminal behavior occurred. We will not pay for treatment mandated by a court as a condition of probation.

Custodial and Maintenance Care. We will not provide coverage for any service or care that is custodial in nature, or any therapy that we determine is not expected to improve your condition. (Custodial Care and Maintenance Care are defined in Section 2.)

Dental Care. We will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth, or any form of dental surgery, regardless of the reason that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, extraction of impacted teeth, treatments for gum disease, therapy or other treatments related to dental TMJ disorder or dental oral surgery.

We will, however, provide coverage for medical treatment that is directly related to an injury or accident involving the jaw or other bone structures adjoining the teeth, including mandibular repositioning to treat TMJ. In addition, we will provide benefits for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. We will also provide the benefits for service and care that is Medically Necessary for treatment due to a congenital (present at birth) disease or anomaly.

Developmental Delay. We will not provide coverage for any service or care related to the educational treatment of behavioral disorders together with services for remedial education, including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This exclusion applies to services, treatment, or educational testing and training related to behavior (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language, to instruct a participant whose ability to speak has been lost or impaired to function without that ability, is not covered.

Durable Medical Equipment; Prosthetic Devices; Medical Supplies. We will not provide coverage for any service or care related to:

(a) Disposable supplies (for examples, diapers, chux, sponges, syringes, incontinence pads, reagent strips, and bandages prescribed for one-time use outside of a provider site), except that this exclusion does not apply to diabetic supplies covered elsewhere in the Plan;
(b) Wigs, hair prosthetics, or hair implants, except wigs necessitated as a result of chemotherapy or radiation therapy covered under the Plan up to a maximum of $800 benefit per Covered Person per lifetime;
(c) Custom-made shoes and arch supports; and
(d) The purchase or rental of household fixtures, including elevators, escalators, ramps, seat lift chairs, stair glides, saunas, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air or unit air conditioners, humidifiers, dehumidifiers, emergency alert equipment, handrails, heat appliances, improvements made to a house or place of business, and adjustments made to vehicles.

Experimental and Investigational Treatment. Unless otherwise required by law, we will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively referred to as "Service"), an inpatient stay in connection with a Service, or treatment of a complication related to a Service if, in our judgment, the Service is Experimental or Investigational. See Section 10 for a description of your right to an external appeal of our determination that a Service is Experimental or Investigational.

"Experimental or Investigational" means that we determine the Service is:

(a) Not of proven benefit for a particular diagnosis or for treatment of a particular condition;
(b) Not generally recognized by the medical community, as reflected in published, peer-reviewed medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or
(c) Not of proven safety for a person with a particular diagnosis or a particular condition, i.e., is currently being evaluated in research studies to ascertain the safety and effectiveness of the treatment on the well being of a person with the particular diagnosis or in the particular condition.

Governmental approval of a Service will be considered in determining whether the Service is Experimental or Investigational, but the fact that a Service has received governmental approval does not necessarily mean it is of proven benefit or appropriate or effective treatment for a particular diagnosis or condition.

In determining whether a Service is Experimental or Investigational, we may, in our discretion, require that any or all of the following five criteria be met:

(a) A Service that is a medical device, drug, or biological product must have received final approval of the United State Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once final FDA approval has been granted for a particular diagnosis or for your particular condition, use of the Service (medical device, drug, or biological product) for another diagnosis or condition may require that any or all of the five criteria be met.
(b) Published, peer-reviewed medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliates, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
(c) Published, peer-reviewed medical literature must provide demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.
(d) Published, peer-reviewed, medical literature must provide proof that the Service is at least as effective in improving health outcomes as established services or technology, and established medical services or technology cannot be used due to medical reasons.
(e) Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in paragraph (c) above, is possible in standard conditions of medical practice, outside of clinical investigatory settings.

This exclusion shall not limit in any way benefits available for prescription drugs otherwise covered under this Plan which have been approved by the FDA for the treatment of certain types of cancer, when those drugs are prescribed for the treatment of a type of cancer for which they have not been approved by the FDA, so long as the drugs prescribed meet the requirements of Section 4303 (q) of the New York State Insurance Law.

Free Care. We will not provide coverage for any service or care that is furnished to you without charge or that would have been furnished to you without charge if you were not covered under the Plan. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your brother, sister, mother, father, son or daughter, or the spouse of any of them, we will presume that the service or care would have been furnished without charge.

Genetic Testing. We will generally not provide coverage for genetic testing or information; however, certain genetic tests may be covered if prospectively reviewed and approved by the Plan's case management consultant. Check with the case management consultant prior to testing to find out if it will be covered by the Plan.

Government Programs. We will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, we will reduce our benefits by the amount Medicare would have paid for the services. Except as otherwise required by law, this reduction is made even if you fail to enroll in Medicare, you do not pay the charges for Medicare, or you receive services at a Facility that cannot bill Medicare. If this plan is secondary to Medicare due to the Medicare Eligibility of the participant, and the Provider does not accept Medicare reimbursement for services, the Plan will pay only what it would have paid if the Provider had accepted Medicare reimbursement.

However, this exclusion will not apply to you if one of the following applies:

(a) Eligibility for Medicare by Reason of Age. You are entitled to benefits under Medicare by reason of your age, and the following conditions are met:
  (1) The Employee is in "current employment status" (working actively and not retired); and
  (2) The Employee's employer maintains or participates in a group health plan that is required by law to have this Plan pay its benefits before Medicare.

(b) Eligibility for Medicare by Reason of Disability Other Than End-stage Renal Disease. You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease); and the following conditions are met:
  (1) The Employee is in "current employment status" (working actively and not retired); and
  (2) The Employee's employer maintains or participates in a large group health plan that is required by law to have this Plan pay its benefits before Medicare.

(c) Eligibility for Medicare by Reason of End-stage Renal Disease. You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. We will not reduce this Plan's benefits, and we will provide benefits before Medicare pays, during the waiting period. We will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before we provide benefits under this Plan.

Late Claims. We will not provide coverage for any claim submitted more than 15 months after the service was rendered or the supply was furnished.

Military Service-Connected Conditions. We will not provide coverage for any service or care related to any military service-connected disability or condition if the Veterans Administration (VA) has the responsibility to provide the service or care.

No-Fault Automobile Insurance. We will not provide coverage for any service or care for which benefits are recovered or recoverable under mandatory no-fault automobile insurance.

Non-Covered Service. We will not provide coverage for any service or care that is not specifically described in this Plan as a covered benefit or that is related to service or care not covered under this Plan, even when a provider considers the service or care to be Medically Necessary and appropriate. For example, we will not provide coverage for any service or care that is not primarily medical in nature, including, but not limited to the following: radio, telephone, television, air conditioner, humidifier, dehumidifier, air purifiers, beauty and barber services, commodes, exercise equipment, arch supports, foot orthotics, or orthotics used solely for sports.

Nutritional Therapy. We will not provide coverage for any service or care related to nutritional therapy, unless we determine that it is Medically Necessary, or that it qualifies as diabetes self management education. We will not provide coverage for commercial weight loss programs or other programs with dietary supplements.

Podiatry and Routine Foot Care. Except as otherwise provided in the Plan, we will not cover routine care of the feet, including treatment of corns, calluses or toenails, unless the charges are for the removal of nail roots or are in conjunction with the treatment of a metabolic or peripheral vascular disease.

Prohibited Referral. We will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.

Self-Help Diagnosis, Training and Treatment. We will not provide coverage for any service or care related to self-care diagnosis, training and treatment for recreational, vocational, employment or educational purposes.

Services Starting Before Coverage Begins. If you are receiving care on the day your coverage under this Plan begins, we will not provide coverage for any service or care you receive:

(a) Prior to the first day of your coverage under this Plan; or
(b) On or after the first day of your coverage under this Plan if that service or care is covered under any other health benefits contract, program or plan.

Sexual Dysfunction. We will not provide coverage for treatment of sexual dysfunction unless Medically Necessary, as determined by the case management consultant.

Smoking Cessation Programs. We will not provide coverage for smoking cessation programs, including but not limited to smoking deterrent patches, gums or devices.

Special Charges. We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Facility because you did not leave the Facility before the Facility's discharge time. It also applies to additional fees charged by Professional Providers or Facilities because care is rendered after hours or on holidays.

Social Counseling and Therapy. We will not provide coverage for any service or care related to family, marital, religious, sex or other social counseling or therapy except unless specifically provided under another section of this Plan.

Timothy's Law Exclusions. Any benefits provided pursuant to "Timothy's Law" will not apply to 1) individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services; 2) services provided solely because such services are ordered by a court; or 3) services determined to be cosmetic on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.

Transsexual Surgery and Related Services. We will not provide coverage for any service or care related or leading up to transsexual surgery, including, but not limited to hospitalizations, hormone therapies, procedures, treatments or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender, unless such surgery is determined to be Medically Necessary. Medical Necessity determinations are made by the Plan and are subject to retrospective denial and external review. Contact the case management consultant before assuming coverage.

Unlicensed Provider. We will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider or that is outside the scope of licensure of the duly-licensed provider rendering the service or care.

Vision and Hearing Examinations, Therapies and Supplies. Unless otherwise provided for in this Plan, we will not provide coverage for any service or care related to:

(a) Routine eye or hearing examinations;
(b) Eyeglasses, lenses, frames, contact lenses or hearing aids;
(c) Vision or hearing therapy, vision training or orthoptics; or
(d) Surgery or medical treatment to correct refractive errors, such as LASIK.

War. We will not provide coverage for any service or care which results from war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto.

Weight Loss Services. We will not provide coverage for any service or care in connection with weight reduction or dietary control, including, but not limited to gastric stapling, gastric by-pass, gastric bubble, or other surgery or service, unless we determine that such care or service is Medically Necessary. Medically Necessity would include, but is not limited to cases of morbid obesity where weight is at least twice the ideal amount specified for frame, age, height, and gender in the most recent generally accepted life insurance tables, and where the patient has an underlying medical condition resulting from or affected by obesity. Medical Necessity determinations are subject to appeal and external review.

Workers' Compensation. We will not provide coverage for any service or care for which benefits are provided under any State or Federal workers' compensation or similar law.

SECTION 12
EMPLOYEE ASSISTANCE PROGRAM

The OU Plan sponsors an Employee Assistance Program (EAP) that is designed to provide professional and confidential assistance in the form of referrals and initial counseling to covered Employees and their immediate families to help resolve personal problems. The definition of immediate family for purposes of the EAP and the services provided by the EAP Network Vendor will include the extended family, such as brothers, sisters, mother, father, and children, regardless of age or place of residence. The EAP may be of assistance if you or any of these family members are experiencing any of the following:

- Parent/child problems
- Marital difficulties
- Alcohol/drug problems
- Depression
- Job stress
- Financial concerns
- Legal problems
- Personal loss
- Other life stresses

The Employee Assistant Program's benefits are available at no charge to the Covered Employee or his family members. To access the services of the Employee Assistance Program (EAP), and to receive the benefits it provides, you should contact the EAP Network Vendor listed in Appendix A.

The Employee Assistance Program in no way extends any other health plan benefits. Only the services available from the EAP and the services directly provided by the EAP Network Vendor are available to members and their extended families. Referrals for treatment beyond the EAP Vendor's facilities, and or

services provided by other service providers are *only* eligible as provided by the OU Plan and *only* for the OU Plan's Covered Persons. Any other referral not provided by the OU Health Plan, is strictly at the cost of the EAP patient.

In order to receive maximum benefits for services provided by <u>other</u> health care professionals to whom you are referred (such as psychologists, therapists, social workers, counselors, etc.), you must select an <u>in-network</u> provider from the Managed Mental Health and Substance Abuse PPO Network of health care providers (Appendix A). If expenses are incurred <u>out-of-network</u>, deductibles, etc., will apply. The EAP benefit is <u>only</u> available through the EAP Network Vendor. If you do not use the benefit provided by the EAP Network Provider there is not benefit available.

SECTION 13
COORDINATION OF BENEFITS

This section only applies if you, your spouse, or a Dependent is covered both under this Plan as well as under another group health plan or program. Coordination of benefits (COB) means that the coverage provided by this Plan is coordinated with coverage that may be available under the other plan, so that there is no duplication of payment or overpayment.

When You Have Other Health Benefits. When you are covered under this Plan as well as another plan, you have what is known as "primary" and "secondary" coverage. The primary plan is the one that pays its benefits first. The secondary plan is the one that pays second. When that is the case and you receive a service which would be covered by both plans, we will coordinate benefit payments with any payment made under the other plan. One company will pay its full benefit as the primary plan. The other company will pay secondary benefits, if necessary, to cover all or some of your remaining expenses. The following are considered to be health insurance plans for purposes of coordination of benefits:

- Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or 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;
- Any coverage under governmental programs, or any coverage required or provided by any 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; and
- Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.

How We Determine Which Plan Pays First. To decide which plan is primary and pays first, we use the following rules:

- If the other plan does not have a provision similar to this one, then it will be primary;

- If you are covered under one plan as an employee and you are only covered as a dependent under the other plan, the plan that covers you as an employee will be primary; except that if you are retired and covered by Medicare, Medicare will be considered primary to your coverage under this contract unless, as a result of federal law, Medicare is deemed to be secondary. If so, the following rules apply:

    1. The program covering you as a dependent of a person in current employment status pays first;

2. Medicare pays second; and
3. The program covering you as a retired employee pays third.

- Subject to the provisions regarding separated or divorced parents below, if you are covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan which covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the rule in the other plan will determine the order of benefits.

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

  - If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.
  - If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

    (1) First, the plan of the parent with custody of the child;
    (2) Then, the plan of the spouse of the parent with custody of the child;
    (3) Finally, the plan of the parent not having custody of the child.

- If you are covered by one of the plans as an active employee, neither laid-off nor retired, or as the dependent of an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

- If none of the above rules determine which plan shall be primary, then the plan which has covered you for the longest time will be primary.

Payment of Benefits When This Plan is Primary. When we are primary, we will pay benefits covered under this Plan as if there were no COB provision.

Payment of Benefits When This Plan is Secondary. When this plan is secondary, the benefits of this plan will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. However, we will not pay more than we would have paid if we were primary. We count as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. We will request information from that plan so we can process your claims. If the primary plan does not respond within 30 days, we will assume its benefits are the same as ours. If the primary plan sends the information after 30 days, we will adjust our payment, if necessary.

Coordination of Benefits with Non-complying Plans. This Plan complies with New York State coordination of benefits regulations, and is referred to in this section as a "complying" plan. We will coordinate our benefits with a plan that is an excess or always secondary plan, or a plan that uses order of benefit determination rules that are inconsistent with those contained in New York Regulations (known as a "non-complying" plan) as follows:

1. If this Plan is the primary plan, we will pay benefits first, and the non-complying plan will pay second.

2. If this Plan is the secondary plan, we will pay benefits first, but the amount of benefits paid will determined as if we were the secondary plan. That payment will be the limit of our liability.

3. If the non-complying plan does not provide the information we need to determine our benefits within 30 days after we request it, we will assume that the benefits of the non-complying plan are identical to ours, and we will pay our benefits accordingly. We will however, adjust our payments if information is received later that specifies the actual benefit of the non-complying plan.

Effect on Deductible and Co-payment Obligations. Any expense paid by another plan which is primary to this Plan pursuant to this COB provision, or which is charged against the primary plan's deductible and/or co-payment obligation of the Covered Person, will be counted toward any deductible and/or co-payment obligation of the Covered Person under this Plan, provided the expenses would be covered under this Plan if it was primary.

Coordination of Benefits with Medicare. Except as otherwise provided below, Medicare will be primary and this Plan will be secondary.

- **Active Employees Medicare-Eligible Due to Age.** If a covered active Employee (or his Dependent) is eligible for Medicare due to age, this Plan will continue to be primary coverage for that covered Employee or Dependent, provided the Employee remains working actively and the Employee's Employer has 20 or more Employees.

- **Employees & Dependents Medicare-Eligible Due to Disability or End-Stage Renal Disease.** If a Covered Person is eligible for Medicare due to disability or end-stage renal disease (ESRD), this Plan will coordinate its benefits with Medicare as follows:

    1. This Plan will be primary only if (a) the disabled person is an active Employee (or covered Dependent of an active Employee), *and* at least one Employer participating in this Plan has 100 or more Employees, or (b) the person becomes eligible for Medicare due to end-stage renal disease while an active Employee (or covered Dependent of an active Employee).

    2. This Plan will be primary for the first 30 months of Medicare-eligibility of a covered Employee or his covered Dependent who is eligible for Medicare due to end-stage renal disease. After 30 months, Medicare will become primary for that person.

- **Failure to Enroll in Medicare.** If a Covered Person is eligible for Part A and/or Part B of Medicare, but does not enroll in one or both parts, the benefits payable under this Plan will be reduced by the amount he would have received if he had actually enrolled. A Covered Person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him. ***It is important to enroll in Medicare as soon as you are eligible, so that you do not lose any benefits the Plan would otherwise pay.***

Right to Receive and Release Needed Information. We have the right to release or obtain information which we believe necessary to carry out the purpose of this section. We need not tell you or obtain anyone's consent to do this 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.

Our Right to Recover Overpayments and Repayment to Other Plans. In some cases, we may have made payment even though you had coverage under another plan. 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 plan if we have not

already received payment from that other plan. You must sign any document which we deem necessary to help us recover any overpayment.

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.

SECTION 14
OTHER PARTY RESPONSIBILITY, ASSIGNMENT OF PROCEEDS, AND MISCELLANEOUS PLAN PROVISIONS

Other Party Responsibility. If you suffer injuries for which another party or payer may be primarily responsible for the loss or payment of the medical expenses, the Plan has an independent right to file a claim or pursue other legal remedies from or against the party that caused the loss, or any entity which may be responsible for payment of the medical expenses, to recoup benefits paid by the Plan that were caused by a third party, or for which payment is potentially the responsibility of another party. If you suffer injuries for which another party may be responsible, or incur medical expenses whose payment may be the responsibility of another party, please notify the claims administrator. The Plan will determine whether it will bring an action against the potentially responsible party for payment of medical benefits it has provided for your treatment.   You will not personally be responsible to repay the Plan for these benefits, but the Plan can file a claim or take action directly against parties which may be potentially responsible for the loss or potentially responsible for payment of the medical expenses.

Assignment of Benefits. Any benefits payable under the Plan are paid to you, unless you specifically request in writing when the claim is submitted that payment be made directly to the provider of service. Most hospitals will require you to sign an “Assignment of Benefits” prior to treatment so that they may be paid directly. Physicians may also request that you assign benefits directly to them. In the event that payment is made directly to the provider of service, you will receive written notification of the payment and how it was computed.

Amendment or Termination of the Plan. Although established as a permanent plan to be maintained indefinitely, the Plan may be amended, canceled or discontinued at any time by the Plan’s Board of Directors without the consent of any covered individual. In the event of termination of the Plan, written notice of such termination and the rights of all Plan participants shall be provided to all covered Employees at least 90 days in advance of the date of discontinuance. In the event of any amendment which affects any rights described in this booklet, new booklets or notices showing the changes will be distributed.

Authority and Discretionary Control of the Plan. The participating Employers and/or the Plan Administrator and their designated Plan representatives have the full power and authority to determine all questions of eligibility for benefits of all claimants, and to interpret and construe the terms of the Plan. Such determinations, upon proper and adequate review, shall be conclusive and binding upon all interested parties.

Named Fiduciary. Unless otherwise specified in this Plan Document, the Named Fiduciary shall be the Plan Administrator, or other such individual(s) specifically designated as Named Fiduciary by the Plan Administrator. The Named Fiduciary shall have authority, as specified by the Plan Administrator, to control and manage the operation, administration and assets of the Plan. The Claims Administrator and managed care vendors are not a named Fiduciary, and are required to process claims strictly in accordance with the Plan Administrator’s Instructions.

SECTION 15
APPEAL PROCEDURES FOR NON-MANAGED CARE BENEFITS

All Health Plan participants are entitled to know why a claim has been denied payment or partially paid.

> **If the denial is due to a medical or surgical decision by one of the Plan's Managed Care Vendors, or due to a question of Medical Necessity or Experimental Treatment, follow the procedures outlined in Section 10.**

All other claim or eligibility denials must be appealed to the Plan using the following procedure:

Step 1: When you receive a claim denial or a partial payment for a claim that you believe should have been paid differently, you should do the following:

a. Review the appropriate Plan booklet;

b. Call the Claims Administrator using the toll-free number in Appendix A;

c. Discuss the paragraphs from our Plan booklet pertaining to the coverage denied with the claims processing representative.

Step 2: If the inquiry fails to resolve your claim problems, you may begin the appeal process. Your Local School District Health Plan representative will act as your ombudsman during the appeal process. If your claim to be appealed is private (or of a medically confidential nature) you may perform all the following steps yourself, privately.

To do so, please request that your Local School District representative provide you with an appeal form and the name, address and phone number of the Plan's Appeal Committee Chairperson and follow each step of the appeals procedure.

a. Request that your Local School District Health Plan representative review the claims with you. (At your option.)

b. Be prepared to submit in writing ALL evidence that supports your claim – a copy of the doctor or hospital bill and supporting receipt, copy of denial letter, or other correspondence on the claim.

c. You or your Local School District Health Plan Representative may contact the Plan's Claims Administrator to find out reasons for the claim denial, and you may contact the Plan Administrator for additional clarification, if necessary.

d. Most denied or partially paid claims are resolved to the Employee's satisfaction by reviewing the Plan provisions and the facts of the claim.

If the claim still cannot be resolved:

Step 3: a. The Employee may request that the Local School District Health Plan Representative submit the matter to the Appeals Committee for review. This Appeal must be presented within 60 days from the claim denial (or final written action by the Claims Administrator which is the cause of the appeal), or within 60 days of receipt of the response from review by your Local Health Plan Representative as detailed above.*

b. The Local School District Health Plan Representative will present a written request to the Health Plan Administrator requesting that the Appeals Committee review the matter. The

Local Health Plan Representative must provide sufficient documentation of the matter to reasonably allow determination by the Appeals Committee.*

c. Your Local School District Health Plan Representative may present your Appeal to the Health Plan Appeals Committee. The Appeals Committee will perform a review of the denial. The Committee will make every effort to provide the claimant with a written response within 60 days from when they received the appeal. If the Appeals Committee is unable to complete the review process within 60 days, the Local School District Health Plan Representative will notify the claimant within the 60-day period. The Appeals Committee will attempt to provide a written response within 120 days.*

*** Steps 3 a, b, and c can be performed personally if the member requests and files completed appeal forms with the Plan Administrator.**

The Appeals Committee's written response shall cite the reasons for their decision and the specific Plan provisions upon which their review decision is based.

If you are not satisfied with the Appeals Committee resolution:

Step 4: a. You are entitled to a hearing before the Appeals Committee. Your request for a hearing must be made in writing to your Local School District Health Plan Representative within 60 days from receipt of the response to your appeal.

b. The Appeals Committee will set a hearing date.

c. Your appeal may be presented to the committee, during the hearing, by your Local School District Health Plan, you and/or your Personnel Representative.

d. The Appeals Committee will review all materials submitted through the hearing process and will make every effort to respond to the claimant within 60 days of the hearing date.

The Appeals Committee is the appointed Plan Representative body to review member appeals. As the designated representative of the Health Plan, the Appeals Committee has the full power and authority in their absolute discretion to determine all questions of eligibility for benefits for all claimants and to interpret and construe the terms of the Plan. Such determinations, upon proper and adequate review, shall be conclusive and binding upon all interested parties.

SECTION 16
PRIVACY PRACTICES

Use and Disclosure of Health Information. The Plan may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure for your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

To Make or Obtain Payment. The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants. Health care operations include such activities as:

- Quality assessment and improvement activities;
- Activities designed to improve health or reduce health care costs;
- Case management and care coordination;
- Contacting health care providers and participants with information about treatment alternatives and other related functions;
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits;
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs;
- Business planning and development, including cost management and planning related analyses and formulary development;
- Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

For Treatment Alternatives. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor (Your Employer). The Plan may disclose your health information to the Plan Sponsor for administration functions performed by the Plan Sponsor on behalf of the Plan, such as enrollment and eligibility, and assistance with claim questions. In addition, the Plan may provide summary health information to the Plan Sponsor so the Plan Sponsor may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan also may disclose to the Plan Sponsor information on whether you are participating in the Health Plan.

When Legally Required. The Plan will disclose your health information when it is required to do so by any federal, state or local law:

- **To conduct health oversight activities.** The Plan may disclose your health information to a health oversight agency for authorized activities, including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclosure your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

- **In connection with judicial and administrative proceedings.** As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

- **For law enforcement purposes.** As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

- **In the event of a serious threat to health or safety.** The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

- **For specified government functions.** In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services of the president and others, and correctional institutions and inmates.

- **For Workers' Compensation.** The Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

Authorization to Use or Disclose Health Information. Other than as stated above, the Plan will not disclose your health information unless it has your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights with Respect to your Health Information. You have the following rights regarding your health information that the Plan maintains:

Your Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Plan's Privacy Official.

Your Right to Receive Confidential Communications. You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Plan's Privacy Official. The Plan will attempt to honor your reasonable requests for confidential communications.

Your Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing to the Plan's Privacy Officer. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

Your Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures of your health information that the Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Plan's Privacy Official. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Your Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Plan's Privacy Official.

Duties of the Plan. The Plan is required by law to maintain the privacy of your health information as set forth in this Notice, and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. For complaints involving this Plan, write to Region II, Office for Civil Rights, U.S. Dept. of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278. Any complaints to the Plan should be made in writing to the Plan's Privacy Official. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

BY THIS AGREEMENT, the Orange Ulster School District Health Plan, for the account of all participating School Districts, is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for the Trustees of the Orange Ulster School Districts Health Plan on the day and year first below written, for the Plan restatement date of January 1, 2007:

By: ____
Trustees – Orange Ulster School Districts Health Plan

Title: ____

Date: ____

Witness: ____

Date: ____

APPENDIX A

PPO NETWORKS, MEDICAL REVIEW AND PRE-CERTIFICATION ORGANIZATIONS
PRESCRIPTION DRUG MANAGER
EMPLOYEE ASSISTANCE PROGRAM

Claims Administration, Eligibility and COBRA Services:

INDECS Corporation
1099 Wall Street, PO Box 668, Lyndhurst, New Jersey, 07071

- Contact INDECS Corporation at 888-4-INDECS (446-3327) or
- E-mail an inquiry to:
  Claims Services: claims@indecscorp.com
  Administration/Eligibility Services: admin@indecscorp.com
  Access the "INDECS Connection" at: www.indecscorp.com

Medical Utilization Review and Hospital Pre-Certification:

HealthCare Strategies
9841 Broken Land Parkway, Columbia, Maryland, 21046

- Contact HealthCare Strategies at: 800-764-3433
- HealthCare Strategies: www.hcare.net

HealthCare Strategies pre-certifies and manages benefits for Hospital, Skilled Nursing, Rehabilitation, Hospice and Home Health Care. Contact them prior to receiving any of these services.

Hospital and Medical/Surgical PPO Networks:

New York State

Empire Blue Cross and Blue Shield
One Liberty Plaza, 165 Broadway, New York, New York 10006

- Contact Empire BC/BS at 800-810-BLUE (2583)
- Empire BC/BS directory of providers: www.empireblue.com (for NYS)

All Other States

The BlueCard® PPO Program
c/o Empire Blue Cross & Blue Shield
One Liberty Plaza, 165 Broadway, New York, New York 10006

- Contact BC/BS at 800-810-BLUE (2583)
- National BC/BS directory of providers: www.bcbs.com

Optum Health PPO Network & Utilization Review:

For Chiropractic, Physical Therapy and Occupational Therapy Services

Optum Health Network
701 Grant Ave., Suite 200, Lake Katrine, NY 12449

- Contact Optum Health: 888-471-0117

- For a directory of participating providers: www.ousdhp.com

Managed Mental Health and Substance Abuse PPO Network & Utilization Review:

For Mental Health and Substance Abuse (Drug and Alcohol) Services

Quantum Health Solutions, Inc.
14 Park Lake Rd., Suite 2, Sparta, New Jersey 07871

- Contact Quantum Health Solutions, Inc. at: 888-214-4001
- For a directory of participating providers: www.ousdhp.com

Employee Assistance Program:

Corporate Services (EAP)
P.O. Box 87, Goshen, New York 10924

- Contact: Corporate Services (EAP) at: 800-962-7487

Pharmacy Benefit Manager of the Prescription Drug Program:

Caremark, Inc.
9501 E. Shea Blvd., Scottsdale, AZ 85260-6719

- Contact Caremark, Inc. at: 800-966-5772
- E-mail Caremark at: www.caremark.com
- Caremark drug formulary for “Preferred Brand Drugs” can be accessed at: www.caremark.com
- Mail Order: Forms and customer service can be obtained through www.caremark.com or call 800-966-5772
- Injectable Prescriptions (and supplies) are available at the Caremark Specialty Pharmacy which is available Monday through Friday (7:00 am – 6:00 pm Central Time) at 866-295-2779 (toll free)
- For drugs that require prior authorization, **have your physician call** Caremark at 888-413-2723