ORANGE - ULSTER
SCHOOL DISTRICTS
HEALTH PLAN

ORANGE-ULSTER SCHOOL DISTRICTS HEALTH PLAN

PLAN AND SUMMARY PLAN DESCRIPTION
JANUARY 1, 2019

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.

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SECTION 1
INTRODUCTION

Your Employer is providing health benefits to you through the self-funded Orange-Ulster School Districts Health Plan (also referred to as the "OU Plan" or "the 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 Central School District
Kiryas Joel Village School District
Monroe-Woodbury Central School District
Pine Bush Central School District
Rondout Valley Central School District
Valley Central School District
Washingtonville School District
Cornwall Central School District
Florida Union Free School District
Greenwood Lake Union Free School District
Highland Falls Central School District
Marlboro Central School District
Orange-Ulster BOCES
Port Jervis City 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.

Board of Trustees – Voting members of the Board of Directors.

Executive Director/Plan Administrator – The Plan Administrator is John Staiger, who can be reached at 4 Harriman Drive, Goshen, New York 10924. 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 Plan Administrator of the Plan (see above).

Plan Effective Date – This Restated Plan's Effective date was January 1, 2018.

Plan Year/Fiscal Year – Jan 1 through Dec 31.

Premium Rate Setting Period – Premiums are adjusted on an annual basis effective July 1st.

Plan Year; Fiscal Year; Calendar Year; Benefit Period – The Plan, Fiscal and Calendar years are January 1 through December 31.

Agent for Service of Process – Service of process may be made upon the Chairman of the Board of Directors, and/or the Plan Administrator, Orange-Ulster School Districts Health Plan, 4 Harriman Drive, Goshen, New York 10924.

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.

ACUTE: The onset of disease or injury, or a change in the covered person's condition that would require prompt medical attention.

ALLOWED AMOUNT: The maximum amount the Plan will pay for the services or supplies covered under this Plan, before any applicable Copayment, Deductible and Co-insurance amounts are subtracted. Allowed Amount is determined under the Plan as follows:

- The Allowed Amount for Participating Providers will be the amount negotiated between the PPO and the Participating Provider. Payments to Participating Providers may include financial incentives to help improve the quality or coordination of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to you. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

- The Allowed Amount for Non-Participating Providers will be determined based on the usually and customary (U&C) charges that represent the 90th percentile of the *Context 4 Healthcare* Usual and Customary profile. Determination whether or not a charge is U&C shall be made by the Board of Directors as administered by their Designated Administrator based on nationally obtained and recognized survey data or on data received from a nationally recognized insurer, consulting service or the gathering and publishing of such data which, as a major portion of its business, is involved in the adjudication of health care claims or gathering 2nd publishing of such data. If a Non-Participating Provider charges more than the Allowed Amount, you will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

AMBULATORY SURGICAL CENTER: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

BALANCE BILLING OR BALANCE BILLED CHARGES: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services, except for Plan Copayments, Co-insurance and Deductibles.

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.

CENTER OF EXCELLENCE - Centers of Excellence are available for specialty care and are intended to offer high-quality options with the expertise for specific needs. These providers demonstrate expertise in delivering quality specialty care – safely, effectively, and cost-efficiently. The goal is to help patients find both quality and value for their specialty care needs. Depending on the specific type of Center, these providers generally provide a range of services, demonstrate better quality care and improved patient outcomes, including lower complication rates and/or readmission rates for the services they provide.

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 *and* 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.

CO-INSURANCE: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

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.

CO-PAYMENT OR CO-PAY: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

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.

COST-SHARING: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Co-insurance.

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 excluded by the Plan, an expense not listed as a Covered Expense may still be excluded or limited 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, and otherwise not excluded or limited from benefits

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.

DEDUCTIBLE: The amount the covered person owes before the Plan begins to pay for Covered Services. The Deductible applies before any Copayments or Co-insurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that you owe before We begin to pay for a particular Covered Service.

DURABLE MEDICAL EQUIPMENT ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury;
- Is not disposable or non-durable; and
- Is exclusive for patient's use and appropriate for use in the home.

Durable Medical Equipment is provided for rental (but only up to the allowed purchase price) or purchase (if equal or less than rental cost) for standard model equipment.

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, with respect to a pregnant woman, the health of the woman or her unborn child 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.

EMERGENCY DEPARTMENT CARE: Emergency Services delivery by a Hospital emergency department.

EMERGENCY SERVICES: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta). NOTE: Use of Emergency Services for a condition which is not an Emergency Condition/Emergency may not be covered because the services may not be considered Medically Necessary.

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 districts or BOCES 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; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). For facilities outside of New York State,

a facility is one that is duly licensed by the applicable state agency responsible for licensing such facilities; the local or state licensing or registration must be in place from the resident state authorities. For treatment for substance use disorder received outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program. For facilities outside of New York State, a facility is duly licensed by the agency responsible for licensing such

GENE THERAPY – means therapy that involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or turning off genes that cause medical problems. To be covered under the Plan, the Gene Therapy must be approved by the FDA and intended to treat a specific disease. Gene Therapy covered under this Plan only includes Chimeric Antigen Receptor T-Cell (CAR-T) Therapy.

HEALTH PLAN REPRESENTATIVE – means an employee of your Employer's Benefit or Human Resources Department. Health Plan Representatives are available to assist you with eligibility, enrollment and general Plan questions.

HEALTH RESOURCES AND SERVICES ADMINISTRATION ("HRSA"), UNITED STATES PREVENTIVE SERVICE TASK FORCE ("USPSTF"), AND ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP): Health Reform (Affordable Care Act "ACA")regulations require that non-grandfathered plans coverage preventive services in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP").

- The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care for people who are geographically isolated, economically or medically vulnerable.

- The U.S. Preventive Services Task Force, (USPSTF), is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine.

- The Advisory Committee on Immunization Practices (ACIP) comprises medical and public health experts who develop recommendations on the use of vaccines in the civilian population of the United States. The recommendations stand as public health guidance for safe use of vaccines and related biological products.

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 sanatorium 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. Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

HOSPITALIZATION: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

HOSPITAL OUTPATIENT CARE: Care in a Hospital that usually does not require an overnight stay.

INTENSIVE OUTPATIENT PROGRAM (IOP): Treatment received in a structured therapeutic outpatient behavioral health environment with individual and/or group counseling treatment on a schedule that is typically no less than six hours per week. Certain intensive outpatient programs can be structured to allow an individual to be able to participate in their daily affairs, such as work or school, and then participate in IOP treatment program in the morning or at the end of the day.

The IOP is an outpatient program and does not include an overnight stay in a facility or an inpatient admission. An IOP may be appropriate for individuals who do not require medically-supervised inpatient treatment (including detoxification) and is an enhanced level of behavioral health support as compared to the standard outpatient visits that involve one 30/45/60 minute visit or two 30/45/60 minute visits per week to an outpatient behavioral health provider for counseling and/or medication management. Through a "step down" process, an IOP progressively transitions individuals to require less therapeutic support, to help the individual become more independent.

MANAGED BENEFITS COORDINATOR (MBC) – means a vendor performing utilization review for Medical and Hospital, Mental Health, Substance Abuse and Managed Physical Medicine. See Appendix A for list of vendor contracts.

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.

NON-PARTICIPATING/OUT-OF-NETWORK PROVIDER: A Provider who does not have a contract with the Plan's Preferred Provider Organizations (PPO) or Networks to provide services to Plan participants. You will pay more to see a Non-Participating Provider.

OFF-LABEL DRUG: Means drugs (pharmaceuticals) requiring a prescription that are not approved by the FDA for the condition, dose, route, duration and frequency for which they are prescribed. Such drugs are considered to be used "off-label". Off-Label drugs are not covered by the Plan except in limited circumstances as described in the Prescription Drug section of this Document.

OUT-OF-POCKET MAXIMUM: The most you pay during a calendar year in Cost-Sharing before the Plan begins to pay 100% of the Allowed Amount for Covered Services. This limit never includes any premium/Employee contributions, Balance Billing charges or the cost of health care services the Plan does not cover.

PARTIAL DAY CARE/ PARTIAL HOSPITALIZATION: Outpatient Hospital Care for treatment of mental, nervous, or emotional disorders and substance abuse at a Hospital for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period, and the care does not include an overnight stay in a hospital/facility.

PARTICIPATING/IN-NETWORK PROVIDER: A Provider who has a contract with the Plan's Participating Provider Organization (PPO) network to provide services to Plan participants. A list of Participating Providers and their locations is available on website (see Appendix A for contact information) or upon request. The list will be revised from time to time by the Plan's Network. You will pay higher out-of-pocket costs if you see a Non-Participating/Out-of-Network Provider as compared to a Participating/In-Network Provider.

PREAUTHORIZATION: A decision by the Plan prior to receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. A list of Covered Services that require Preauthorization is includes in Section 6.

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.

REHABILITATION SERVICES: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

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.

ROUTINE FOOT CARE: Includes but is not limited to hygienic cleaning of the feet with trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked foot skin, preventive care with assessment of pulses, skin condition and sensation.

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 an institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by us to meet the standards of any of these authorities. 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) – The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. See the Definition of Allowed Amount for information on how much this Plan pays providers.

URGENT CARE - Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered at an Urgent Care Center.

UTILIZATION REVIEW - The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

WE – As used in this document refers to the Orange-Ulster School Districts Health Plan or its Board of Director or any designee who performs services for the Plan on the Board of Director's behalf.

When referring to "you" in this Document, it is referring to the participant/Member.

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 Health Plan Representative.

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. Required documentation of eligibility is listed later in this section under "Documentation of Eligibility".

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 Health Plan Representative 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 **(if it is elected and premium payments are made)** as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) 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. **Only the Employee may elect such continuation coverage (on a self-pay basis)** 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 (as long as this provision exists under the Plan), 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 to either 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.)

Please note that these provisions are not vested and may be changed or eliminated by the Board of Directors.

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 natural 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). A pre-adoptive child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption. Eligibility ends the last day of the month in which] the child reaches his or her 26th birthday.

(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 Employee or covered spouse must provide at least 50% of the child's support for the child to be eligible for coverage.

(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.

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 as listed below.

Documentation of Eligibility.
The following documentation is required to show proof of dependent status:

(1) **Spouse:** copy of certified marriage certificate.
(2) **Child:** copy certified birth certificate showing biological child of employee.
(3) **Stepchild:** Certified birth certificate and marriage certificate between you (the employee) and child's parent.
(4) **Adoption or pre-adoptive child**: court order paper signed by the judge showing that employee has adopted or intends to adopt the child and copy of the certified birth certificate.
(5) **Other children who are supported by Employee or Spouse of Employee**. Certified birth certificate and proof that the child is claimed as a dependent for federal income tax purposes.
(6) **Disabled Dependent Child**: Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you

and/or your spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of dependent child including proof that the child is claimed as a dependent for federal income tax purposes.

(7) **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by a judge or a National Medical Support Notice.

The following additional documentation is required for all dependents:

- **Social Security Number and Information about Medicare Enrollment:** This information is required in order to comply with federal coordination of benefits regulations and certain IRS reporting rules. This information is requested upon enrollment but may also be requested at a later date.

- **Divorce Decree**: In any situation where there is a divorce or court order that establishes the order of payment or custody, you must provide a copy of the entire divorce decree.

- **Documentation about other Group Health Plan Coverage:** You are required to provide information about the existence of other coverage for yourself and/or any covered Dependents. **Claims will be denied if you fail to provide the required information about other coverage for you or any covered Dependents.**

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 New York State Young Adult Option explained below. In order to qualify for this option, the Employee must be covered under this plan.

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; 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 for Young Adult 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.

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 Coverage Ends under the Young Adult Coverage Option.

Coverage will end under this provision when one of the following occurs:

1. Coverage is terminated pursuant to the terms of the Plan.
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 During Period of Total Disability

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.

Leaves Under the Family Medical Leave Act

The Family Medical Leave Act, 29 USC §2601 et seq provides that if you work for an employer covered by that Act, you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own illness. If you are taking FMLA leave that has been approved by your employer, you and your employer are responsible any premiums/contributions for coverage, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

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. If you enroll for coverage before becoming eligible or within 30 days of becoming eligible, coverage begins on the date you become eligible and begin to pay any applicable premiums. If you do not elect coverage (or enroll your Dependents) when you are first eligible or within 30 days of becoming eligible, you must wait until the open enrollment period to enroll, except for special enrollment events as described below or if otherwise allowed by your Employer for late enrollment. If you request enrollment as a late enrollee, benefits will begin on the first day of the month

following late enrollment, or on the first day of the month following the Employer's waiting period, whichever is later.

Dependents (other than newborns). Employees may elect family (Dependent) coverage when (1) they are first eligible for coverage, (2) they acquire a Spouse or child who meets the definition of Dependent, or (3) they wish to enroll a previously eligible but un-enrolled Spouse or child who meets the definition of Dependent, e.g., late enrollment.

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 (except in the case of a newborn or adopted newborn as described below). Otherwise, family coverage will not begin until the first day of the second complete month following application.

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 or Adopted Newborn Coverage. If an Employee has family coverage, a newborn Dependent child or adopted newborn Dependent child will automatically become covered as a Dependent from the date of his birth. However, the newborn's or adopted newborn's eligibility for coverage will terminate 30 days after birth unless the Employer's Health Plan Representative has received enrollment materials by that date.

NOTE: An Employee MUST notify the Employer's Health Plan Representative as soon as possible, but no later than 30 days after birth to ensure the Dependent child's coverage continues beyond the initial automatic 30 day coverage period. If the child is not enrolled within 30 days of the birth, coverage will not begin until the first day of the second complete month following application.

An adopted newborn 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.

If the Employee does *not* have family coverage at the time of the newborn's birth or adoption of a newborn, the infant will be covered from the moment of birth if the Employee elects Dependent medical coverage and submits enrollment materials to the school district's Health Plan Representative no later than 30 days after the birth. The contribution payment, if any, 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 and Physician charges for routine nursery care. This coverage is provided for up to 30 days after birth, at which time the newborn Dependent child must be enrolled in Plan coverage.

Following Cessation of Other Coverage. If, you did not enroll in this Plan when first eligible because you had other health plan coverage (including other group health plan coverage, COBRA Continuation Coverage, certain types of individual health insurance, Medicare, Medicaid, or other public program) and you and/or any Dependents lose coverage under that other plan, you may request enrollment for yourself and/or your Dependents within 30 days after the termination of other coverage or termination of employer

contributions. If you enroll within 30 days, coverage begins retroactive to the date of the loss of other coverage.

When you are eligible for benefits under this Plan, you and your dependents may also enroll in this Plan if:):

- You (or your eligible Dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends.
- You (or your eligible Dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days.

If you enroll within 60 days, coverage begins retroactive to the date of the loss of Medicaid or eligibility for a premium assistance plan.

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 Health Plan coverage 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 Health Plan coverage 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.

Rescission of Coverage. If the Employee or the Employee's Dependent has performed an act that constitutes fraud or the Employee has made an intentional misrepresentation of material fact in writing on his or her enrollment or employment application, or in order to obtain coverage for a service, coverage will terminated immediately upon written notice of termination by the Plan. However, if the Employee makes an intentional misrepresentation of material fact in his or her enrollment material, the Plan will rescind coverage if the facts misrepresented would have led the Plan to refuse to enroll the individual(s). In such cases, the Plan will provide you with 30-days advanced notice. Coverage may also be rescinded if contributions or premiums (including COBRA premiums) are not timely paid. Failure to notify the Plan or Employer of a dependent's loss of dependent status (including divorce or a child losing eligibility) constitutes a failure to pay COBRA premiums and will result in a rescission of coverage back to the date of the event. In such cases advanced notice of the rescission is not required. Rescission means that the termination of your coverage will have a retroactive effect of up to one (1) year; however, retroactive premium adjustments will have a retroactive effect of up to three (3) months. If termination is a result of the Employee's action, coverage will terminate for the Employee and any Dependents. If termination is a result of the Dependent's action, coverage will terminated for the Dependent.

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 is **your** responsibility to notify your Health Plan Representative of enrollment changes; for example, you must notify your Health Plan Representative of the following:

1. Adding a newly acquired Spouse or Dependent child, including a Newborn 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 an obligation 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.
8. Changing your address, name or status.

Open Enrollment Period. You and your eligible Dependents may also enroll in the Plan during the Plan's "open enrollment" period that generally 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. ***Some school districts have a different Open Enrollment Period. Check with your Health Plan Representative to verify your Open Enrollment Period.***

SECTION 4
COBRA CONTINUATION COVERAGE AND TEMPORARY SUSPENSION RIGHTS DURING ACTIVE DUTY

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.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

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.

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.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions. Questions concerning COBRA continuation coverage rights under this Plan should be addressed to your Health Plan Representative. For general information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting this Plan, call the New York State Department of Financial Services at 1-800-342-3736 or write them at: New York State Department of Financial Services, Consumer Assistance Unit, One Commerce Plaza Albany, NY 12257, Website: www.dfs.ny.gov.

Temporary Suspension Rights During Active Duty

If You, the Member, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and

2. You serve no more than four (4) years of active duty.

Your coverage during active duty, coverage under this plan will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee,

member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Plan may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.

2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

SECTION 5
HOW YOUR COVERAGE WORKS AND CHOOSING A PROFESSIONAL PROVIDER

Once you are properly enrolled in the Plan, you and your covered Dependents are eligible for benefits described in this Plan Document. However, this Document is not a contract between you and the Plan. You should keep this Plan Document with your other important papers so that it is available for your future reference.

You will receive Covered Services under the terms and conditions of this Plan only when the Covered Services are:

- Medically Necessary;
- Provided by a Professional Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in this Document including the Summary of Medical Benefits and the Schedule of Benefits (See Section 7); and
- Received while you are covered by the Plan.

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*** or ***Participating 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*** or ***Non-Participating Providers***. You or your covered Dependents may choose either for your medical care. However, *your out-of-pocket costs will differ depending upon which provider you choose and will generally be lower when you choose an In-Network Provider.*

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 Cost-Sharing (including Deductibles, Co-Pay or Co-Insurance), is usually considered payment in full. To find out if a Provider is an In-Network Provider, and for details about licensure and training, you should check the Provider directory, which is available on the Plan's website or call the number on your ID card. (See Appendix A for contact information.) Sometimes Providers in the Provider directory are not available. Therefore, you should always call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

Choosing an Out-of-Network Provider.
If you choose or for some reason are required to obtain care or services from an Non-Participating/Out-of-Network Provider, you are responsible for any Cost-Sharing (including Deductibles, Co-Pay and Co-insurance) as well as any charges that exceed the Allowed Amount (which is sometimes called the U&C allowance). This means that Out-of-Network Providers may "balance bill" you the difference between what the Plan will pay and what they charge in addition to the Plan's Cost-Sharing amounts. Please keep in mind that the Plan offers as large a network as possible; however, it cannot guarantee that all Hospitals, Professional 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.

Protection from Surprise Bills

Surprise Bills. A surprise bill is a bill you receive for Covered Services in the following circumstances:

- For services performed by a Non-Participating Physician at a Participating Hospital or Ambulatory Surgical Center, when:
  - A Participating Physician is unavailable at the time the health care services are performed;
  - A Non-Participating Physician performs services without your knowledge; or

- Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a Participating Physician is available and you elected to receive services from a Non-Participating Physician.

- You were referred by a Participating Physician to a Non-Participating Provider without your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by the Plan. For a surprise bill, a referral to a Non-Participating Provider means:

  - Covered Services are performed by a Non-Participating Provider in the Participating Physician's office or practice during the same visit;
  - The Participating Physician sends a specimen taken from you in the Participating Physician's office to a Non-Participating laboratory or pathologist; or
  - For any other Covered Services performed by a Non-Participating Provider at the Participating Physician's request, when Referrals are required under this Plan.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed your In-Network Copayment, Deductible or Co-insurance if you assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill you for your In-Network Copayment, Deductible or Co-insurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov. You need to mail a copy of the assignment of benefits form to the Plan and to your Provider.

Independent Dispute Resolution (IDR) Process. Either the Plan or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether the Plan's payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

The IDR process only applies for services provided in New York. However, the IDR process may be able to apply to surprise bills for health care services provided by an out-of-state provider if the service is performed in part in New York and the out-of-state provider has a sufficient relationship with New York. For example, if a Covered Person has blood drawn in New York by his or her participating physician and the participating physician sends the sample to an out-of-state laboratory that regularly conducts business with the New York provider, the laboratory may be providing services in New York and subject to the IDR process.

Delivery of Covered Services Using Telemed

The Plan offers a Telemed option which is described in the Schedule of Benefits. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Document that are at least as favorable as those requirements for the same service when not delivered using telemed. "Telemed" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to you while your location is different than your Provider's location e.g., online using a computer, tablet or smart phone).

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 and to determine whether services are or were Medically Necessary or Experimental or Investigations. 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. The Managed Benefits Program includes all utilization review services. These reviews can take place prior to the service being performed (pre-certification), when the service is being performed (concurrent review) or after the service was performed (retrospective review). Make sure to review Sections 9 and 10 for additional information on the Managed Benefits Program as well as details on filing claims and appeals.

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 appropriate 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. There are three types of determinations are described below and include Pre-Certification Requirement, Notice Requirement and Pre-Determination Requirement.

Pre-Certification Requirement.
If you are going to receive any of the services described below, *you must call* the appropriate Managed Benefits Coordinator for pre-approval of care.

If you fail to notify the applicable Managed Benefits Coordinator (contact information can be found in Appendix A), you may be responsible to pay up to $500 of Covered Expenses, in addition to any other Cost-Sharing or other payment requirements. In addition, if a service is determined not to meet the Plan's definition of Medical Necessary or is otherwise not covered, it will be denied and your benefits may be significantly reduced or the service may be denied in its entirety.

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.)

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 prior to the beginning of home care or hospice visits.

3. **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.)

4. **Genetic Testing and Infertility.** If you are going to receive genetic testing or infertility services, you must notify the appropriate Managed Benefits Coordinator within 5 days prior to receiving the services.

5. **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 appropriate Managed Benefits 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; and spinal fusion.

6. **Gene Therapy/CAR-T Therapy**. You must contact the appropriate Managed Benefits Coordinator prior to receiving CAR-T Therapy in order to assess if the proposed therapy meets the strict FDA-approved indications for use of the therapy, would be considered Medically Necessary and will be covered by the Plan. ***No benefits will be provided for CART-Therapy if you do not contact the appropriate Managed Benefits Coordinator prior to receiving the therapy.***

7. **Surgery/Surgical Procedures.** If you are scheduled to have elective surgery, you must receive approval at least five working days *prior* to the scheduled surgery/surgical procedure. (Emergency, urgent, and maternity procedures do not require pre-approval; however, notification must be made within 48 hours after the surgery/procedure, or as soon as reasonably possible.)

8. **Treatment of Gender Dysphoria/Sex Reassignment Surgery.** You should contact the appropriate Managed Benefits Coordinator as soon as possible after the initial diagnosis to ensure that services are Medically Necessary and will be covered. In no case should notice be given less than 30 days prior to reassignment surgery.

9. **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 Managed Care Coordinator 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 or start of Partial Hospitalization Program (PHP). Many psychiatric and most substance abuse admissions or Partial Hospitalization Programs are planned and, therefore, require authorization prior to the admission or start of the Partial Hospitalization Program.
   - ***Emergency Hospital Admission:*** You must call within two (2) working days after an Emergency hospitalization begins, or as soon as reasonably possible thereafter. Either you, 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 including Intensive Outpatient Program (IOP).

Notice Requirement
If you are going to receive any of the services described below, you *should call* the appropriate Managed Medical Benefit Coordinator for pre-approval of care.

1. **Private Duty Nursing**
2. **Advanced Imaging (includes MRI/MRA, CAT Scans, PET Scans)**

Pre-Determination Requirement
If you are going to receive outpatient surgery or any other described below, *you should call* the Claims Administrator to ensure that the services or supplies are covered under the Plan and at what level benefits will be covered.

1. **Outpatient Surgery**
2. **Any services that you wish to have reviewed in order to obtain a determination whether the services would be covered by the Plan.**

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.

Mental Health and Substance Abuse

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Board of Directors has elected to exempt the Orange-Ulster School Districts Health Plan from the protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan. The exemption from these Federal requirements will be in effect for the each plan year beginning January 1st and ending December 31st of each year. The Plan will provide an annual notification each year prior to the start of the Plan year. It is the intent of the Board of Directors to renew the election each plan year until they decide otherwise. The Plan will comply with the New York State requirement known as "Timothy's Law" as described below.

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 Manager Care Coordinator.

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. 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 health/substance abuse services by providing enhanced benefit levels, or reduced out-of-pocket expenses to the patient through access to a Specialty Participating 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 are available by calling the Mental Health and Substance Abuse PPO Network listed in Appendix A.

> ***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."***

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 Managed Care. *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 in the Hospital and Medical Expense Benefit under "Managed Mental Health & Substance Abuse

Benefits" 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 Physical Medicine

Pre-Certification Assistance. Pre-certification and authorization for Physical Medicine treatment is a contractual responsibility between the Managed Benefits Coordinator for Managed Physical Medicine and Participating Providers. Members being treated by Participating Providers 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 Non-Participating Providers, the Covered Person is responsible for pre-certification of benefits**. Otherwise, you risk that treatment will not be paid when care is no longer considered 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 in the Hospital and Medical Expense Benefit under "Managed Physical Medicare Benefits" for details on charges that are the responsibility of the patient depending on where care is received.

SECTION 7
SUMMARY OF 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. Below is a summary of the Cost-Sharing provisions that apply to all Medical Benefits under the Plan for In- and Out-of-Network Benefits.

Out-of-Pocket Maximum

Under this Plan, there is an Out-of-Pocket Maximum which is the most you can pay before the Plan begins to pay 100% of Covered Expenses for the remainder of the calendar year. The Plan maintains a single Out-of-Pocket Maximum for both In-Network and Out-of-Network expenses which is listed in the Plan Cost-Sharing chart on the next page. Keep in mind that not all expenses accumulate toward the Out-of-Pocket Maximum and certain expenses will still be applicable even after you meet the Out-of-Pocket Maximum:

- The following expenses accumulated toward the Out-of-Pocket Maximum:
  - In-Network Cost-Sharing (which generally includes Co-Pays) on Essential Health Benefits;
  - Out-of-Network Deductible and Co-insurance; and
  - Cost-Sharing for In-Network Providers to whom Out-of-Network Charges apply (see the Medical Expense Benefits section for details on this provision) including Co-Pay, Co-insurance and Deductible amounts.

- The following expenses will NOT accumulated toward the Out-Pocket Maximum:
  - Penalties/Expenses resulting from failure to comply with the Managed Benefits Program requirements;
  - Expenses for services that are not covered by the Plan including services or supplies that are not considered Medically Necessary or are considered Investigational and/or Experimental; and
  - Charges from an Out-of-Network Provider that exceed the Plan's Allowed Amount (e.g., Balance Billed Charges).

- The following expenses will continue to apply even after the Out-of-Pocket Maximum has been met:
  - Penalties/Expenses resulting from failure to comply with the Managed Benefits Program requirements;
  - Expenses for services that are not covered by the Plan including for services or supplies that are not considered Medically Necessary or are considered Investigational and/or Experimental; and
  - Charges from an Out-of-Network Provider that exceed the Plan's Allowed Amount (e.g., Balance Billed Charges).

Plan Cost Sharing Provisions

PLAN /COST-SHARING PROVISION	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Calendar Year Deductible		
• *Hospital and Hospital Alternative Benefits Calendar Year Deductible (for Actives and Pre-Medicare Primary (PMP) Retirees)*	You are not required to pay a Deductible for Covered Expenses for Hospital and Hospital Alternative services and supplies	
• *Medical Expense Benefit Calendar Year Deductible (for Actives and Pre-Medicare Primary (PMP) Retirees)*	You are not required to pay a Deductible for In-Network Providers.	Individual: $1,000 Family: $3,000
• *Medicare Primary Retirees Calendar Year Deductible*	Not Applicable (No access to In-Network Benefits)	Individual: $300 Family: $800
Combined Out-of-Pocket (OOP) Maximum Annual Out-of-Pocket Maximum changes, per the Affordable Care Act (ACA) Out-of-Pocket Maximum (OOP) published allowances.	Includes all Cost-Sharing for In-Network benefits	Only includes Co-insurance amounts; does not include Deductible or Co-Pays or any expenses listed on the prior page
• *Out-of-Pocket Maximum Combined Medical and Prescription Drugs (See prior page for list of what counts towards this OOP Maximum)*	Individual: $7,150 Family: $14,300	
• *Medicare Primary Retirees Out-of-Pocket Maximum*	Not Applicable	Individual: $1,000 Family: $1,800
Other Cost-Sharing: Copayments (Co-Pays) and Co-Insurance • *Copayments*	You are generally required to pay a flat dollar amount (known as a Co-Payment or Co-Pay) for most In-Network and Out-of-Network services and supplies. Copayments vary depending on the type and place of service. Specific copayments are outlined in the Schedule of Benefits.	
• *Co-Insurance*	You are not required to pay Co-insurance for In-Network Providers.	You are generally required to pay a percentage of costs (known as Co-insurance) after the Co-Pay and Deductible for Out-of-Network services and supplies. Co-insurance can vary depending on the type and place of service but is generally 20% of the Plan's Allowed Amount. Specific Co-insurance levels are outlined in the Schedule of Benefits.
Lifetime maximum	Unlimited	

Hospital and Hospital-Alternative Benefits

The Schedule of Hospital and Hospital-Alternative Benefits starting below is an outline of the Cost-Sharing and 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.**

The Cost-Sharing applicable to In- and Out-of-Network *benefits* for inpatient Hospital and Hospital-alternative services are listed below in the Schedule of Hospital and Hospital-alternative services. Your *cost* for these services depends upon whether you choose an in-or an Out-of-Network provider as described in the Schedule. 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.

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 SCHEDULE OF BENEFITS		
Type of Service/Plan Benefit:	**In-Network Provider** What You Pay (Your Cost-Sharing) and what the Plan Pays:	**Out-of-Network Provider** What You Pay (Your Cost-Sharing) and What the Plan Pays:
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 Plan Pays 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.	$100 Co-Pay per admission, then the Plan pays 100% of Covered Charges	$500 Co-Pay per admission plus amounts over the Allowed Amount then the Plan pays 100% of the Allowed Amount for Covered Charges You are responsible for any balances over the Allowed Amount
BIRTHING CENTER **Call the Managed Benefits Coordinator prior to admission.**	The Plan pays 100% of Covered Charges	The Plan pays 100% of the Allowed Amount of Covered Charges You are responsible for any balances over the Allowed Amount

HOSPITAL AND HOSPITAL-ALTERNATIVE SCHEDULE OF BENEFITS		
Type of Service/Plan Benefit:	**In-Network Provider** What You Pay (Your Cost-Sharing) and what the Plan Pays:	**Out-of-Network Provider** What You Pay (Your Cost-Sharing) and What the Plan Pays:
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.**	$100 Co-Pay per admission, then the Plan pays 100% of Covered Charges up to 180 days per calendar year	$500 Co-Pay for each admission plus any amounts over the Allowed Amount for Covered Charges, then the Plan pays 100% of the Allowed Amount of Covered Charges for up to 180 days per calendar year You are responsible for any balances over the Allowed Amount
INPATIENT CARE IN A REHABILITATION FACILITY **Call the Managed Benefits Coordinator prior to admission to a rehabilitation facility.**	The Plan pays 100% of Covered Charges up to 100 days per calendar year	The Plan pays 100% of the Allowed Amount of Covered Charges up to 100 days per calendar year You are responsible for any balances over the Allowed Amount
HOME HEALTH CARE **Call the Managed Benefits Coordinator prior to beginning home health care services.**	The Plan pays 100% of Covered Charges up to 180 days per calendar year	The Plan pays 100% of the Allowed Amount of Covered Charges up to 180 days per calendar year You are responsible for any balances over the Allowed Amount
HOSPICE **Call the Managed Benefits Coordinator prior to beginning hospice services.**	The Plan pays 100% of Covered Charges	The Plan pays 100% of the Allowed Amount of Covered Charges You are responsible for any balances over the Allowed Amount

Hospital Outpatient Benefits. In addition to the benefits described in the preceding Schedule, the following Hospital Outpatient Services are also covered under the Plan as described below.

Hospital Outpatient Schedule Of Benefits		
Type of Service/Plan Benefit:	**In-Network Provider** What You Pay (Your Cost-Sharing) and what the Plan Pays:	**Out-of-Network Provider** What You Pay (Your Cost-Sharing) and What the Plan Pays:
EMERGENCY MEDICAL TREATMENT The Out-of-Network Deductible may be reduced if you are forced to utilize an Out-of-Network Professional 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.	$100 Co-Pay per visit, then the Plan pays 100% of Covered Charges (Co-Pay may be waived if the patient is admitted directly to the Hospital.)	$100 Co-Pay per visit, then the Plan pays 100% of the Allowed Amount for Covered Charges There may be other expenses, including those for Professional Providers. Expenses for Professional Providers are subject to the Out-of-Network Medical Expense Deductible (unless you are forced to utilize an Out-of-Network Professional Provider due to an Emergency). You are responsible for any balances over the Allowed Amount. The Allowed Amount for Emergency Medical Treatment is the greater of: **(1) Network Fee (if more than one amount is negotiated, the median of the amounts);** **(2) Allowed Amount for Emergency Services provided by an out-of-network provider; or** (3) **Medicare allowance**. (Co-Pay may be waived if the patient is admitted directly to the Hospital.)
DIAGNOSTIC X-RAYS AND LABORATORY TESTING, INCLUDING CERVICAL CYTOLOGY SCREENING IN AN OUTPATIENT HOSPITAL FACILITY	$50 Co-Pay per day, then the Plan pays 100% of Covered Charges The Co-Pay is not applied and expenses will be paid at 100% if they are for ACA Preventive Services as described in this Document.	$85 Co-Pay per day, then the Plan pays 100% of the Allowed Amount for Covered Charges You are responsible for any balances over the Allowed Amount

Hospital Outpatient Schedule Of Benefits		
Type of Service/Plan Benefit:	**In-Network Provider** What You Pay (Your Cost-Sharing) and what the Plan Pays:	**Out-of-Network Provider** What You Pay (Your Cost-Sharing) and What the Plan Pays:
PRE-ADMISSION TESTING IN AN OUTPATIENT HOSPITAL FACILITY	The Plan pays 100% of Covered Charges	The Plan pays 100% of the Allowed Amount for Covered Charges You are responsible for any balances over the Allowed Amount
PHYSICAL THERAPY IN AN OUTPATIENT HOSPITAL OR FREE-STANDING FACILITY	$50 Co-Pay per service, then the Plan pays 100% of Covered Charges	$85 Co-Pay per service, then the Plan pays 100% of the Allowed Amount for Covered Charges You are responsible for any balances over the Allowed Amount
OUTPATIENT HOSPITAL OR FREE-STANDING/AMBULATORY SURGICAL CARE FACILITY	The Plan pays 100% of Covered Charges	The Plan pays 100% of the Allowed Amount for Covered Charges You are responsible for any balances over the Allowed Amount
PARTIAL HOSPITALIZATION OR INTENSIVE OUTPATIENT TREATMENT IN AN OUTPATIENT HOSPITAL OR FREE-STANDING FACILITY FOR MENTAL HEALTH OR SUBSTANCE DISORDERS	See the "Hospital and Medical Expense Benefits" section for details about how this benefit is paid.	
HEMODIALYSIS, CHEMOTHERAPY OR RADIATION THERAPY IN AN OUTPATIENT HOSPITAL FACILITY	The Plan pays 100% of Covered Charges	The Plan pays 100% of the Allowed Amount for Covered Charges You are responsible for any balances over the Allowed Amount
ROUTINE (SCREENING) MAMMOGRAMS IN AN OUTPATIENT HOSPITAL FACILITY	The Plan pays 100% of Covered Charges	The Plan pays 100% of the Allowed Amount for Covered Charges You are responsible for any balances over the Allowed Amount

Medical Expense Benefits

If you have a medical expenses that are not covered as a Hospital, Hospital-alternative or Outpatient Hospital benefit, they may be covered as a Medical Expense Benefit. Examples of Medical Expense Benefits are services rendered by a Professional Provider for care and treatment as well as benefits provided by free-standing facilities (diagnostic services like x-rays and laboratory). Your Cost-Sharing for the Medical Expense Benefit is described in the Schedule of Medical Expense Benefits that begins on the next page. Make sure to refer to the Cost-Sharing Provision charge and Section 9 for a detailed description of how your Medical Expense Benefits are paid 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 specialty care, you will generally only be responsible for a Co-Pay (except where benefits are paid subject to Out-of-Network Cost-Sharing described on the next page) up to the annual Out-of-Pocket Maximum described in the Plan/Cost-Sharing Provisions Chart at the beginning of this section. To determine whether the Professional Provider you have contracted to be is an In-Network Provider, please refer to the Network directories (contact information can be found in Appendix A).

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 applicable Co-Pay, ***as well as*** annual Deductibles and Co-insurance payments as described in the Summary of Benefits Section of this document.

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 different if you have individual or family coverage. The amounts are outlined in the Plan/Cost-Sharing Provisions chart at the beginning of this Section. 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 in the form of Co-Insurance, up to the Out-of-Pocket Maximum which is listed in the Plan/Cost Sharing Provisions chart at the beginning of this section.

In-Network Providers to whom Out-of-Network Cost-Sharing Apply. A few benefits provided under this Plan do require that you pay the Out-of-Network Cost-Sharing even though the Professional Provider may actually be In-Network providers. The following benefits will be subject to Out-of-Network Cost-Sharing (Co-Pay, Deductibles, Co-insurance and out-of-pocket maximums), even if the provider is In-network or a Participating Provider: Home Infusion or Intravenous Services; Durable Medical Equipment and Supplies; Non-hospital Occupational Therapy; Speech Therapy; and all other Professional Providers eligible under the Plan but not specifically identified as In-Network Providers. If you are retired and Medicare is primary, your benefits will be subject to the provisions outlined in the "Medicare coordination of Benefits" in Section 13.

Schedule Of Medical Expense Benefits		
SERVICE CATEGORY	**IN-NETWORK PROVIDERS Your Cost-Share:**	**OUT-OF-NETWORK PROVIDERS Your Cost-Share**
Physician/Professional Provider Services • Office Visit • Inpatient Care • Surgery • Anesthesia *Services sent from a Provider's office to an independent lab, radiologist, or similar services provider incur an additional Co-Pay per service*	$25 Co-Pay	$25 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount
Urgent Care Facility	$35 Co-Pay	$45 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount
Empire Live Health Online *Telemed 24/7 by computer, tablet or smart phone – in lieu of medical office visit, ER or Urgent Care Facility*	$10 Co-Pay	N/A
Laboratory *Other than Quest*	$25 Co-Pay	$25 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount
Quest Laboratory	$5 Co-Pay	N/A
Free-standing/Independent Radiology (not hospital) *X-ray, MRI, CAT scan, PET scan*	$25 Co-Pay	$25 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount
Advanced imaging at US Imaging PPO Network (USI) requires notice to HCS	No Co-Pay	N/A
Maternity *Professional Provider/Physician Services (See the Hospital Schedule of Benefits for payment of Hospital Services including Nursery Care (Well-Baby))*	$25 Co-Pay (Co-Pay waived for ACA required preventive services)	$25 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount

Schedule Of Medical Expense Benefits		
SERVICE CATEGORY	**IN-NETWORK PROVIDERS Your Cost-Share:**	**OUT-OF-NETWORK PROVIDERS Your Cost-Share**
Physical Therapy and Chiropractic Benefit *Requires Pre-Certification, see Section 6* *Co-insurance after the 15th Out-of-Network visit does not count toward the Out-of-Pocket Maximum*	Managed Physical Medicine: $25 Co-Pay (up to scheduled amount)	• 1-15th visit: $25 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount (OH Rate) after the calendar year Deductible plus balances over Allowed Amount • 16th and subsequent visits: $25 Co-Pay and then you pay 50% (and the Plan pays 50%) of the Allowed Amount (OH Rate) after the calendar year Deductible plus balances over Allowed Amount
Home Infusion, IV Therapy; Durable Medical Equipment (rental up to purchase price) and Wigs following Chemotherapy *You are responsible for all Out-of-Network Cost-Sharing even though these providers may be In-Network.*	You pay 20% (and the Plan pays 80%) of the Allowed Amount after the calendar year (for Out-of-Network Providers, you will also be responsible for balances over Allowed Amount)	
Speech Therapy (non-Hospital)	$25 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount after the calendar year Deductible (for Out-of-Network Providers, you will also be responsible for balances over Allowed Amount)	
Mental Health Outpatient Professional Provider/Physician *(see the "Managed Mental Health & Substance Abuse Benefits" in the Hospital and Medical Expense Benefits Section of this document for details on how and when benefits are payable)*	Managed Mental Health PPO: $25 Co-Pay up to 100 days/calendar year	$25 Co-Pay and then you pay 50% (and the Plan pays 50%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount up to 30 visits per calendar year and 60 visits per lifetime

Schedule Of Medical Expense Benefits		
SERVICE CATEGORY	**IN-NETWORK PROVIDERS Your Cost-Share:**	**OUT-OF-NETWORK PROVIDERS Your Cost-Share**
Substance Abuse Outpatient Professional Provider/Physician	Managed Substance Abuse PPO: No Co-Pay up to 60 visits per calendar year, including 20 family visits	50% (and the Plan pays 50%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount up to 60 visits per calendar year, including 20 family visits.
WELLNESS BENEFITS: Preventive Care		
Adult Annual Physical Examinations	Covered in full	Not covered (only covered In-Network)
Adult Immunizations	Covered in full	Not covered (only covered In-Network)
Well Child Visits and Immunizations *Frequency schedule established by the American Academy of Pediatrics and Immunizations and Boosters as required by ACIP as adopted by New York State* *Age 21 through age 25*	Covered in full birth through age 21 Covered in full for one visit per calendar year	Plan pays 100% and you are responsible for any balances over the Allowed Amount; Deductible does not apply Only covered to age 19; Not covered over age 19
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer ***Mammography*** Age 35-39: One baseline mammography Age 40 and older: One per calendar year High Risk: Any age based on medical criteria	Covered in full	Deductible does not apply 100% of Allowed Amount (U&C) plus balances over Allowed amount
Routine Gynecological Services/Well Woman Exams* Two per calendar year including HPV immunization for 11-26 year olds	Covered in full	$25 Co-Pay plus balances over Allowed Amount; Deductible does not apply
Bone Density Testing	Covered in full	$25 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount
Family Planning and Reproductive (Contraception Services, Implant Devices, and Sterilization Procedures *)	Covered in full	$25 Co-Pay and then you pay 20% (and the Plan pays 80%) of the Allowed Amount (U&C) after the calendar year Deductible plus balances over Allowed Amount
Screening for Prostate Cancer Age 50 or older or 40 or older with family history	Covered in full as part of annual physical one per calendar year	Not covered
Colon Cancer (Colonoscopy) Age 50 or younger with family history	Covered in full one every 60 months	Not covered
Breast feeding consultation	100% of Plan's Allowance	$25 Co-Pay and then the Plan

Schedule Of Medical Expense Benefits		
SERVICE CATEGORY	**IN-NETWORK PROVIDERS Your Cost-Share:**	**OUT-OF-NETWORK PROVIDERS Your Cost-Share**
One per pregnancy and initial supplies only		pays 100% of the Allowed Amount (U&C); you pay balances over Allowed Amount
Breast pump equipment and supplies *One per pregnancy and initial supplies only*	100% of Plan's Allowance	100% of Allowed Amount (U&C);
All other preventive services required by the Affordable Care Act (ACA)	Covered in full	Not covered

SECTION 8
PRESCRIPTION DRUG BENEFITS

Orange Ulster Health Plan contracts with a prescription benefits manager (PBM) who administers the Prescription Drug benefit. See Appendix A for contact information.

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.

Prescription Drugs include the following

- Contraceptive drugs and devices or generic equivalents approved as substitutes by the FDA.
- Insulin and oral agents for controlling blood sugar and other diabetic supplies. (Please see Section 9 for additional details on diabetic supplies furnished through the **Medical Expense Benefit.)**
- Medically Necessary prescription or non-prescription enteral formulas whether administered orally or via tube feeding 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, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to a written order.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- 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 that do not by law require a prescription, except for insulin, smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), or as otherwise provided in this Document. The Plan does not cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. If an over-the-counter drug is payable under this provision, it must be prescribed by a Physician.
- 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. Note: This Plan contains a mandatory generic requirement meaning you must fill your Prescription Drugs with generics when available or your cost will be the applicable Co-Pay PLUS the difference in the cost of the brand minus the cost of the generic. For a list of preferred drugs (PDL), see the Pharmacy Benefit Manager's web site listed in Appendix A.

Using a Participating Pharmacy. The Plan's Pharmacy Benefit Manager offers a large retail prescription drug Network that includes national chains (e.g., CVS Stores, Walgreens, Wal-Mart and Rite Aid) and

many independent pharmacies. In order to receive a prescription from a Participating Pharmacy, all you need to do is present your prescription and your ID card and pay the necessary copayment. You will be entitled to up to a 34-day supply for up to 3-refills.

Using the Mail Order Pharmacy. When you require a 90-day supply of long term or maintenance drugs, you must use 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 required to order additional refills through the Mail Order Pharmacy. Drugs purchased from the Mail Order Pharmacy will be sent directly to your home, postage paid. Forms for the Mail Order Pharmacy are available from the Plan's Prescription Benefit Manager (see Appendix A for contact information).

You may also fill your prescription for Maintenance drugs for up to a 90-day supply at a CVS Pharmacy (also called a 'Designated Pharmacy') at the applicable Mail Order Copayment. To maximize your benefit, ask your Provider to write a script or refill for a 90-day supply and not a 30-day supply with three refills.

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.

Specialty Pharmacy. Specialty medications prescribed for a chronic or difficult health condition will only be available through the Specialty Pharmacy (see Appendix A for contact information). The Specialty Pharmacy offers you access to pharmacists and nurses who specialize in your condition will coordinate your care with you and your doctor and provide online support. All specialty medications are dispensed through CVS Caremark Specialty Pharmacy [or from designated CVS Pharmacies]. All specialty medications require prior authorization. See the subsection "Drugs that Require Prior Authorization". In addition, to find out if a medication you have been prescribed is a specialty medication and for prior approval, contact the Prescription Benefit Manager (see Appendix A for contact information).

The table below shows your Co-Pay for drugs, depending on the Tiered Status or 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 is Purchased	**Your Co-Payment Amount**		
	Generic Drugs (Tier 1)	***Preferred Drugs (Tier 2)***	***Non-Preferred Drugs (Tier 2)***
Retail Pharmacy *(34-day maximum supply)*	$5 Co-Payment per prescription	$35 Co-Payment per prescription	$60 Co-Payment per prescription
Mail Order Pharmacy *(90-day maximum supply)*	$10 Co-Payment per prescription	$70 Co-Payment per prescription	$120 Co-Payment per prescription
Out-of-Pocket Maximum See Section 7: Summary of Benefits for details on how this works	Combined Medical and Prescription Drug Maximum: Individual: $7,150 Family: $14,300		

Refills. The Plan covers refills of Prescription Drugs only when dispensed at a retail pharmacy or Mail Order Pharmacy as ordered by an authorized Provider and only after 75% of the original Prescription Drug has been used. Benefits for refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, the Plan will allow for the limited refilling of the

prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early refill of renewals. To the extent practicable, the quantity of eye drops in the early refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited refill is the amount that applies to each prescription or refill as set forth above in the Schedule of Prescription Drug Benefits.

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. Some of these drugs include those used to treat migraines, obesity, ADD, narcolepsy, arthritis and erectile dysfunction. The pharmacist will let your physician know if there are any authorization or limitation requirements on the prescribed drugs. For a list of Prescription Drugs that need Preauthorization, contact the Pharmacy Benefit Manager (see Appendix A for contact information) or call the number on your ID card. The list will be reviewed and updated from time to time. The Plan also reserves the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not covered under this Plan. Your Provider may check with the pharmacy benefits manager to find out which Prescription Drugs are covered.

Step Therapy. Step therapy is a process in which you may need to use one (1) or more types of Prescription Drugs before the Plan will cover another as Medically Necessary. A "step therapy protocol" means a policy, protocol or program that establishes the sequence in which the Plan will approve Prescription Drugs for your medical condition. When establishing a step therapy protocol, the Plan will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to your request for coverage of a Prescription Drug, you, your designee, or your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this

Tier Status. The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six (6) times per calendar year, based on periodic tiering decisions. These changes may occur without prior notice to you. However, if you have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug as described below) you will be notified. When such changes occur, your out-of-pocket expense may change. You may access the most up to date tier status by contacting the pharmacy benefits manager (whose contact information is listed in Appendix A) or call the number on your ID card.

When a Brand-Name Drug Becomes Available as a Generic Drug. When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, you will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned.

Formulary Exception Process. If a Prescription Drug is not on the Plan's Formulary, you, your designee or your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under the Plan's standard or expedited Formulary exception process, you are entitled to an external appeal as outlined in the External Appeal section of this Plan Document. See the Pharmacy Benefit Manager's web site listed in Appendix A or call the number on the back of your ID card to find out more about this process.

Standard Review of a Formulary Exception. The Plan will make a decision and notify you or your designee and the prescribing Health Care Professional no later than 72 hours after receipt of your request. If request is approved, Prescription Drug will be covered while you are taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception. If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment using a non-Formulary Prescription Drug, you may request an expedited review of a Formulary exception. A decision will be made and you or your designee and the prescribing Health Care Professional will be notified no later than 24 hours after receipt of your request. If the request is approved, the Prescription Drug will be covered while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the non-Formulary Prescription Drug.

Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment. If you have an Emergency Condition, you may immediately access, without Preauthorization, a five (5) day emergency supply of a covered Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. If you have a Copayment, it will be prorated. If you receive an additional supply of the Prescription Drug within the 30-day period in which you received the emergency supply, your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than your Co-Payment for a 30-day supply.

In this paragraph, "Emergency Condition" means a substance use disorder condition that manifests itself by acute symptoms of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Initial Limited Supply of Prescription Opioid Drugs. If you receive an initial limited prescription for a seven (7) day supply or less of any Schedule II, III, or IV opioid prescribed for acute pain, and you have a Copayment, your Copayment will be prorated. If you receive an additional supply of the Prescription Drug within the 30-day period in which you received the seven (7) day supply, your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than your Copayment for a 30-day supply.

Cost-Sharing for Orally-Administered Anti-Cancer Drugs. Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to you as the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Plan Document.

Information about Medicare Part D Prescription Drug Plans for Active Employees and Dependents with Medicare

Medicare prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans (also called Part D) provide for at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium

If you or your dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D prescription drug coverage. This Plan offers "Creditable Coverage," which means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard Medicare prescription drug benefit will. Because this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you are eligible for Plan coverage and you will

not pay a late enrollment penalty to Medicare if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. When you leave this Plan, you may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. For more information about creditable coverage see the Orange-Ulster School District Health Plan Notice of Creditable Coverage or call the Plan Office (contact information can be found in Appendix A).

Prescription Drugs for Medicare-Eligibility Retirees and Medicare-Eligibility Dependents of Retirees

Retirees and their dependents who are eligible for Medicare are eligible for the SilverScript (Employer PDP) Program. This Program is considered a Part D Employer Group Waiver Plan and provides both basic Medicare Part D benefits and supplemental prescription drug benefits. Be aware that in order to be eligible to join SilverScript (Employer PDP), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in SilverScript service area (which includes the entire United States and its territories). This benefit is described in separate documents which you will receive from this Plan as well as SilverScript. Please be sure to read the information carefully as it contains important information including eligibility requirements, enrollment and deadlines.

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 for the Schedule of Benefits that describe your Cost-Sharing responsibilities).

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 Behavioral Health conditions or Substance Use Disorders.

Hospital services. The Plan covers Hospital services for acute care or treatment given or ordered by a Professional Provider for an illness, injury or disease of a severity that must be treated on an inpatient basis, including:.

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to you;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

Observation services. The Plan covers observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge you. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

Inpatient Medical services. The Plan covers medical visits by a Health Care Professional on any day of covered inpatient care under the Medical Expense Benefit.

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.

The Plan does not cover 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 radios, television and telephone or beauty or barber services;
- Medications, supplies, and equipment you take home from the hospital;
- Custodial care; and
- Any charges incurred after the Plan advises you it is no longer Medically Necessary for you to receive inpatient care unless overturned by and External Appeal Agent.

Remember to contact the Medical Managed Benefits Coordinator prior to planned Hospital admissions or immediately following Emergency admissions.

Inpatient Stay for Maternity Care. The Plan covers inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The Plan will also cover any additional days of such care that are determined to be Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, the Plan will cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Coverage of this home care visit will be in addition to home health care visits under this Plan and will not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Plan Document that apply to home care benefits.

Inpatient Stay for Mastectomy Care. The Plan covers inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by you and your attending Physician.

Autologous Blood Banking Services. The Plan covers autologous blood banking services only when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, the Plan covers storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

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 listed above 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 Medical 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 inpatient Rehabilitation Services (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. The Plan covers physical therapy, speech therapy and occupational therapy. The visit limit applies to all therapies combined.

Remember to contact the Medical 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 Home Health Agency;
- medical supplies, prescription drugs and medication prescribed by a physician, and laboratory services by or on behalf of the Home Health 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 Medical 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 Medical Managed Benefits Coordinator prior to beginning Hospice Care services.

Outpatient Care in a Hospital-based Facility

Charges for the following outpatient Hospital services are covered as described in the Schedule of Benefits, 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 (Emergency Services)**. The Plan covers Emergency Services for treatment of an Emergency condition. (See Definition of Emergency Medical Treatment/Emergency Treatment in Section 2.) Coverage of Emergency Services for treatment of your emergency Condition will be provided regardless of whether the Provider is a Participating Provider. However, only those Emergency Services and supplies that are Medically Necessary and are preformed to treat or stabilize your Emergency Condition in a Hospital will be covered.

Hospital Emergency Room/Department Visits. In the event of an emergency where you require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department of call 911. Emergency Department care does not require Pre-Authorization. However, you should remember that only Emergency Services for the treatment of an Emergency Condition are covered in an emergency department/room of a Hospital. If you are uncertain whether a Hospital Emergency Room is the most appropriate place to receive care, you can call the Medical Managed Benefits Coordinator 24-hours, 7-days a week. The Plan does not cover follow-up care or routine care provided in a Hospital emergency department.

Remember, in the event that you are admitted to the Hospital, you or someone on your behalf must notify the Managed Care Coordinator within 48 hours of your admission, or as soon as is reasonably possible.

(2) **Surgery, Inhalation Therapy, Pulmonary Rehabilitation, Infusion Therapy, Cardiac Rehabilitation, Chemotherapy and Radiation Therapy**. The Plan pays for outpatient hospital charges (Facility charges excluding Physician charges) related to the performance of a surgical operation, inhalation therapy, pulmonary rehabilitation, infusion therapy, cardiac rehabilitation, 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 Condition/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. The Plan 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, the Plan 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. Coverage for air ambulance related to an Emergency Condition is provided when your medical condition is such that transportation by land ambulance is not appropriate, you medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance and one for the following is met: (1) the point of pick-up is inaccessible by land vehicle; or (2) great distances or other obstacles (e.g., heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.
C. Transportation between facilities when Medically Necessary and not just for the convenience of the patient or the Professional Provider.

Air ambulance transportation requires approval from the Medical Managed Benefits Coordinator 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. **Effective July 1, 2019, the Plan Benefits will require a $70 co-payment for in-network ambulance services. Out-of-network ambulance services will require a $70 co-payment plus the amount above the Plan's Reasonable and Customary Allowance.** 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. An ambulance service may not charge or seek reimbursement from you for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Co-insurance. In the absence of negotiate rates, the Plan will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which will not be excessive or unreasonable.

The Plan does not cover any other travel or transportation expense excepted as described above. Non-ambulance transportation such as ambulate, van or taxi cab is not covered by the Plan.

Second Medical Opinions. The Plan covers second surgical opinion by a qualified Physician on the need for surgery.

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.

Preventive Care

The Plan covers the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Co-insurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services and for Out-of-Network Providers and some services may not be covered if you use an Our-of-Network Provider. Please refer to the *Scheduled of Medical Expenses Benefit* for details about how benefits are paid. In addition, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. See the Schedule of Medical Benefits for a description of the Cost-Sharing provisions for Preventive Care including if and how benefits are payable for Out-of-Network providers. You may contact the Plan's Claims Administrator for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

- **Well-Woman Examinations.** The Plan covers well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. The Plan also covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on the Plan's website (see Appendix A) or will be mailed to you upon request. This benefit is not subject to Copayments, Deductibles or Co-insurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider. If services are performed by an Out-of-Network provider office Co-Pays will apply.)

- **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** The Plan pays for 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 Co-Pay, Deductible or Co-insurance will be applied. In no event will more than one (1) preventive screening per Plan Year be covered. The Plan also covers additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs

- **Osteoporosis (Bone Mineral Density Measurement and Testing).** The Plan pays for bone mineral density testing, as well as drugs and devices approved by the FDA or generic equivalents as approved substitutes to treat 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.

The Plan also covers bone mineral density measurements or tests, and prescription drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

- **Screening for Prostate Cancer (PSA Testing).** The Plan pays In-Network benefits for annual standard diagnostic examination screening for prostate cancer including but not limited to, a digital rectal exam and prostate-specific antigen (PSA) test for asymptomatic men age 50 and older and men age 40 and over who have a family history of prostate cancer, or other prostate cancer risk factors. The Plan also covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer. This benefit is paid In-Network only at 100% not subject to any Cost-Sharing. There is no benefit payable if you utilize 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; benefits are paid at 100% with no Cost-Sharing. There is no benefit payable if you utilized an Out-of-Network provider.

- **Adult Wellness Benefits.** In addition to the benefits described, in this section, the Plan covers adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and adult immunizations as recommended by American Academy of Family Physicians (ACIP) including shingles vaccine where appropriate. Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available from the Claims Administrator (see Appendix A for contact information).

  You are eligible for a physical examination once every calendar year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions. This benefit is not subject to Copayments, Deductibles or Co-insurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF or when provided in accordance with the recommendations of ACIP when provided by a an In-Network Provider only.

- **Well Child Care.** The Plan pays for well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan also covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per calendar year, the Plan will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also covered.

- **Family Planning and Reproductive Health.** The Plan covers family planning services which consist of FDA-approved contraceptive methods prescribed by a Professional Provider, not otherwise Covered under the Prescription Drug Coverage benefits of this Plan, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Co-insurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by an In-Network Provider. The Plan pays Covered Charges for voluntary sterilization, including Professional Provider and Hospital charges. It does not pay for reversal of voluntary sterilization.

Maternity Care

The Plan pays for inpatient Hospital or hospital-alternative care (birthing center) 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 covers one breast pump at no cost sharing for female members any time during their pregnancy or following delivery. Standard manual breast pump models are covered for purchase at 100%, up to the Plan's Allowed Amount. Hospital grade pumps are available as rentals when medically necessary, and are covered up to the purchase price of the hospital grade breast pump. Initial breast pump supplies are covered with no cost share to the members. Ongoing supplies and ancillary items, such as replacement tubing, nursing bras, or creams are not covered. If a member purchases a non-standard or "deluxe" model breast pump that exceeds the Plan's reimbursement for the devise, that is considered medically necessary, provider may balance bill the member for the additional cost above the Plan's Allowed Amount. The Plan also provides coverage for complications of pregnancy and for anesthesia during delivery.

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. However, the Plan will not pay for duplicative routine services provided by both a midwife and a Physician.

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.

Physician Medical Services are health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates as listed in this section and the Scheduled of Medical Benefits. Services which are not Medically Necessary or considered excessive by the Medical Management Program Coordinator(s) will not be covered.

Services for surgical procedures, include operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

Sometimes two (2) or more surgical procedures can be performed during the same operation. 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 Foot 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, manual hospital beds, Pap and C-Pap equipment 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 electric 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 that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. The Plan does not cover wigs.

- 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 or necessary due to congenital disease or anomaly, 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 (limited to two per calendar year);
- Blood glucose monitors for the visually impaired (limited to two per calendar year);
- 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.

  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.

The Plan covers services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction as follows.

Basic Infertility Services. Services will be provided to a Covered Person who is an appropriate candidate for infertility treatment. In order to determine eligibility, the Plan will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Covered Individuals must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services.

Basic infertility services include:
- Initial evaluation;
- Semen analysis;
- Laboratory evaluation;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

Comprehensive Infertility Services. If the basic infertility services do not result in increased fertility, the Plan will cover comprehensive infertility services which include:

- Ovulation induction and monitoring;
- Pelvic ultra sound;
- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

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.

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

- Advanced Reproductive Technology (ART) including but not limited to in-vitro fertilization, gamete intrafallopian tube transfers (GIFT), zygote intrafallopian tube transfers (ZIFT), intracytoplasmic sperm injection (ICIS), assisted hatching, or microsurgical sperm aspiration and extraction procedures, including microsurgical epididymis sperm aspiration (MESA);
- Costs for an ovum donor or donor sperm;
- Sperm, egg and/or inseminated egg procurement and processing or banking/storage costs of sperm or inseminated eggs;
- Cryopreservation and storage of embryos;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless denial is overturned by an External Appeal Agent.
- Medical expenses or any other charges in connection with surrogacy (of a person not covered under the Plan).
- Psychological evaluations and counseling.

Other exclusions and limitations that apply to this benefit are included under Limitations and Exclusions section of the Plan.

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 non-Experimental organ or tissue transplant, **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 an Organ and Tissue 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 the Medical Managed Benefits Coordinator whose contact information can be found in Appendix A.**

- 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 any Plan day or visit limit maximums.

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 Mental Health and Substance Abuse 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.

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Board of Directors has elected to exempt the Orange-Ulster School Districts Health Plan from the protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan. The exemption from these Federal requirements will be in effect for the each plan year beginning January 1st and ending December 31st of each year. The Plan will provide an annual notification each year prior to the start of the Plan year. It is the intent of the Board of Directors to renew the election each Plan year until they decide otherwise. The Plan will comply with the New York State requirement known as "Timothy's Law" as described below.

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 Benefits Coordinator.

> ***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 and Partial Hospitalization (PHP) Mental Health Care Pre-Certified Two (2) days of Partial Hospitalization (PHP) are equal to one day of inpatient Hospitalization	$100 Co-Pay per admission, then the Plan pays 100% of Covered Charges up to 100 days per calendar year (no Hospital Co-Pay applies)	You pay 50%. The Plan pays 50% of Allowed Amount (U&C) to 30 days per calendar year (after the $500 Out-of-Network Hospital Co-Pay).
Inpatient and Partial Hospitalization (PHP) Mental Health Care Not Pre-Certified	Out-of-Network benefit level applies.	You pay 50%. The Plan pays 50% of U&C to 30 days per calendar year (after the $500 Out-of-Network Hospital Co-Pay).
Outpatient Mental Health Care Professional Provider Pre-Certified	100%, after $25 per visit Co-Pay, as indicated.	The Plan pays 50% of Allowed Amount (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 Professional Provider Not Pre-Certified	Out-of-Network benefit level applies.	The Plan pays 50% of Allowed Amount (U&C), after $15 per visit Co-Pay, up to 30 visits per calendar year (after the $300 Out-of-Network Deductible).
Intensive Outpatient (IOP) Mental Health Care Pre-Certified	100%	The Plan pays 50% of Allowed Amount (U&C), after $15 per visit Co-Pay, up to 30 visits per calendar year (after the $300 Out-of-Network Deductible).
Intensive Outpatient (IOP) Mental Health Care Not Pre-Certified	Out-of-Network benefit level applies.	The Plan pays 50% of Allowed Amount (U&C), after $15 per visit Co-Pay, up to 30 visits per calendar year (after the $300 Out-of-Network Deductible).
Outpatient (Professional and Intensive Outpatient (IOP)) Mental Health Calendar Year Maximum Combined Counts (Network & Out-of-Network)	100 visits: Pre-Certified only.	30 visits

Lifetime Outpatient (Professional and Intensive Outpatient (IOP)) Mental Health Maximum Combined Counts (Network & Out-of-Network)	Unlimited: Pre-Certified only	60 visits
Inpatient Substance Abuse and Partial Hospitalization (PHP) Pre-Certified	100% of Covered Charges (no Deductible). Limit of 4 weeks per period of confinement and 6 weeks per calendar year. Two (2) days of Partial Hospitalization (PHP) are equal to one day of inpatient Hospitalization	50% of Covered Charges after the $500 Out-of-Network Hospital Co-Pay. Limit of 4 weeks per period of confinement and 6 weeks per calendar year.
Inpatient Substance Abuse and Partial Hospitalization (PHP) Not Pre-Certified	100% of Covered Charges (no Deductible). Limit of 4 weeks per period of confinement and 6 weeks per calendar year. Two (2) days of Partial Hospitalization (PHP) are equal to one day of inpatient Hospitalization	50% of Covered Charges after the $500 Out-of-Network Hospital Co-Pay. Limit of 4 weeks per period of confinement and 6 weeks per calendar year.
Outpatient Substance Abuse (both Professional and Intensive Outpatient (IOP))	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

Autism Spectrum Disorder.

The Plan covers the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by the Plan to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

- **Screening and Diagnosis.** The Plan covers assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- **Assistive Communication Devices.** The Plan covers a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if you are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. The Plan will only cover devices that generally are not useful to a person in the absence of a communication impairment. The Plan does not cover items, such as, but not limited to, laptop, desktop or tablet computers. The Plan covers software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. The Plan will determine whether the device should be purchased or rented.

The Plan covers repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in your physical condition. The Plan does not cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. The Plan does not cover delivery or service charges or routine maintenance.

- **Behavioral Health Treatment.** The Plan covers counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. The Plan covers applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

- **Psychiatric and Psychological Care.** The Plan covers direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

- **Therapeutic Care.** The Plan covers therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise covered under this Plan. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Plan.

- **Pharmacy Care.** The Plan covers Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Plan.

- **Limitations.** The Plan does not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Plan for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Co-insurance provisions under this Plan for similar services. For example, any Copayment, Deductible or Co-insurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Co-insurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. The same Cost-Sharing requirements that apply to other Mental Health services are applicable to applied behavior analysis services. Assistive communication devices are covered under Durable Medical Equipment subject to those Cost-Sharing requirements.

Nothing in this Plan shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

Mental Health Care Services

Inpatient Services. The Plan covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders.

Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health; and in other states, to similarly licensed or certified Facilities.

The Plan also covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

Outpatient Services. The Plan covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist; or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage. The Plan does not cover:

- Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
- Services solely because they are ordered by a court.

Substance Use Services

Inpatient Services. The Plan covers inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes Coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

The Plan also covers inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and Part 817; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

Outpatient Services. The Plan covers outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

The Plan also covers up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same Plan that covers the person receiving, or in need of, treatment for substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

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 Managed Physical Benefit Coordinator (whose contact information can be found in Appendix A) to have services reviewed in order to obtain the highest available network benefit.

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 Allowed Amount.

To receive the maximum Out-of-Network benefits available, the patient should contact the Managed Physical Benefits Coordinator 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 Managed Physical Benefits Coordinator 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 the Managed Physical Benefit Coordinator and the network providers. Members being treated by an In-Network Provider do not need to arrange for pre-

certification. Professional 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	**$25 patient Co-Pay** Per office visit (no Deductible).	$25 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 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 $25 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 Allowed Amount 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

Telemedicine Program

In addition to providing Covered Services via telehealth, the Plan covers online internet consultations between you and Providers who participate in the telemedicine program for medical conditions that are not an Emergency Condition. Only certain Providers participate in the telemedicine program. You will be assigned one of the doctors on duty when using the telemedicine program "Life Health Online".

The telemedicine program is called LiveHealth Online and enables you to video chat with a physician using you mobile phone, tablet or computer to receive care and treatment of certain medical conditions. If the LiveHealth Online writes you a prescription during your visit, the applicable prescription Plan Co-Pay will apply. In order to utilize the LiveHealth Online, you will need to register. You may also register your enrolled Spouse and Children. If you enrolled child is under the age of 18, a parent or guardian must participate in the session. You can find contact information in Appendix A.

Keep in mind that not only a ceratin non-Emergency conditions can be treated via telemedicine. If you require Emergency Care, you should contact your physician or go to the emergency room.

The telemedicine program is limited to non-Emergency Care such as:

- Cold and flu symptoms (e.g., cough, fever, congestion or headache);
- Allergies;
- Sinus infections; and
- Similar routine non-emergency ailments.

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

Utilization Review

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:

Pre-Certification Process

All requests for pre-certification of Hospital admissions or other services are reviewed to determine Medical Necessity (including the appropriate standard of care and 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.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. The Managed Benefits Program does not compensate or provide financial incentives to its employees or reviewers for determining that services are not Medically Necessary. It has developed guidelines and protocols to assist in this process.

For substance use disorder treatment, the Coordinator will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for your review upon request. For more information, see Appendix A for contact information. 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.

A. Preauthorization Reviews

1. **Non-Urgent Preauthorization Reviews.** If the Coordinator has all the information necessary to make a determination regarding a Preauthorization review, they will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three (3) business days of receipt of the request. If the Managed Benefits Coordinator needs additional information, the Coordinator will request it within three (3) business days. You or your Provider will

then have 45 calendar days to submit the information. If the requested information is received within 45 days, the Coordinator will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three (3) business days of receipt of the information. If all necessary information is not received within 45 days, a determination will be made within 15 calendar days of the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if the Managed Benefits Coordinator has all information necessary to make a determination, the Coordinator will make a determination and provide notice to you (or your designee) and your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If additional information is needed, it will be requested it within 24 hours. You or your Provider will then have 48 hours to submit the information. The Coordinator will make a determination and provide notice to you (or your designee) and your Provider by telephone and in writing within 48 hours of the earlier of receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of receipt of the information or three (3) calendar days after the verbal notification.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if you (or your designee) certify, in a format prescribed by the Superintendent of Financial Services, that you will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, the Coordinator will make a determination and provide notice to you (or your designee) and your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

B. Concurrent review process.

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. 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 at paragraph 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 beginning on the next page).

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If the Coordinator needs additional information, it will be requested within one (1) business day. You or your Provider will then have 45 calendar days to submit the information. The Coordinator will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within one (1) business day of receipt of the information or, if they do not receive the information, within 15 calendar days/one (1) business day of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, the Coordinator will make a determination and provide notice to you (or your designee) and your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and the Coordinator has all the information necessary to make a determination, the Coordinator will make a determination and

provide written notice to you (or your designee) and your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If the Coordinator needs additional information, it will be requested within 24 hours. You or your Provider will then have 48 hours to submit the information. The Coordinator will make a determination and provide written notice to you (or your designee) and your Provider within the earlier of one (1) business day or 48 hours of receipt of the information or, if they do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews**. After receiving a request for coverage of home care services following an inpatient Hospital admission, the Managed Benefits Coordinator will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, the Coordinator will make a determination and provide notice to you (or your designee) and your Provider within 72 hours of receipt of the necessary information. When the Coordinator receives a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, coverage for home care services will not be denied while the decision on the request is pending.

4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to the Managed Benefits Coordinator at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, the Coordinator will make a determination within 24 hours of receipt of the request and provide coverage for the inpatient substance use disorder treatment while the determination is pending.

5. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a Participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OASAS-certified Facility notifies the Managed Benefits Coordinator of both the admission and the initial treatment plan within 48 hours of the admission. After the first 14 days of the inpatient admission, the Managed Benefits Coordinator may review the entire stay to determine whether it is Medically Necessary and will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, you are only responsible for the In-Network Cost-Sharing that would otherwise apply to your inpatient admission.

C. Retrospective review process.

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.

If the Coordinator has all information necessary to make a determination regarding a retrospective claim, 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. If additional information is needed, it will be requested within 30 calendar days. You or your Provider will then have 45 calendar days to provide the information. The Coordinator will make a determination and provide notice to you and your Provider in writing within 15 calendar days of the earlier of receipt of the information or the end of the 45-day period.

Once all the information to make a decision has been received, a failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

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. Retrospective Review of Preauthorized Services.

The Plan or the Managed Care Coordinator may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented upon retrospective review existed at the time of the Preauthorization but was withheld or not made available;
- The Coordinator was not aware of the existence of such information at the time of the Preauthorization review; and
- Had the Coordinator been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

E. Step Therapy Override Determinations

You, your designee, or your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for you and your medical condition.

1. **Supporting Rationale and Documentation**. A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to you;
   - The required Prescription Drug(s) is expected to be ineffective based on your known clinical history, condition, and Prescription Drug regimen;
   - You have tried the required Prescription Drug(s) while covered by Us or under your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
   - You are stable on a Prescription Drug(s) selected by your Health Care Professional for your medical condition, provided this does not prevent Us from requiring you to try an AB-rated generic equivalent; or
   - The required Prescription Drug(s) is not in your best interest because it will likely cause a significant barrier to your adherence to or compliance with your plan of care, will likely worsen a comorbid condition, or will likely decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review**. We will make a step therapy protocol override determination and provide notification to you (or your designee) and where appropriate, your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

3. **Expedited Review**. If you have a medical condition that places your health in serious jeopardy without the Prescription Drug prescribed by your Health Care Professional, We will make a step therapy protocol override determination and provide notification to you (or your designee) and your Health Care Professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to you (or your designee) and your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to you (or your designee) and your Health Care Professional] within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to you (or your designee) and your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to you (or your designee) and your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

F. Reconsideration.

If the Plan or the Managed Care Coordinator did not attempt to consult with your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your Provider, by telephone and in writing.

How Do I Appeal A Managed Decision I Disagree With?

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 180 days from the date that you receive notice of the adverse determination. To request a Level One Internal Appeal, contact the applicable Managed Care Coordinator (contact information can be found in Appendix A). Your request for an internal Appeal will be acknowledged within 15 calendar days of receipt. This acknowledgment will, if necessary, inform you of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

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.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an Out-of-Network health service when a determination is made that the Out-of-Network health service is not materially different from an available In-Network health service. A denial of an

Out-of-Network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an Out-of-Network health service, you or your designee must submit:

- A written statement from your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested Out-of-Network health service is materially different from the alternate health service available from a Participating Provider that was approved to treat your condition; and

- Two (2) documents from the available medical and scientific evidence that the Out-of-Network service: 1) is likely to be more clinically beneficial to you than the alternate In-Network service; and 2) that the adverse risk of the Out-of-Network service would likely not be substantially increased over the In-Network health service.

2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when it is determined that the Plan has a Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an Out-of-Network authorization denial, you or your designee must submit a written statement from your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition:

   - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet your particular health care needs for the health care service; and

   - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

Standard Level One Internal Appeal.

1. **Preauthorization Appeal.** If your Appeal relates to a Preauthorization request, the Clinical Care Reviewer/Managed Care Coordinator will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If your Appeal relates to a retrospective claim, the Clinical Care Reviewer/Managed Care Coordinator will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Level One Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to you (or your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request. If you are not

satisfied with the resolution of your expedited Appeal, you may file a standard internal Appeal or an external appeal.

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. Failure to render a determination of your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission was denied, and you or your Provider file an expedited internal Appeal of the adverse determination, the clinical peer reviewer will decide the Appeal within 24 hours of receipt of the Appeal request. If you or your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of the adverse determination, coverage will be provided for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

Level Two Internal Appeals.

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 the Externa Appeal section that starts on the next page). The Level Two internal appeal must be received by us within 60 business days from the date of the final adverse determination on the Level One Internal Appeal. 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. Your case will be reviewed by at least one clinical peer reviewer who did not make the prior determinations.

You or your designee can also file an external appeal. **The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for you to file an external appeal.**

1. **Preauthorization Appeal.** If your Appeal relates to a Preauthorization request, the Appeal will be decided within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If your Appeal relates to a retrospective claim, the Appeal will be decided within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** If your Appeal relates to an urgent matter, the Appel will be decided and written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within the lesser of two (2) business days or 72 hours of receipt of the Appeal request.

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.

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.

In addition, if you need assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

External Review

A. Your Right to an External Appeal.

In some cases, you have a right to an external appeal of a denial of coverage. If the Plan has denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an Out-of-Network treatment, you or your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal you must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Plan; and
- In general, you must have received a final adverse determination through the first level of the Plan's internal Appeal process. However, you can file an external appeal even though you have not received a final adverse determination through the first level of the Plan's internal Appeal process if:

  - The Plan agrees in writing to waive the internal Appeal. The plan is not required to agree to your request to waive the internal Appeal; or
  - You file an external appeal at the same time as you apply for an expedited internal Appeal; or
  - The Plan fails to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond its control and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary

If the Plan has denied coverage on the basis that the service is not Medically Necessary, you may appeal to an External Appeal Agent if you meet the requirements for an external appeal as described above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.

If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two (2) requirements for an external appeal described above and your attending Physician must certify that your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which you are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.

If the Plan has denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, you may appeal to an External Appeal Agent if you meet the two (2) requirements for an external appeal in paragraph "A" above, and you have requested Preauthorization for the Out-of-Network treatment.

In addition, your attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate In-Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-Network health service.

For purposes of this section, your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat you for the health service.

E. Your Right to Appeal an Out-of-Network Authorization Denial to a Non-Participating Provider.

If coverage has been denied because of a request for an authorization to a Non-Participating Provider because it was determined that the Plan has a Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service, you may appeal to an External Appeal Agent if you meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, your attending Physician must: 1) certify that the Participating Provider recommended does not have the appropriate training and experience to meet your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

For purposes of this section, your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat you for the health service.

F. Your Right to Appeal a Formulary Exception Denial.

If the Plan has denied your request for coverage of a non-formulary Prescription Drug through the formulary exception process, you, your designee or the prescribing Health Care Professional may appeal

the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Plan Document for more information on the formulary exception process.

G. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If you are filing an external appeal based on the Plan's or the Managed Care Coordinator's failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

You will be provided with an external appeal application with the final adverse determination issued through the first level of the internal Appeal process or a written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with your external appeal request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which the Plan based the denial, the External Appeal Agent will share this information with the Plan in order for it to exercise the right to reconsider the decision. If the Plan chooses to exercise this right, it will have three (3) business days to amend or confirm the decision. Please note that in the case of an expedited external appeal (described below), the Plan does not have a right to reconsider the decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your Physician, or the Plan. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending Physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care or continued stay, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must notify you and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns the decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an Out-of-Network treatment, the Plan will provide coverage subject to the other terms and conditions of this Plan. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the cost of services required to provide treatment to you according to the design of the trial. The Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this Plan for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both you and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

The Plan will charge you a fee of $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. The Plan will waive the fee if it determines that paying the fee would be a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to you.

H. Your Responsibilities.
It is your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal Appeal, or failure to adhere to claim processing requirements. The Plan has no authority to extend this deadline.

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:

Aviation. We do not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline

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.

Conversion Therapy. We do not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

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, the Plan will provide benefits for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. The Plan 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.

The Plan does not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Plan for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

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 the Plan's (or its designee) 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, the Plan (or its designees) may, in our discretion, require that any or all of the following five criteria be met:

i. 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.

ii. 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

iii. 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.

iv. 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.

v. 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.

Felony Participation. We do not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).

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. Benefits for genetic testing are generally excluded. However, benefits may be provided under the diagnostic testing provision of this Plan if all the following requirements are met:

a. The testing is recommended by a Physician because family history indicates the patient is at risk to develop a hereditary disease; and

b. There are treatment options available that could reduce the risk that the patient will develop the hereditary disease; and
c. Approval for the testing is obtained from the Managed Benefits Coordinator prior to the proposed testing.
d. Genetic Testing required as part of the ACA Preventive benefits are covered in accordance with preventive benefits guidelines.

Gene Therapy. Benefits for Gene Therapy are excluded except for Chimeric Antigen Receptor T-Cell Therapy (CAR-T) as specifically described in this Document.

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 do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.

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 or Supplies that are NOT Determined to be Medically Necessary. In general, We will not cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns our denial, however, We will cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise covered under the terms of this Plan.

Services Provided by a Family Member. We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of you or your Spouse.

Services Separately Billed by Hospital Employees. We do not cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge. We do not cover services for which no charge is normally made.

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 Medical Managed Benefits Coordinator (see Appendix A for contact information).

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 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. The Plan 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 appropriate Managed Care Coordinator before receiving any services in order to assure 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 medical or surgical treatment for weight-related disorders including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, dietary/weight loss programs, dietary instructions, skin reduction procedures/treatment and any complications thereof, except bariatric surgery in cases of morbid obesity (a weight of at least 100 pounds more than normal body weight for the patient's age, gender, height and body frame based on Body Mass Index BMI weight tables generally used by Physicians to determine normal body weight). This exclusion does not apply to the extent that it constitutes screening and counseling for obesity or otherwise qualifies as Preventive Services as required by the ACA.

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, is strictly at the cost of the EAP patient.

In order to receive maximum benefits for services provided by other health care professionals to whom you are referred (such as psychologists, therapists, social workers, counselors, etc.), you must select an In-Network provider from the Managed Mental Health and Substance Abuse PPO Network of health care providers (Appendix A). If expenses are incurred Out-of-Network, calendar year Deductibles, Co-insurance and Co-Pays will apply. The EAP benefit is only 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 one whose benefits must be determined without taking the existence of any other plan into consideration and is the one that pays its benefits first. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).The secondary plan is one which is not a primary plan and the plan that pays second. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

When this is the case and you receive a service which would be covered by two or more plans, We will coordinate benefit payments with any payment made under the other plan. One plan will pay its full benefit as the primary plan. The other plan 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) The plan of the parent with custody of the child will be primary;
    (2) If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third;
    (3) If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

- 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.

     If you are eligible for Medicare only because of permanent kidney failure, Medicare coverage will end:
     - 12 months after the month you stop dialysis treatments.
     - 36 months after the month you have a kidney transplant.

     Medicare coverage will resume again if:
     - You start dialysis again, or you get a kidney transplant within 12 months after the month you stooped getting dialysis.
     - You start dialysis or get another kidney transplant within 36 months after the month you get a kidney transplant.

Payment of Benefits When Medicare is Secondary

- **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.***

Coordination with Medicaid.

The Plan shall comply with the following:

1. The payment of benefits with respect to a covered Employee shall be made in accordance with any assignment of rights made by or on behalf of such Covered Person under the Medicaid laws of any state;

2. The enrollment of and provision of benefits to a covered Employee shall be made without regard to the covered Employee's eligibility for Medicaid under the laws of any state; and

3. To the extent that payment has been made under the Medicaid laws of any state in a case where the Plan has legal liability for such payments, payment of benefits under the Plan shall be made in accordance with any state law which provides that such state has acquired the rights of the Covered Person to such payment

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.

Plan's Right of Recovery in Third-Party Actions / Subrogation

Payment Condition. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have the equitable first lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a Copaymentee any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable"' fund from which the plan may seek reimbursement.

Subrogation. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, the automatic equitable first lien attaches in favor of the Plan to any claim, which any Covered Person{s) may have against any Coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have the equitable first lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of

rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien. reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft.

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf

Excess Insurance. If at the time of Injury, sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds. Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the-Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable first lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.
The following exist separately from the property and estate of a Covered Person:

1. Benefits paid by the Plan;

2. Funds recovered by the Covered Person; or

3. Funds held in trust over which the Plan has an equitable lien.

As such, neither the death of a Covered Person, nor the filing of bankruptcy by a Covered Person, will affect the Plan's equitable lien (funds over which the Plan has a lien) or the Plan's right to subrogation and reimbursement.

SECTION 14
ASSIGNMENT OF PROCEEDS
AND MISCELLANEOUS PLAN PROVISIONS

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 Board of Directors/Trustees, 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 direction of the Board of Directors/Trustees and this Plan Document.

Fraud and Abusive Billing. We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Right to Develop Guidelines and Administrative Rules. We may develop or adopt standards that describe in more detail when We will or will not make payments under this Plan. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Plan Document. If you have a question about the standards that apply to a particular benefit, you may contact us and We will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this Plan.

We review and evaluate new technology according to technology evaluation criteria developed by the Managed Medical Program's medical directors and reviewed by a designated committee, which consists of Health Care Professionals from various medical specialties. Conclusions of the committee are incorporated into medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

Right to Offset. If We make a claim payment to you or on your behalf in error or you owe the Plan any money, you must repay the amount you owe. Except as otherwise required by law, if the Plan owes you

a payment for other claims received, it has the right to subtract any amount you owe the Plan from any payment the Plan owes you.

Right to Hold Claims/Coverage in Abeyance. If We request information instrumental in determining a person's or claimant's eligibility for coverage, claims will not be processed until requested documents are received. This applies to all requests made by your Employer, the Plan Administrator or the Plan's Claims Administrator(s). Such requests include, but are not limited to:

- Requests for information about or documentation of other health plan coverage/insurance;
- Documents of marriage, divorce, or any other life even status changes; and/or
- Personal data requests for Plan Administration, such as social security numbers, Medicare number, date of birth, address and/or other demographic information that may be necessary to administer the Plan in accordance with this Plan Document.

SECTION 15
CLAIMS DETERMINATIONS AND GRIEVANCE/APPEAL PROCEDURES FOR NON-MANAGED CARE BENEFITS

Claim Determinations.

Claims. A claim is a request that benefits or services be provided or paid according to the terms of this Plan. When you receive services from an In-Network provider, you will not need to submit a claim form. However, if you receive services from an Out-of-Network provider, either you or the provider must file a claim form with the Plan. If the Out-of-network provider is not willing to file the claim form, you will need to file it. See the Coordination of Benefits section of this document for information on how the Plan coordinates benefit payments when you also have group health coverage with another plan.

Notice of Claim. Claims for services must include all information designated by the Claims Administrator as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available by contacting the Plan's administrator(s) (see Appendix A for contact information in addition for information on sending electronic claims) or the number on your ID card. Completed claim forms should be sent to the Claims Administrator (see Appendix A for contact information or you can find the address on your ID card.

Timeframe for Filing Claims. Claims for services must be submitted for payment within 15 months after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 15-month period, you must submit it as soon as reasonably possible. In no event, except in the absence of legal capacity, may a claim be filed more than one 15 months from the time the claim was incurred.

Claims for Prohibited Referrals. The Plan is not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

Claim Determinations. Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, the claim determination procedure applies to contractual benefit denials. If you disagree with the claim determination, you may submit a Grievance pursuant to the Grievance Procedures described later in this Section.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Document.

Pre-Service Claim Determinations. A pre-service claim is a request that a service or treatment be approved before it has been received. If all the information necessary is available to make a determination regarding a pre-service claim (e.g., a covered benefit determination), the determination will be made and you (or your designee) will be provided with notice within 15 days from receipt of the claim.

If additional information is needed, it will be requested within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If the information is received within 45 days, a determination will be made and you (or your designee) will be provided with notice in writing, within 15 days of receipt of the information. If all necessary information is not received within 45 days, the determination will be made within 15 calendar days of the end of the 45-day period.

Urgent Pre-Service Reviews. With respect to urgent pre-service requests, if all information necessary to make a determination has been received, the determination will be made and you (or your designee) will be provided with notice by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If additional information is needed, it will be requested within 24 hours. You will then have 48 hours to submit the information. A determination will be made and notice will be provided to you (or your designee) by telephone within 48 hours of the earlier of receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

Post-Service Claim Determinations. A post-service claim is a request for a service or treatment that you have already received. If all the information necessary has been received to make a determination regarding a post-service claim, a determination will be made and you (or your designee) will be notified within 30 calendar days of the receipt of the claim. If additional information is needed, it will be requested within 30 calendar days. You will then have 45 calendar days to provide the information. A determination will be made and notice will be provided to you (or your designee) in writing within 15 calendar days of the earlier of receipt of the information or the end of the 45-day period.

Payment of Claims. Where the obligation to pay a claim is reasonably clear, the claim will be paid within 30 days of receipt of the claim. If additional information is requested, the claim will be paid within 30 days of receipt of the information.

Grievance Procedures

Grievances. Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by the Plan. For example, it applies to contractual benefit denials or issues or concerns you have regarding administrative policies or access to Providers.

Filing a Grievance. When you receive a denial 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 applicable section from the Plan booklet pertaining to the coverage denied with the claims processing representative.

If the inquiry fails to resolve your claim problems, you may begin the appeal process described on the next page. You can contact the Plan's Claims Administrators by phone or in writing to file a Grievance. See the Appendix A for contact information. You or your designee has up to 180 calendar days from when you received the decision you are asking the Plan to review to file the Grievance. When the applicable Claims Administrator receives your Grievance, they will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your Grievance, and indicate what additional information, if any, must be provided. All requests and discussions will be kept confidential and the Plan will take no discriminatory action because of your issue. There is a process for both standard and expedited Grievances, depending on the nature of your inquiry.

Grievance Determination. Qualified personnel will review your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. The Grievance will be decided and you will be notified within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of your Grievance. Written notice will be provided within 72 hours of receipt of your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of your Grievance.

Grievance Appeal Procedures

If you are not satisfied with the resolution of your Grievance, you or your designee may file an Appeal by following the process outlined below. **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: If your grievance 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 as well as any appeal's determinations.

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 2: a. The Employee may request that the Local School District Health Plan Representative submit the matter to the Appeals Committee for review (or the Employee may submit the request directly to the Appeals Committee (see Appendix A for contact information)). This Appeal must be presented within 180 days from the claim denial (or final written action by the Claims Administrator which is the cause of the appeal), or within 180 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. When We receive your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will indicate what additional information, if any, must be provided.

d. 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, due to special circumstances, 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 provide a written response within 120 days.*

*** Steps 2 a, and b 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 3: 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.

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

b. 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.

Assistance. If you remain dissatisfied with the Appeal determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If you need assistance filing a Grievance or Appeal, you may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Provision Requiring all Appeal Options be exercised before a suit against the Plan can be brought. In no event can the Plan be sued before all applicable appeal's remedies are exercised and in no event more than 2 years after the claim was denied in whole or in part.

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 (PHI)" as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), 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 term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form. PHI does not include health information contained in employment records held by any School District who participates in this Plan in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which is distributed to you upon enrollment in the Plan and is also available from the Plan Administrator. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, the Plan Sponsor and the Board of Directors will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law.

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

Treatment. Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes

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. These include, but are not limited to, the following activities:

a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and
c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

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 (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating or related functions to create, renew or replace health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- 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, quality assessment, and patient safety activities;
- 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 will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan. 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.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;
2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;
3. Not use or disclose the information for employment-related actions and decisions;
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of PHI disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

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. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization.
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. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the Plan Administrator and staff designated by the Board of Trustees and Business Associates under contract to the Plan (see Appendix A for a list of the Plan's Business Associates) may be given access to use and disclosure PHI. These persons may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer (contact information can be found in Section 1).

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.

In compliance with HIPAA Security regulations, the Plan Sponsor:

1. Maintains administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensures that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensures that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Will Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

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 {DATE, 2018}:

By: Deborah Hepner
Trustees – Orange Ulster School Districts Health Plan

Title: CHAIRWOMAN

Date: 5-1-19

Witness: _____

Date: _____

APPENDIX A

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

Claims Administrator for 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

Managed Care Benefit Coordinators

- **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, Home Health Care, Durable Medical Equipment over $500, Infertility, services for Sexual Dysfunction and CAR-T review. Contact them prior to receiving any of these services.

- **Managed Physical Benefits Coordinated for Chiropractic, Physical Therapy and Occupational Therapy Services Utilization Review:**
  Optum Health Network
  701 Grant Ave., Suite 200, Lake Katrine, NY 12449
  - Contact Optum Health: 888-471-0117

- **Managed Benefits Coordinator for Mental Health and Substance Abuse (Drug and Alcohol) Utilization Review:**

  Quantum Health Solutions, Inc.

  - Contact Quantum Health Solutions, Inc. at: 888-214-4001

Preferred Provider Organizations (PPO Networks)

- **Hospital and Medical/Surgical PPO Networks:**

  New York State
  Empire Blue Cross and Blue Shield (An Anthem Affiliate)
  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 Benefits Coordinator for Mental Health and Substance Abuse PPO Network & Utilization Review**

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

- **Quest**

- **USI**

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:

CVS Caremark