ALLEGANY – CATTARAUGUS SCHOOLS

HEALTH PLAN

PLAN DOCUMENT

EFFECTIVE

JANUARY 1, 2010

AS RESTATED

EFFECTIVE

OCTOBER 1, 2016

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 Financial Services. Municipal corporations participating in the Municipal Cooperative Health Benefit Plan are subject to contingent assessment liability.

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SCHEDULE OF MEDICAL BENEFITS – POS 298, CLASS 0001			
	In-Network	**Out-of-Network**	**Limitations and Explanations**
Co-pay	$10	Not applicable	
Individual Deductible	Not applicable	$250	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	Not applicable	$500	
Coinsurance	0%	20%	Coinsurance is your share of the costs of a covered service, calculated as a percent of the *allowed amount* for the service.
Individual Maximum Out-Of-Pocket Amount	$5,000	$2,000	Includes co-pays, deductible and coinsurance. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the Out-of-Pocket Amount.
Family Maximum Out-Of-Pocket Amount	$10,000	$4,000	
√ A visit co-pay applies to any Physician supervised treatment encounter unless stated otherwise. √ Co-pay applies per provider, per day unless stated otherwise. √ Maximums are combined for In-Network and Out-of-Network services. √ Out-of-Network claims are considered based on the Fee Schedule, except where noted otherwise. √ Out-of-Area Out-of-Network claims are considered based on the Host Plan Fee Schedule.			

POS Plan	Your Cost for In-Network Providers	Your Cost for Out-of-Network Providers	Limitations and Explanations
Accidental Dental –Facility	$10 co-pay	No Charge	Limited to treatment of sound and natural teeth within 12 months of the injury. Prior authorization is required.
Accidental Dental - Physician	$10 co-pay	20%*	
Allergy Testing and Injections	$10 co-pay	20%*	The co-pay is waived for the allergy serum.
Ambulance – Ground / Air	$50 co-pay	$50 co-pay	Prior authorization is required for air transport.
Anesthesia	No charge	20%*	Non participating services are paid at 100% when related services are in-network.
Applied Behavioral Analysis for Autism	$10 co-pay	20%*	Prior authorization is required.
Artificial Insemination	$10 co-pay	20%*	
Assistive Communication Devices (ACD) for Autism	$10 co-pay	20%*	Prior authorization is required.
Cardiac Rehabilitation	$10 co-pay	20%*	Limited to 24 visits in a 12 week period.
Cast Room	No charge	No charge	
Chemotherapy / Radiation Therapy	$10 co-pay	20%*	
Chiropractic Care	$10 co-pay	20%*	
Diabetic Education	No charge	20%*	
Diabetic Equipment and Supplies	$10 co-pay per item	20%*	
Diagnostic PAP Smear	No charge	20%*	
Diagnostic Mammogram	$10 co-pay	20%*	
* Deductible applies.			

POS Plan	Your Cost for In-Network Providers	Your Cost for Out-of-Network Providers	Limitations and Explanations
Diagnostic Laboratory Services – Outpatient	No charge	20%*	Routine services are not covered Out-of-Network.
Diagnostic MRI / MRA	$10 co-pay	20%*	Out-of-Network benefits are limited to Out-of-Area providers. Prior authorization is required for participating providers.
Diagnostic X-ray	$10 co-pay	20%*	
Dialysis	No charge	20%*	
Durable Medical Equipment	20%	50%*	Prior authorization is required for some equipment.
EEG	$10 co-pay	20%*	Limited to one out-of-network test per calendar year (reduced by the number of in-network tests). Routine benefits are not available out-of-network.
EKG	$10 co-pay	20%*	Limited to two out-of-network test per calendar year (reduced by the number of in-network tests). Routine benefits are not available out-of-network.
False Labor	No charge	No Charge	
Hearing Examination	$10 co-pay	20%*	
Hemophilia Center	$10 co-pay	20%*	
Home Health Care	$10 co-pay	20%*	Out-of-Network services are limited to 365 visits per calendar year (reduced by the number of In-Network visits). Early maternity discharge home care is not subject to deductibles, co-insurance or co-pay.
Home Care – Respiratory Therapy	No charge	Not covered	
Hospice Care	No charge	20%*	Limited to 210 days per calendar year and 5 additional bereavement visits.
Hospital - Emergency Room	$50 co-pay	$50 co-pay	The co-pay is waived if the patient is admitted.
Hospital - Inpatient Acute Physical Rehabilitation Facility	No charge	20%*	Prior Authorization is required.
* Deductible applies.			

POS Plan	Your Cost for In-Network Providers	Your Cost for Out-of-Network Providers	Limitations and Explanations
Hospital – Inpatient Substance Abuse Detoxification	No charge	20%*	Prior Authorization is required.
Hospital – Inpatient Substance Abuse Rehabilitation	No charge	20%*	Prior Authorization is required.
Hospital – Inpatient Treatment of Mental/ Nervous Conditions	No charge	20%*	Prior Authorization is required.
Hospital – Inpatient Treatment Of Other Covered Conditions	No charge	20%*	Prior Authorization is required.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	$10 co-pay	20%*	Prior Authorization is required for certain procedures.
Hospital – Urgent Care Facility	$10 co-pay	20%*	
Hospital – All Other Outpatient Services	No charge	20%*	
Infusion Therapy – Home	No charge	20%*	Prior authorization is required.
Infusion Therapy – All Other	$10 co-pay	20%*	
* Deductible applies.			

POS Plan	Your Cost for In-Network Providers	Your Cost for Out-of-Network Providers	Limitations and Explanations
Injectable Medications – Non-self Administer	$10 co-pay	20%*	The co-pay applies when billed alone.
Observation/ Acuity Evaluation	No charge	No charge	
Orthotics/ External Prosthetics	20%	Not covered	Prior authorization is required.
Outpatient Therapy – Mental/ Nervous	$10 co-pay	20%*	Prior authorization is required. Applicable to individual therapy sessions and electroshock therapy sessions.
Outpatient Therapy – Substance Abuse/ Substance Abuse Codependence	$10 co-pay	20%*	Prior authorization is required.
Physician Visit-Emergency Room	No charge	No charge	
Physician Visit-Office / Clinic / Home	$10 co-pay	20%*	The co-pay is waived for members under age 19.
Physician Visit-Inpatient	No charge	20%*	Out-of-Network consultations are limited to two visits per hospital stay. Out-of-Network inpatient visits are limited to one per day per condition. Non participating services are paid at 100% when related services are in-network.
Physician Visit – Skilled Nursing Facility	$10 co-pay	20%*	
Physician – Critical Care	No charge	20%*	Non participating services are paid at 100% when related services are in-network.
Physician – Observation Room	No charge	No charge	
Physician – Inpatient Surgeon	No charge	20%*	Non participating services are paid at 100% when related services are in-network.
* Deductible applies.			

POS Plan	Your Cost for In-Network Providers	Your Cost for Out-of-Network Providers	Limitations and Explanations
Physician – Hospital or Free-Standing Surgical Center Surgeon	No charge	20%*	Services rendered in a participating facility will be reimbursed at the participating provider benefit level regardless of whether the provider is a participating provider.
Physician – Office Surgeon	$10 co-pay	20%*	
Physician – Assistant Surgeon	No charge	20%*	Non participating services are paid at 100% when related services are in-network.
Physician – Electroshock	No charge	20%*	Includes anesthesiologists and other physicians.
Podiatry Services – Office Visit	$10 co-pay	20%*	Routine services are not covered.
Podiatry Services – Surgery	$10 co-pay	20%*	Co-pay applies to office surgery only.
Post-Mastectomy External Prosthetic	No charge	20%*	Limited to one per affected breast in any two calendar years.
Post-Mastectomy Surgical Bra	20%	50%*	Limited to four per calendar year.
Pre-Admission Testing	No charge	20%*	
Rehabilitative Therapy - Physical / Occupational/ Speech	$10 co-pay	20%*	Limited to an aggregate of 20 visits per calendar year.
Sleep Studies	$10 co-pay	20%*	
Skilled Nursing Facility	No charge	20%*	Prior authorization is required.
TMJ	$10 co-pay	20%*	
Transfusion	$10 co-pay	20%*	
* Deductible applies.			

Preventive Care			
Well Child Visits and Immunizations	No charge	20%*	
Adult Annual Physical Examinations	No charge	Not covered	Includes lab work ordered as part of a routine physical. Limited to one examination per year.
Adult Immunizations	No charge	Not covered	
Routine Gynecological Services/ Well Woman Examinations	No charge	20%*	Lab work ordered as part of a routine gynecological examination is not covered out-of-network. Examinations are limited to 2 per year. Pap smear is limited to 1 per year.
Mammography Screenings	No charge	20%*	Limited to 1 baseline age 35-39; annual age 40+; additionally: 1 mammogram per year for individual, any age, having a prior history of breast cancer or a 1st degree relative with prior history of breast cancer.
Sterilization Procedures for Women	No charge	20%*	
Bone Density Testing	No charge	20%*	
Screening For Prostate Cancer – Primary Care Physician	No charge	Not covered	
Screening For Prostate Cancer- Specialist	No charge	Not covered	
*Deductible applies.			

Preventive Care			
All Other Preventive Services	No charge	20%*	Includes all mandated preventive testing as required under the Patient Protection and Affordable Care Act (PPACA). The following services are not covered Out-of-Network: Bacteriuria screening (lab), chlamydial infection screening (lab), cholesterol abnormalities screening (lab), Congenital hypothyroidism screening (Lab), diabetes screening (lab), Gonorrhea: screening (Lab), Sickle cell, screening (Lab), Hepatitis B screening (Lab,) HIV screening (Lab), Iron deficiency anemia screening (Lab), PKU screening (Lab), Rh incompatibility screening (Lab), Vision - Routine Eye Exam (Well) (Office visit).
*Deductible applies.			

SCHEDULE OF MEDICAL BENEFITS, Indemnity 998, Classes 0T01, 0T02 and 0T03			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
Individual Deductible	N/A	Class 0T01 -$50 Class 0T02 - $100 Class 0T03 - $250	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	N/A	Class 0T01 - $100 Class 0T02 - $200 Class 0T03 - $500	
Coinsurance	0%	20%	Coinsurance is your share of the costs of a covered service, calculated as a percent of the *allowed amount* for the service.
Individual Maximum Out-Of-Pocket Amount - Participating Providers	$5,000		Includes co-pays, deductible and coinsurance. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount - Participating Providers	$10,000		
Individual Maximum Out-Of-Pocket Amount – Major Medical	N/A	$400	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount- Major Medical	N/A	N/A	

Basic Benefit					
Indemnity 998 Classes 0T01, 0T02, 0T03	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	20%*	
Ambulance	No charge	No charge	No charge	20%*	Basic benefit pays a maximum of $250. The balance is covered under Major Medical.
Anesthesia	No charge	No charge	No charge	N/A	
Applied Behavioral Analysis (ABA) for Autism	$10 co-pay	N/A	N/A	20%*	
Artificial Insemination – Outpatient Facility	No charge	No charge	20%	N/A	
Artificial Insemination – Physician	No charge	No charge	No charge	N/A	
Assistive Communication Device (ACD) for Autism	No charge	No charge	No charge	N/A	
Cardiac Rehabilitation	N/A	N/A	N/A	20%*	
Chemotherapy	No charge	No charge	No charge	N/A	
Chiropractic Care – Chiropractor	$10 co-pay	N/A	N/A	20%*	
Chiropractic Care – Physician	$10 co-pay	N/A	N/A	20%*	
Diabetic Education	N/A	N/A	N/A	20%*	
Diabetic Equipment & Supplies	N/A	N/A	N/A	20%*	
*Deductible applies.					

Indemnity 998 Classes 0T01, 0T02, 0T03	Basic Benefit Your cost for Par Providers	Your cost for In-Area Non-Par Providers	Your cost for Out-of-Area Non-Par Providers	Your cost for Major Medical	Limitations and Explanations
Diagnostic Laboratory Services	No charge	No charge	No charge	N/A	
Diagnostic MRI / MRA / PET / CT	No charge	No charge	No charge	N/A	Prior authorization is required.
Diagnostic X-Ray	No charge	No charge	No charge	N/A	
Dialysis - Facility	No charge	No charge	20%	N/A	
Dialysis -Physician	No charge	No charge	No charge	N/A	
Durable Medical Equipment	N/A	N/A	N/A	20%*	Prior authorization is required for some equipment.
Hearing Examination	No charge	No charge	No charge	N/A	
Home Health Care	No charge	No charge	20%	N/A	
Hospice Care	No charge	No charge	20%	N/A	
Hospital - Emergency Room	No charge	No charge	No charge	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	No charge	No charge	No charge	N/A	Prior authorization is required. Limited to 45 days per calendar year.
Hospital - Inpatient Substance Abuse / Mental Health	No charge	No charge	No charge	N/A	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	No charge	No charge	20%	N/A	Prior authorization is required.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T01, 0T02, 0T03	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	No charge	No charge	20%	N/A	Prior authorization is required for certain services.
Hospital - Pre-Admission Testing	No charge	No charge	No charge	N/A	Should be performed within 7 days prior to admission.
Hospital - Urgent Care Center	$10 co-pay	$10 co-pay	20%	20%*	
Hospital – Clinic Visit	$10 co-pay	N/A	N/A	20%*	
Hospital – Outpatient Observation Room	No charge	No charge	20%	N/A	
Hospital - All Other Outpatient Services	No charge	No charge	No charge	N/A	
Infusion Therapy - Office	N/A	N/A	N/A	20%*	
Infusion Therapy – Home/ Outpatient	No charge	No charge	No charge	N/A	
Injectable Medications Non-Self Administered	No charge	N/A	N/A	20%*	
Insulin, Glucagon, & Prescription Oral Agents for Controlling Blood Sugar	N/A	N/A	N/A	20%*	
Medical Supplies	No charge	No charge	No charge	N/A	
Orthoptic Therapy	N/A	N/A	N/A	20%*	Prior authorization is required.
Orthotics & External Prosthetics	N/A	N/A	N/A	20%*	Prior authorization is required. Wigs are limited to a lifetime maximum of $400.
Outpatient Facility - Mental Health	No charge	No charge	No charge	N/A	Prior authorization is required.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T01, 0T02, 0T03	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Outpatient Therapy - Mental Health/ - Physician	$10 co-pay	N/A	N/A	20%*	
Outpatient Facility-Substance Abuse Rehab	No charge	No charge	No charge	N/A	Prior authorization is required. Includes co-dependence and intensive outpatient/ partial hospitalization.
Outpatient Therapy - Substance Abuse/ Codependence Physician	$10 co-pay	N/A	N/A	20%*	Prior authorization is required.
Physician Visit-Emergency Room	N/A	N/A	N/A	20%*	
Physician Visit-Office / Clinic/ Home	$10 co-pay	N/A	N/A	20%*	
Physician Visit-Inpatient	No charge	No charge	No charge	N/A	
Physician Visit – Skilled Nursing Facility	No charge	N/A	N/A	20%*	
Physician - Inpatient Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician - Hospital or Free-Standing Surgical Center Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician - Office Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician - Assistant Surgeon	No charge	No charge	No charge	N/A	
Post-Mastectomy Prosthetic	No charge	No charge	No charge	N/A	
Post-Mastectomy Surgical Bra	No charge	No charge	No charge	N/A	
Prescription Drugs	N/A	N/A	N/A	20%	Prescription drug co-pays are reimbursed under the Major Medical Benefit.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T01, 0T02, 0T03	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Radiation Therapy	No charge	No charge	No charge	N/A	
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	20%*	
Second Surgical Opinions	No charge	No charge	No charge	N/A	
Skilled Nursing Facility	No charge	No charge	No charge	N/A	Prior authorization is required. Limited to 365 days per confinement.
Sleep Studies	No charge	No charge	No charge	N/A	
Transfusion	No charge	No charge	No charge	N/A	
Vision – Lenses	N/A	N/A	N/A	20%*	Limited to the initial purchase for lenses purchased after cataract surgery.
Vision – Medical Eye Exam	$10 co-pay	N/A	N/A	20%*	
Wigs	No charge	No charge	No charge	N/A	Includes wigs when baldness is a result of chemotherapy or radiation therapy. Limited to a maximum of $400.
*Deductible applies.					
Preventive Care					
Well Child Visits and Immunizations	No charge	No charge	No charge	N/A	
Adult Annual Physical Examination	No charge	20%*	20%*	20%*	Limited to one examination per year.
Adult Immunizations	No charge	20%*	20%*	20%*	
Routine Gynecological Services/ Well Woman Examination	No charge	20%*	20%*	20%*	Examinations are limited to 2 per year. Pap smear is limited to 1 per year.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T01, 0T02, 0T03	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Mammography Screening	No charge	20%*	20%*	20%*	Limited to 1 baseline age 35-39; annual age 40+; additionally: 1 mammogram per year for individual, any age, having a prior history of breast cancer or a 1st degree relative with prior history of breast cancer.
Sterilization Procedures for Women	No charge	20%*	20%*	20%*	
Bone Density Testing	No charge	20%*	20%*	20%*	
Screening For Prostate Cancer – Primary Care Physician	No charge	20%*	20%*	20%*	
Screening For Prostate Cancer – Specialist	No charge	20%*	20%*	20%*	
All Other Preventive Services	No charge	20%*	20%*	20%*	Includes all mandated preventive testing as required under the Patient Protection and Affordable Care Act (PPACA).
*Deductible applies.					

SCHEDULE OF MEDICAL BENEFITS, Indemnity 998, Classes 0T04, 0T05 and 0T06			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
Individual Deductible	$0	Class 0T04 -$50 Class 0T05 - $100 Class 0T06 - $250	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	Class 0T04 - $100 Class 0T05 - $200 Class 0T06 - $500	
Coinsurance	No charge	20%	Coinsurance is your share of the costs of a covered service, calculated as a percent of the *allowed amount* for the service.
Individual Maximum Out-Of-Pocket Amount - Participating Providers	$5,000		Includes co-pays, deductible and coinsurance. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount - Participating Providers	$10,000		
Individual Maximum Out-Of-Pocket Amount – Major Medical	N/A	$400	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount- Major Medical	N/A	N/A	

Basic Benefit					
Indemnity 998 Classes 0T04, 0T05, 0T06	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	20%*	
Ambulance	No charge	No charge	No charge	20%*	Basic benefit pays a maximum of $250. The balance is covered under Major Medical.
Anesthesia	No charge	No charge	No charge	N/A	
Applied Behavioral Analysis (ABA) for Autism	$10 co-pay	N/A	N/A	20%*	
Artificial Insemination – Outpatient Facility	No charge	No charge	No charge	N/A	
Artificial Insemination – Physician	No charge	No charge	No charge	N/A	
Assistive Communication Device (ACD) for Autism	No charge	No charge	No charge	N/A	
Cardiac Rehabilitation	N/A	N/A	N/A	20%*	
Chemotherapy	No charge	No charge	No charge	N/A	
Chiropractic Care – Chiropractor	$10 co-pay	N/A	N/A	20%*	
Chiropractic Care – Physician	$10 co-pay	N/A	N/A	20%*	
Diabetic Education	N/A	N/A	N/A	20%*	
Diabetic Equipment & Supplies	N/A	N/A	N/A	20%*	
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T04, 0T05, 0T06	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Diagnostic Laboratory Services	No charge	No charge	No charge	N/A	
Diagnostic MRI / MRA / PET / CT	No charge	No charge	No charge	N/A	Prior authorization is required.
Diagnostic X-Ray	No charge	No charge	No charge	N/A	
Dialysis - Facility	No charge	No charge	20%	N/A	
Dialysis - Physician	No charge	No charge	No charge	N/A	
Durable Medical Equipment	N/A	N/A	N/A	20%*	Prior authorization is required for some equipment.
Hearing Examination	No charge	No charge	No charge	N/A	
Home Health Care	No charge	No charge	20%	N/A	Limited to 365 visits per calendar year.
Hospice Care	No charge	No charge	20%	N/A	
Hospital - Emergency Room	No charge	No charge	No charge	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	No charge	No charge	20%	N/A	Prior authorization is required. Limited to 45 days per calendar year.
Hospital - Inpatient Substance Abuse/ Mental Health	No charge	No charge	No charge	N/A	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	No charge	No charge	20%	N/A	Prior authorization is required.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	No charge	No charge	20%	N/A	Prior authorization is required for certain services.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T04, 0T05, 0T06	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Hospital - Pre-Admission Testing	No charge	No charge	No charge	N/A	Should be performed within 7 days prior to admission.
Hospital - Urgent Care Center	$10 co-pay	$10 co-pay	20%	80%*	
Hospital – Clinic Visit	$10 co-pay	N/A	N/A	20%*	
Hospital - All Other Outpatient Services	No charge	No charge	No charge	N/A	
Infusion Therapy - Office	N/A	N/A	N/A	20%*	
Infusion Therapy – Home/ Outpatient	No charge	No charge	No charge	N/A	
Injectable Medications Non-Self Administered	No charge	N/A	N/A	20%*	
Insulin, Glucagon, & Prescription Oral Agents for Controlling Blood Sugar	N/A	N/A	N/A	20%*	
Medical Supplies	No charge	No charge	No charge	N/A	
Orthoptic Therapy	N/A	N/A	N/A	20%*	Prior authorization is required.
Orthotics & External Prosthetics	N/A	N/A	N/A	20%*	Prior authorization is required.
Outpatient Facility – Mental Health	No charge	No charge	No charge	N/A	Prior authorization is required.
Outpatient Therapy – Mental Health/ - Physician	$10 co-pay	N/A	N/A	20%*	
Outpatient Facility-Substance Abuse Rehab	No charge	No charge	No charge	N/A	Prior authorization is required. Includes co-dependence and intensive outpatient/ partial hospitalization.
Outpatient Therapy – Substance Abuse/ Codependence Physician	$10 co-pay	N/A	N/A	20%*	Prior authorization is required.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T04, 0T05, 0T06	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Physician Visit-Emergency Room	N/A	N/A	N/A	20%*	
Physician Visit-Office / Clinic/ Home	$10 co-pay	N/A	N/A	20%*	
Physician Visit-Inpatient	No charge	No charge	No charge	N/A	
Physician Visit – Skilled Nursing Facility	No charge	N/A	N/A	20%*	
Physician – Inpatient Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Hospital or Free-Standing Surgical Center Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Office Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Assistant Surgeon	No charge	No charge	No charge	N/A	
Post-Mastectomy Prosthetic	No charge	No charge	No charge	N/A	
Post-Mastectomy Surgical Bra	No charge	No charge	No charge	N/A	
Prescription Drugs	N/A	N/A	N/A	20%*	Certain medications considered preventive care under the Affordable Care Act (ACA) are payable at $0 co-pay to the member.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T04, 0T05, 0T06	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Radiation Therapy	No charge	No charge	No charge	N/A	
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	20%*	
Second Surgical Opinions	No charge	No charge	No charge	N/A	
Skilled Nursing Facility	No charge	No charge	20%	N/A	Prior authorization is required. Limited to 365 days per confinement.
Sleep Studies	No charge	No charge	No charge	N/A	
Transfusion	No charge	No charge	No charge	N/A	
Vision – Lenses	N/A	N/A	N/A	20%*	Limited to the initial purchase for lenses purchased after cataract surgery.
Vision – Medical Eye Exam	$10 co-pay	N/A	N/A	20%*	
Wigs	No charge	No charge	No charge	N/A	Includes wigs when baldness is a result of chemotherapy or radiation therapy. Limited to a maximum of $400.
*Deductible applies.					
Preventive Care					
Well Child Visits and Immunizations	No charge	No charge	No charge	N/A	
Adult Annual Physical Examination	No charge	20%*	20%*	20%*	Limited to one examination per year.
Adult Immunizations	No charge	20%*	20%*	20%*	
Routine Gynecological Services/ Well Woman Examination	No charge	20%*	20%*	20%*	Examinations are limited to 2 per year. Pap smear is limited to 1 per year.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T04, 0T05, 0T06	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Mammography Screening	No charge	20%*	20%*	20%*	Limited to 1 baseline age 35-39; annual age 40+; additionally: 1 mammogram per year for individual, any age, having a prior history of breast cancer or a 1st degree relative with prior history of breast cancer.
Sterilization Procedures for Women	No charge	20%*	20%*	20%*	
Bone Density Testing	No charge	20%*	20%*	20%*	
Screening For Prostate Cancer – Primary Care Physician	No charge	20%*	20%*	20%*	
Screening For Prostate Cancer – Specialist	No charge	20%*	20%*	20%*	
All Other Preventive Services	No charge	20%*	20%*	20%*	Includes all mandated preventive testing as required under the Patient Protection and Affordable Care Act (PPACA).
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS, Indemnity 998, Classes 0T07, 0T08 and 0T09			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
Individual Deductible	$0	Class 0T07 -$50 Class 0T08 - $100 Class 0T09 - $250	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	Class 0T07 - $100 Class 0T08 - $200 Class 0T09 - $500	
Coinsurance	No charge	20%	Coinsurance is your share of the costs of a covered service, calculated as a percent of the *allowed amount* for the service.
Individual Maximum Out-Of-Pocket Amount – Major Medical	N/A	$400	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount- Major Medical	N/A	N/A	

Basic Benefit					
Indemnity 998 Classes 0T07, 0T08, 0T09	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Allergy Testing and Injections	N/A	N/A	N/A	20%*	
Ambulance	No charge	No charge	No charge	20%*	Basic benefit pays a maximum of $250. The balance is covered under Major Medical.
Anesthesia	No charge	No charge	No charge	N/A	
Applied Behavioral Analysis (ABA) for Autism	N/A	N/A	N/A	20%*	
Artificial Insemination – Outpatient Facility	No charge	No charge	20%	N/A	
Artificial Insemination – Physician	No charge	No charge	No charge	N/A	
Assistive Communication Device (ACD) for Autism	No charge	No charge	No charge	N/A	
Cardiac Rehabilitation	N/A	N/A	N/A	20%*	
Chemotherapy	No charge	No charge	No charge	N/A	
Chiropractic Care – Chiropractor	N/A	N/A	N/A	20%*	
Chiropractic Care – Physician	N/A	N/A	N/A	20%*	
Diabetic Education	N/A	N/A	N/A	20%*	
Diabetic Equipment & Supplies	N/A	N/A	N/A	20%*	
Diagnostic Laboratory Services	No charge	No charge	No charge	N/A	
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T07, 0T08, 0T09	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Providers**	**Your cost for Major Medical**	**Limitations and Explanations**
Diagnostic MRI / MRA / PET / CT	No charge	No charge	No charge	N/A	Prior authorization is required.
Diagnostic X-Ray	No charge	No charge	No charge	N/A	
Dialysis - Facility	No charge	No charge	20%	N/A	
Dialysis -Physician	No charge	No charge	No charge	N/A	
Durable Medical Equipment	N/A	N/A	N/A	20%*	Prior authorization is required for some equipment.
Hearing Examination	No charge	No charge	No charge	N/A	
Home Health Care	No charge	No charge	20%	N/A	
Hospice Care	No charge	No charge	20%	N/A	
Hospital - Emergency Room	No charge	No charge	No charge	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	No charge	No charge	20%	N/A	Prior authorization is required. Limited to 45 days per calendar year.
Hospital - Inpatient Substance Abuse / Mental Health	No charge	No charge	No charge	N/A	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	No charge	No charge	20%	N/A	Prior authorization is required.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	No charge	No charge	20%	N/A	Prior authorization is required for certain services.
Hospital - Pre-Admission Testing	No charge	No charge	No charge	N/A	Should be performed within 7 days prior to admission.
Hospital - Urgent Care Center	N/A	N/A	N/A	20%*	
*Deductible applies.					

Basic Benefit Indemnity 998 Classes 0T07, 0T08, 0T09	Your cost for Par Providers	Your cost for In-Area Non-Par Provider	Your cost for Out-of-Area Non-Par Providers	Your cost for Major Medical	Limitations and Explanations
Hospital – Clinic Visit	N/A	N/A	N/A	20%*	
Hospital - All Other Outpatient Services	No charge	No charge	No charge	N/A	
Infusion Therapy - Office	N/A	N/A	N/A	20%*	
Infusion Therapy – Home/ Outpatient	No charge	No charge	No charge	N/A	
Injectable Medications Non-Self Administered	N/A	N/A	N/A	20%*	
Insulin, Glucagon, & Prescription Oral Agents for Controlling Blood Sugar	N/A	N/A	N/A	20%*	
Medical Supplies	No charge	No charge	No charge	N/A	
Orthoptic Therapy	N/A	N/A	N/A	20%*	Prior authorization is required.
Orthotics & External Prosthetics	N/A	N/A	N/A	20%*	Prior authorization is required.
Outpatient Facility – Mental Health	No charge	No charge	No charge	N/A	Prior authorization is required.
Outpatient Therapy – Mental Health/ - Physician	N/A	N/A	N/A	20%*	
Outpatient Facility-Substance Abuse Rehab	No charge	No charge	No charge	N/A	Prior authorization is required. Includes co-dependence and intensive outpatient/ partial hospitalization.
Outpatient Therapy – Substance Abuse/ Codependence Physician	N/A	N/A	N/A	20%*	Prior authorization is required.
Physician Visit-Emergency Room	N/A	N/A	N/A	20%*	
*Deductible applies.					

Indemnity 998 Classes 0T07, 0T08, 0T09	Basic Benefit Your cost for Par Providers	Your cost for In-Area Non-Par Provider	Your cost for Out-of-Area Non-Par Providers	Your cost for Major Medical	Limitations and Explanations
Physician Visit-Office / Clinic/ Home	N/A	N/A	N/A	20%*	
Physician Visit-Inpatient	No charge	No charge	No charge	N/A	
Physician Visit – Skilled Nursing Facility	No charge	No charge	No charge	N/A	
Physician – Inpatient Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Hospital or Free-Standing Surgical Center Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Office Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Assistant Surgeon	No charge	No charge	No charge	N/A	
Post-Mastectomy Prosthetic	No charge	No charge	No charge	N/A	
Post-Mastectomy Surgical Bra	No charge	No charge	No charge	N/A	
Prescription Drugs	N/A	N/A	N/A	20%*	
Radiation Therapy	No charge	No charge	No charge	N/A	
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	20%*	
Second Surgical Opinions	No charge	No charge	No charge	N/A	
Radiation Therapy	No charge	No charge	No charge	N/A	
*Deductible applies.					

Basic Benefit Indemnity 998 Classes 0T07, 0T08, 0T09	Your cost for Par Providers	Your cost for In-Area Non-Par Provider	Your cost for Out-of-Area Non-Par Providers	Your cost for Major Medical	Limitations and Explanations
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Pulmonary	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	20%*	
Second Surgical Opinions	No charge	No charge	No charge	N/A	
Skilled Nursing Facility	No charge	No charge	20%	N/A	Prior authorization is required. Limited to 365 days per confinement.
Sleep Studies	No charge	No charge	No charge	N/A	
Transfusion	No charge	No charge	No charge	N/A	
Vision – Lenses	N/A	N/A	N/A	20%*	Limited to the initial purchase for lenses purchased after cataract
Vision – Medical Eye Exam	N/A	N/A	N/A	20%*	
Wigs	No charge	No charge	No charge	N/A	Includes wigs when baldness is a result of chemotherapy or radiation
*Deductible applies					
Preventive Care					
Well Child Visits and Immunizations	No charge	No charge	No charge	N/A	
Adult Annual Physical Examination	No charge	0%*	0%*	0%*	Limited to one examination per year.
Adult Immunizations	No charge	0%*	0%*	0%*	
Routine Gynecological Services/ Well Woman Examination	No charge	0%*	0%*	0%*	Examinations are limited to 2 per year. Pap smear is limited to 1 per year.
*Deductible applies					

Basic Benefit Indemnity 998 Classes 0T07, 0T08, 0T09	Your cost for Par Providers	Your cost for In-Area Non-Par Provider	Your cost for Out-of-Area Non-Par Providers	Your cost for Major Medical	Limitations and Explanations
Mammography Screening	No charge	0%*	0%*	0%*	Limited to 1 baseline age 35-39; annual age 40+; additionally: 1 mammogram per year for individual, any age, having a prior history of breast cancer or a 1st degree relative with prior history of breast cancer.
Sterilization Procedures for Women	No charge	0%*	0%*	0%*	
Bone Density Testing	No charge	0%*	0%*	0%*	
Screening For Prostate Cancer – Primary Care Physician	No charge	0%*	0%*	0%*	
Screening For Prostate Cancer – Specialist	No charge	0%*	0%*	0%*	
All Other Preventive Services	No charge	0%*	0%*	0%*	Includes all mandated preventive testing as required under the Patient Protection and Affordable Care Act (PPACA).
*Deductible applies					

SCHEDULE OF MEDICAL BENEFITS, Indemnity 998, Classes 0T10, 0T11 and 0T12			
Medical Plan	**Basic Benefit**	**Major Medical**	**Limitations and Explanations**
Individual Lifetime Maximum Benefit	Unlimited		
Individual Deductible	$0	Class 0T10 -$50 Class 0T11 - $100 Class 0T12 - $250	The family deductible applies collectively to all covered persons in the same family.
Family Deductible	$0	Class 0T10 - $100 Class 0T11 - $200 Class 0T12 - $500	
Coinsurance	No charge	20%	Coinsurance is your share of the costs of a covered service, calculated as a percent of the *allowed amount* for the service.
Individual Maximum Out-Of-Pocket Amount – Major Medical	N/A	$400	Excludes deductible. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the calendar year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount- Major Medical	N/A	N/A	

Indemnity 998 Classes 0T10, 0T11, 0T12	Basic Benefit Your cost for Par Providers	Your cost for In-Area Non-Par Provider	Your cost for Out-of-Area Non-Par Providers	Your cost for Major Medical	Limitations and Explanations
Allergy Testing and Injections	N/A	N/A	N/A	20%*	
Ambulance	No charge	No charge	No charge	20%*	Basic benefit pays a maximum of $250. The balance is covered under Major Medical.
Anesthesia	No charge	No charge	No charge	N/A	
Applied Behavioral Analysis (ABA) for Autism	N/A	N/A	N/A	20%*	
Artificial Insemination – Outpatient Facility	No charge	No charge	No charge	N/A	
Artificial Insemination – Physician	No charge	No charge	No charge	N/A	
Assistive Communication Device (ACD) for Autism	No charge	No charge	No charge	N/A	
Cardiac Rehabilitation	N/A	N/A	N/A	20%*	
Chemotherapy	No charge	No charge	No charge	N/A	
Chiropractic Care – Chiropractor	N/A	N/A	N/A	20%*	
Chiropractic Care – Physician	N/A	N/A	N/A	20%*	
Diabetic Education	N/A	N/A	N/A	20%*	
Diabetic Equipment & Supplies	N/A	N/A	N/A	20%*	
Diagnostic Laboratory Services	No charge	No charge	No charge	N/A	
*Deductible applies.					

Indemnity 998 Classes 0T10, 0T11, 0T12	Basic Benefit Your cost for Par Providers	Your cost for In-Area Non-Par Provider	Your cost for Out-of-Area Non-Par Providers	Your cost for Major Medical	Limitations and Explanations
Diagnostic MRI / MRA / PET / CT	No charge	No charge	No charge	N/A	Prior authorization is required.
Diagnostic X-Ray	No charge	No charge	No charge	N/A	
Dialysis - Facility	No charge	No charge	20%	N/A	
Dialysis - Physician	No charge	No charge	No charge	N/A	
Durable Medical Equipment	N/A	N/A	N/A	20%*	Prior authorization is required for some equipment.
Hearing Examination	No charge	No charge	No charge	N/A	
Home Health Care	100%	100%	20%	N/A	
Hospice Care	100%	100%	20%	N/A	
Hospital - Emergency Room	100%	100%	100%	N/A	
Hospital - Inpatient Acute Physical Rehabilitation Facility	No charge	No charge	20%	N/A	Prior authorization is required. Limited to 45 days per calendar year.
Hospital - Inpatient Substance Abuse / Mental Health	No charge	No charge	No charge	N/A	Prior authorization is required.
Hospital - Inpatient Treatment Of Other Covered Conditions	No charge	No charge	20%	N/A	Prior authorization is required.
Hospital - Outpatient Ambulatory Surgery or Free-Standing Surgical Facility	No charge	No charge	20%	N/A	Prior authorization is required for certain services.
Hospital - Pre-Admission Testing	No charge	No charge	No charge	N/A	Should be performed within 7 days prior to admission.
Hospital - Urgent Care Center	N/A	N/A	N/A	20%*	
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T10, 0T11, 0T12	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Provider**	**Your cost for Major Medical**	**Limitations and Explanations**
Hospital – Clinic Visit	N/A	N/A	N/A	20%*	
Hospital - All Other Outpatient Services	No charge	No charge	No charge	N/A	
Infusion Therapy - Office	N/A	N/A	N/A	20%*	
Infusion Therapy – Home/ Outpatient	No charge	No charge	No charge	N/A	
Injectable Medications Non-Self Administered	N/A	N/A	N/A	20%*	
Insulin, Glucagon, & Prescription Oral Agents for Controlling Blood Sugar	N/A	N/A	N/A	20%*	
Medical Supplies	No charge	No charge	No charge	N/A	
Orthoptic Therapy	N/A	N/A	N/A	20%*	Prior authorization is required.
Orthotics & External Prosthetics	N/A	N/A	N/A	20%*	Prior authorization is required.
Outpatient Facility – Mental Health	No charge	No charge	No charge	N/A	Prior authorization is required.
Outpatient Therapy – Mental Health/ - Physician	N/A	N/A	N/A	20%*	
Outpatient Facility-Substance Abuse Rehab	No charge	No charge	No charge	N/A	Prior authorization is required. Includes co-dependence and intensive outpatient/ partial hospitalization.
Outpatient Therapy – Substance Abuse/ Codependence Physician	N/A	N/A	N/A	20%*	Prior authorization is required.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T10, 0T11, 0T12	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Provider**	**Your cost for Major Medical**	**Limitations and Explanations**
Physician Visit-Emergency Room	N/A	N/A	N/A	20%*	
Physician Visit-Office / Clinic/ Home	N/A	N/A	N/A	20%*	
Physician Visit-Inpatient	No charge	No charge	No charge	N/A	
Physician Visit – Skilled Nursing Facility	No charge	No charge	No charge	N/A	
Physician – Inpatient Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Hospital or Free-Standing Surgical Center Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Office Surgeon	No charge	No charge	No charge	N/A	Prior authorization is required for certain services.
Physician – Assistant Surgeon	No charge	No charge	No charge	N/A	
Post-Mastectomy Prosthetic	No charge	No charge	No charge	N/A	
Post-Mastectomy Surgical Bra	No charge	No charge	No charge	N/A	
Prescription Drugs	N/A	N/A	N/A	20%*	
Radiation Therapy	No charge	No charge	No charge	N/A	
Rehabilitative Therapy –Physical / Occupational/ Speech	N/A	N/A	N/A	20%*	
Rehabilitative Therapy – Pulmonary	No charge	No charge	No charge	No charge	
Rehabilitative Therapy – Respiratory	N/A	N/A	N/A	20%*	
Second Surgical Opinions	No charge	No charge	No charge	N/A	
Skilled Nursing Facility	No charge	No charge	20%	N/A	Prior authorization is required. Limited to 365 days per confinement.
*Deductible applies.					

Basic Benefit					
Indemnity 998 Classes 0T10, 0T11, 0T12	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Provider**	**Your cost for Major Medical**	**Limitations and Explanations**
Sleep Studies	No charge	No charge	No charge	N/A	
Transfusion	No charge	No charge	No charge	N/A	
Vision – Lenses	N/A	N/A	N/A	20%*	Limited to the initial purchase for lenses purchased after cataract surgery.
Vision – Medical Eye Exam	N/A	N/A	N/A	20%*	
Wigs	No charge	No charge	No charge	N/A	Includes wigs when baldness is a result of chemotherapy or radiation therapy. Limited to a maximum of $400.
*Deductible applies					
Preventive Care					
Well Child Visits and Immunizations	No charge	No charge	No charge	N/A	
Adult Annual Physical Examination	No charge	0%*	0%*	0%*	Limited to one examination per year.
Adult Immunizations	No charge	0%*	0%*	0%*	
Routine Gynecological Services/ Well Woman Examination	No charge	0%*	0%*	0%*	Examinations are limited to 2 per year. Pap smear is limited to 1 per year.
Mammography Screening	No charge	0%*	0%*	0%*	Limited to 1 baseline age 35-39; annual age 40+; additionally: 1 mammogram per year for individual, any age, having a prior history of breast cancer or a 1st degree relative with prior history of breast cancer.
Sterilization Procedures for Women	No charge	0%*	0%*	0%*	
Bone Density Testing	No charge	0%*	0%*	0%*	
*Deductible applies					

Basic Benefit					
Indemnity 998 Classes 0T10, 0T11, 0T12	**Your cost for Par Providers**	**Your cost for In-Area Non-Par Providers**	**Your cost for Out-of-Area Non-Par Provider**	**Your cost for Major Medical**	**Limitations and Explanations**
Screening For Prostate Cancer – Primary Care Physician	No charge	0%*	0%*	0%*	
Screening For Prostate Cancer – Specialist	No charge	0%*	0%*	0%*	
All Other Preventive Services	No charge	0%*	0%*	0%*	Includes all mandated preventive testing as required under the Patient Protection and Affordable Care Act (PPACA).
*Deductible applies					

INTRODUCTION

Allegany – Cattaraugus Schools has prepared this document to help you understand your benefits. **PLEASE READ IT CAREFULLY AS YOUR BENEFITS ARE AFFECTED BY CERTAIN LIMITATIONS AND CONDITIONS.** Also, benefits are not provided for certain kinds of treatments or services, even if your health care provider recommends them.

This Plan provides benefits only for covered expenses; payment is based on the lesser of actual charges or the applicable *fee schedule*. However, any amounts you are obligated to pay in excess of the amount listed in our *fee schedule* or in excess of any dollar limitation on benefits will not be counted in determining when you, or a member of your family, have reached the maximum payments in a calendar year. In addition, you will remain responsible for all charges in excess of the amount listed in the applicable *fee schedule* even after the thresholds are met.

This document is written in simple, easy-to-understand language. Technical terms are printed in *italics* and defined in the Definitions section. The headings in the Plan are inserted for convenience of reference only and are not to be construed or used to interpret any of the provisions of the Plan.

As used in this document, the word *year* refers to the *calendar year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *calendar year*. The word *lifetime* as used in this document refers to the period of time a covered person is a participant in this Plan sponsored by Allegany – Cattaraugus Schools.

Benefits described in this document are effective October 1, 2016. The terms and conditions of the Allegany – Cattaraugus Schools Health Plan are governed by the provisions in this document. Any and all other written communication regarding the Plan or the benefits provided under the Plan are superseded and are of no force or effect.

This Plan is in compliance with all applicable federal laws. In the event of a change in federal law, the Plan will be deemed to be in compliance and administered accordingly.

ARTICLE I -- ELIGIBILITY AND PARTICIPATION

A. Who Is Eligible

You are eligible to participate in this Plan if you are:

1. a regularly scheduled employee of a participating employer, as determined by the individual school, or

2. a *retiree.*

Your eligible dependents may also participate. Eligible dependents include:

1. A legal spouse. In the event of legal separation, you may but are not required to cover your spouse. However, coverage for your spouse will terminate at the time of divorce.

2. A child from birth to age twenty-six (26).

   The term child includes:

   a. a natural child;

   b. a step-child by legal marriage;

   c. a child who is adopted or has been placed with you for adoption by a court of competent jurisdiction;

   d. a proposed adopted 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.

   e. a child for whom legal guardianship has been awarded;

   f. a child who is the subject of a *Qualified Medical Child Support Order* (QMCSO) dated on or after August 10, 1993. To be "qualified," a state court medical child support order must specify: the name and last known mailing address of the Plan participant and each alternate recipient covered by the order, a reasonable description of the type of coverage or benefit to be provided to the alternate recipient, the period to which the medical child support order applies, and each plan to which the order applies; and

   g. Your unmarried child who is older than the age dependent coverage would otherwise terminate and who is incapable of self-sustaining employment because of mental illness, developmental disability or mental retardation, as defined in the New York State Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which dependent coverage would otherwise have terminated. The child's disability must be certified by a physician. In addition to this certification we have the right to check whether a child is and continues to qualify as an incapacitated child.

In order to continue coverage, you must furnish written proof of the disability within thirty-one (31) days of the child's twenty-sixth (26th) birthday. The *Plan Administrator* may require you to furnish periodic proof of the child's continued disability but not more often than annually after the child's twenty-sixth (26th) birthday. If such proof is not satisfactory to the *Plan Administrator*, coverage for the child will end immediately.

Under New York Law, coverage for unmarried children residing, living, or working in New York State or the service area for the Plan is available through age twenty-nine (29) regardless of the child's financial dependence, so long as they are not insured by or eligible for coverage under any employee health benefit plan as an employee or plan participant. Contact your individual school district to obtain this coverage, which is provided under a single contract. The covered individual is responsible for 100% of the premium under the single contract and after exhausting the benefits (reaching age twenty-nine), is not eligible for COBRA or New York State continuation coverage.

No one who is on active duty with the armed forces will be eligible for coverage under this Plan.

B. Who Pays For Your Benefits

Allegany – Cattaraugus Schools shares the cost of providing benefits for you and your dependents.

C. Enrollment Requirements

If you want Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to your *employer* within thirty-one (31) days of your eligibility date. If you also desire dependent coverage, you must enroll your eligible dependents by this deadline.

If you do not have any eligible dependents at the time of initial enrollment but acquire eligible dependents at a later date, you must enroll dependents, including newborns, by properly completing and returning an enrollment form to your *employer* within thirty-one (31) days of the date they become your dependent(s).

Failure to enroll by the deadline noted above will subject you and your dependents to the Late Enrollment, or Special Enrollment Period provisions below.

D. When Coverage Begins

Your coverage begins according to each school's requirements.

Coverage for your eligible dependents begins the later of when your coverage begins or the first day a dependent becomes your dependent.

A young adult may also enroll during the annual thirty (30) day open enrollment period. Coverage is effective within thirty (30) days of the Plan's receipt of notice of the election to enroll and payment of first premium.

If you have a newborn or adopted newborn child and your employer receives notice of such birth within 31 days thereafter, coverage for the newborn starts at the moment of birth; otherwise, coverage begins on the date on which the Plan receives notice. The adopted newborn child will be covered from the moment of birth if you take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, the plan will not provide hospital benefits for the adopted newborn's initial hospital stay if one of the infant's natural parents has coverage for the newborn's initial hospital stay. If you have individual or family coverage, you must also notify your employer of your desire to add the child/children to your family coverage and pay any additional premium.

When coverage begins for a Late Enrollee or a Special Enrollee is described in the following sections.

Any time you or your eligible dependents have accumulated toward the satisfaction of a *waiting period* under the *employer's* previous Employee Plan will be counted toward the satisfaction of the *waiting period* of this Plan.

E. Late Enrollment

If you declined coverage or did not enroll yourself and your eligible dependents at the time initially eligible, coverage cannot become effective until the next annual *open enrollment period* unless application for coverage is due to a Special Enrollment as defined under the Special Enrollment Period provision below. The employee or dependent must request enrollment in this Plan within the *open enrollment period.* This provision does not apply to a dependent who becomes eligible for coverage as the result of a *Qualified Medical Child Support Order*, or who is adopted or is placed with you for adoption by a court of competent jurisdiction, as long as he is enrolled within thirty-one (31) days of his eligibility date.

The *enrollment date* for a *late enrollee* is the first day of coverage. Thus, the time between the date a *late enrollee* first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a *waiting period as* defined in Article XV.

F. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a *special enrollee* first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a *waiting period*. Special Enrollment Periods apply to the following:

1. Individuals losing other coverage. An employee or dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

    a. The employee or dependent was covered under a group health plan, Medicaid including coverage under state funded Children's Health Insurance Plan (CHIP), or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

    b. If required by the *Plan Administrator*, the employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

    c. The coverage of the employee or dependent who has lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated.

    d. The employee requests enrollment in this Plan not later than:

        i. thirty (30) days following the termination of coverage or employer contributions, as described above;
        ii. thirty (30) days following the date COBRA coverage was exhausted;
        iii. sixty (60) days following the termination of Medicaid or CHIP.

        Coverage will begin on the day following the loss of coverage.

    If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

2. Dependent beneficiaries. If:

    a. The employee is a participant under this Plan (or has met the *waiting period* applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

    b. A person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption then the dependent (and if not otherwise enrolled, the employee) may be enrolled under this Plan as a covered dependent of the employee. In the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage.

3. Transitional rule dependent beneficiaries are eligible to enroll in the Plan if either of the following conditions is met:

   a. The dependent beneficiary was previously enrolled in the Plan and their eligibility was terminated due to age: or

   b. The dependent beneficiary was previously not eligible under the Plan when the employee first became eligible as their age at that time exceeded the Plan limitation. Other changes in circumstances, for example, a young adult moving back to New York State after living outside of the state or losing health insurance sponsored by an employer.

   The special enrollment period is a period of thirty (30) days that begins on the date of notification regarding the transitional rule. Coverage begins on the date the plan adopts the transitional rule provision.

G. When Coverage Ends

Coverage under this plan will automatically be terminated on the first of the following to apply:

1. The date as defined by the individual school.

2. The date on which the employee ceases to meet the eligibility requirements as defined by the plan.

3. Upon the employee's death, coverage will terminate unless the employee has coverage for dependents.

4. The date you fail to make the required contributions. This will account for the thirty (30) day grace period for the payment of premiums.

5. For spouses in cases of divorce, the date of the divorce.

6. For children, until the day in which the child turns 26 years of age.

7. For all other dependents, the day in which the dependent ceases to be eligible

8. 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 application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the plan to the employee and/or the employee's dependent, as applicable. 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 terminate for the dependent.

9. The date the plan is terminated. The plan will provide ninety (90) days prior written notice before terminating.

10. The plan has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the COBRA Continuation of Benefits section of this document for rights to continuation of this coverage.

H. Extension Of Coverage

If you cease to be eligible for coverage due to an approved leave of absence or a *total disability,* you and your eligible dependents may continue to be covered under the Plan. The benefit termination date will be treated the same as an employment termination date with respect to COBRA Continuation of Benefits.

1 Leave of Absence

If you qualify for an approved family or medical leave of absence (as defined in the Family and Medical Leave Act of 1993 (FMLA) and as amended by the National Defense Authorization Act of 2008), eligibility may continue for the duration of the leave. Failure to make payment within thirty (30) days of the due date established by your *employer* will result in the termination of coverage. If you fail to return to work after the leave of absence, your *employer* has the right to recover from you any contributions that were made on your behalf toward the cost of coverage during the leave.

If you are on any other approved leave of absence, eligibility may continue as defined by the individual school following the date that the leave of absence began provided you make any required contribution to the Plan.

2. Total Disability

If you are covered under the Plan and your active service terminates due to *total disability*, you may continue to be covered under the Plan for a period as defined by the individual school or until the disability ends, whichever occurs first. Continuation under this section of the Plan may be combined with that period of time determined to be allowable under the Family and Medical Leave Act of 1993.

You may not be engaged in any other occupation for compensation, profit or gain while *totally disabled.* In addition, if you fail to make the required contribution, when due, coverage will terminate at the end of the period for which you made the last required contribution.

I. The Uniformed Services Employment And Re-employment Rights Act (USERRA)

This Plan will comply with the requirement of all the terms of The Uniformed Services Employment And Re-employment Rights Act of 1994 (USERRA) including § 4305 (g) and (h) and Circular Letter No. 7 (2003). This is a federal law which gives members and former members of the U.S. armed forces (active and reserves) the right to return to their civilian job they held before military service.

ARTICLE II -- MEDICAL MANAGEMENT PROGRAM

Allegany-Cattaraugus Schools desires to provide you and your family with a health care benefit plan that helps protect you from significant health care expenses and helps to provide you with quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

THE PROGRAM IS NOT INTENDED TO DIAGNOSE OR TREAT MEDICAL CONDITIONS, GUARANTEE BENEFITS, OR VALIDATE ELIGIBILITY. The medical professionals who conduct the program focus their review on the appropriateness of treatment. Any questions pertaining to eligibility, Plan limitations or *fee schedule* should be directed to the eligibility and claims department.

Your participating *physician* or *provider* is required to call to obtain certification prior to the following services:

- Any *inpatient hospital* admission, including admission to the hospital following a visit to the emergency room. Certification is not required for emergency services that do not result in an *inpatient* admission.
- Home Health Aide
- MRI/MRA/PET/Nuclear Radiology, for local participating providers only
- Any *Skilled Nursing Facility* admission
- Some *durable medical equipment*
- Orthotics
- External Prosthetics
- Non-emergency Air Ambulance transport
- Injectable medications, non-self administered, for local participating providers only
- Outpatient alcohol and substance abuse rehabilitation
- Outpatient mental health/ electroshock
- Applied behavioral analysis for autism
- Assistive Communication Devices (ACD) for Autism

When the required review procedures outlined above are followed, your benefits will be unaffected. However, failure to comply with this provision may result in a penalty being applied to eligible expenses related to the treatment:

- When services are received from a participating provider, precertification will be obtained by the *health care provider*. If certification is not received, the benefit paid to the provider may be reduced. You cannot be billed for the amount of the benefit reduction.

- If services are not provided by a participating provider, no benefit will be paid toward treatment that is determined not to be *medically necessary*.

ARTICLE III – NETWORK PROVISIONS

Applicable to those enrolled in the POS Plan

In the POS Plan, you may see any *health care provider* in or out of the network for covered health care services whenever you like. However, when you see a *health care provider* who is not a participating provider, you may receive a lesser benefit as outlined on the Schedule of Medical Benefits, and your out-of-pocket expenses will be greater.

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 us. 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 your plan.

You will be held harmless for any non-participating Provider charges for the surprise bill that exceed your In-Network Copayment, Deductible or Coinsurance 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 Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or you can visit the website for the claims processor for a copy of the form. You need to mail a copy of the assignment of benefits form to the claim processor at the address on your ID card and to your Provider.

Exceptions:

If you receive emergency room treatment at an in-network facility, any services rendered by a physician during the emergency room encounter will be reimbursed at the in-network benefit level, regardless of whether the provider is participating with the contracted network.

Professional Components charges rendered in an in-network facility regardless of whether the provider is participating with the network will be reimbursed at the in-network benefit level when:

- A participating provider is unavailable at the time the health care services are performed;
- A non-participating provider performs services without your knowledge; or
- Unforeseen medical issues or services arise at the time the health care services are performed.

If specialist services cannot be obtained through a network provider within the network service area, benefits for treatment rendered or supplies received from an out-of-network specialty provider will be reimbursed at the in-network benefit level.

When laboratory services are performed within the BlueCross Blue Shield Of Western New York operating area or the Blue Shield Of Northeastern New York operating area, services must be provided by the designated laboratory:

Operating Area	**Designated Laboratory**
BlueCross Blue Shield Of Western New York: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties	Quest Diagnostic Laboratory

Exceptions:

Laboratory services by a non-designated laboratory provider will be reimbursed at the in-network benefit whenever:

1. Services cannot be performed by the designated laboratory listed above and prior approval was obtained,

2. Specific laboratory test is approved to be performed in the treating *Physician's* office, or

3. Services are performed in conjunction with treatment in a free-standing surgical facility or *hospital*.

ARTICLE IV -- MEDICAL BENEFITS

A. About Your Medical Benefits

All medical benefits provided under this Plan must satisfy some basic terms. The following terms which apply to your Plan's benefits are commonly included in medical benefit plans but often overlooked or misunderstood.

1. Medical Necessity

   Medically necessary care is care which according to criteria, is:

   - consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury,
   - in accordance with standards of good medical practice,
   - not for your convenience or that of your physician or other provider,
   - the most appropriate supply, level of care, or service which can be safely provided to you.

   The *Plan Administrator* may consult the *Medical Director* of the *Claims Processor* in order to determine the medical necessity of treatment. Medical treatments which are not proven, effective and appropriate are not covered by this Plan unless specifically mentioned.

2. Health Care Providers

   The Plan provides benefits only for covered services and supplies rendered by a *physician, practitioner, nurse, hospital,* or *specialized treatment facility* as those terms are specifically defined in the Definitions section.

3. Custodial Care

   The Plan does not provide benefits for services and supplies furnished primarily to assist an individual in the activities of daily living, unless medically necessary. Activities of daily living include such things as help in transferring, eating, dressing, bathing, toileting, and other such related activities.

4. Calendar Year

   The word *year,* as used in this document, refers to the *calendar year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *calendar year.*

5. Alternate Benefit Provision

The *Plan Administrator* may elect to provide alternative benefits which are not listed as covered services in this contract. The alternative covered benefits should be determined on a case by case basis by the *Plan Administrator* for services which the *Plan Administrator* deems are *medically necessary*, cost effective and agreeable to the covered person and participating provider. The *Plan Administrator* shall not be committed to provide these same, or similar alternative benefits for another covered person nor shall the *Plan Administrator* lose the right to strictly apply the express provisions of this contract in the future.

B. Deductibles

A deductible is the amount of covered expenses you must pay during each *calendar year* before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that *calendar year*. Co-payments and penalties do not apply to the deductible.

Any covered expenses that you or your dependents accumulated toward the deductible under the Allegany – Cattaraugus Schools plan prior to the restatement date, October 1, 2016, will be counted toward the satisfaction of the deductible under this Plan.

C. Deductible Carry-Over

When covered expenses incurred in the last three (3) months of the *year* are applied to the deductible, that amount will also be used to satisfy the deductible for the following *year*.

D. Member Coinsurance

Member coinsurance percentages represent the portion of covered expenses paid by the member after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed the applicable *fee schedule*.

The member coinsurance percentages are shown on the Schedule of Medical Benefits.

E. Maximum Out-Of-Pocket Amount

A maximum out-of-pocket amount is the maximum amount of covered expenses you must pay during a *calendar year* before the payment percentage of the Plan increases. The individual maximum out-of-pocket amount applies separately to each covered person. When a covered person reaches their annual maximum out-of-pocket amount, the Plan will pay one hundred percent (100%) of additional covered expenses, subject to any applicable co-payments, for that individual during the remainder of that *calendar year.*

The family maximum out-of-pocket amount applies collectively to all covered persons in the same family. When the family reaches their annual maximum out-of-pocket amount, the Plan will pay one hundred percent (100%) of additional covered expenses, subject to any applicable co-payments, for that family during the remainder of that *calendar year*. Expenses excluded from the maximum out-of-pocket amount are shown in the Schedule of Medical Benefits. The maximum out-of-pocket amount also excludes charges in excess of the *fee schedule.*

Any covered expenses that you or your dependents accumulated toward the maximum out-of-pocket amount under the Allegany – Cattaraugus Schools plan prior to the restatement date, October 1, 2016, will be counted toward the satisfaction of the maximum out-of-pocket amount under this Plan.

If applicable, the annual individual and family maximum out-of-pocket amounts are shown on the Schedule of Medical Benefits.

F. Benefit Maximums

Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime*. Whenever the word *lifetime* appears in this Plan in reference to benefit maximums, it refers to the time you or your dependents are covered by this Plan.

The benefit maximums applicable to this Plan are shown in the Schedule of Medical Benefits. Any benefit amounts that you or your dependents accumulated toward the benefit maximums and *lifetime* benefit maximums under the Allegany – Cattaraugus Schools plan prior to the restatement date, October 1, 2016, will be counted toward the benefit maximums and *lifetime* benefit maximums under this Plan.

G. Covered Medical Expenses

When all of the requirements of this Plan are satisfied, the Plan will provide benefits as outlined on the Schedule of Medical Benefits but only for the services and supplies listed in this section.

Hospital Services

Please refer to the Schedule of Benefits section of this plans cost-sharing requirements, day or visit limits, and any Preauthorization or referral requirements that apply to these benefits.

A. Inpatient Hospital Services.

The plan covers inpatient hospital services for acute care or treatment given or ordered by a health care professional 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 plaster 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.

The plan does not cover personal comfort or service items while confined in a hospital including, but not limited to, radio, television, telephone, and guest meals.

The cost-sharing requirements in the Schedule of Benefits section of this plan apply to a continuous hospital confinement, which is consecutive days of in-hospital service received as an inpatient.

B. 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.

C. Inpatient Medical Services.

The plan covers medical visits by a health care professional on any day of inpatient care covered under this plan.

D. 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 it determines are 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. The plans coverage of this home care visit shall be in addition to home health care visits under this plan and shall not be subject to any cost-sharing amounts in the Schedule of Benefits section of this plan that apply to home care benefits.

E. 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.

F. 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. The plan does not cover blood and storage of self-donated blood.

G. Rehabilitation Services.

The plan covers inpatient rehabilitation services consisting of physical therapy, speech therapy and occupational therapy. Please refer to the Schedule of Benefits for any plan limitations.

H. Skilled Nursing Facility.

The plan covers services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in “Hospital Services” above. Custodial, convalescent or domiciliary care is not covered (see the Exclusions and Limitations section of this plan). Please refer to the Schedule of Benefits for any plan limitations.

I. End of Life Care.

If you are diagnosed with advanced cancer and you have fewer than 60 days to live, the plan will cover acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients. Your attending physician and the facility’s medical director must agree that your care will be appropriately provided at the facility. If the plan disagrees with your admission to the facility, it has the right to initiate an expedited external appeal to an external appeal agent. The plan will cover and reimburse the facility for your care, subject to any applicable limitations in this plan until

the external appeal agent renders a decision in the plan's favor.

The plan will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between the plan and the provider.
2. If there is no negotiated rate, the plan will reimburse acute care at the facility's current Medicare acute care rate.

J. Limitations/Terms of Coverage.

1. When you are receiving inpatient care in a facility, the plan will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is medically necessary), or medications and supplies you take home from the facility. If you occupy a private room, and the private room is not medically necessary, the plan's coverage will be based on the facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. The plan does not cover radio, telephone or television expenses, or beauty or barber services.

Outpatient Hospital Services.

The plan covers hospital services and supplies as described in the Inpatient Hospital Services section of this plan that can be provided to you while being treated in an outpatient facility. For example, covered services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

The plan covers infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a physician or other authorized health care professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

Please refer to the Schedule of Benefits section of this plan for cost-sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Emergency Services.

The plan covers Emergency Services for the treatment of an Emergency Condition in hospital.

The plan defines an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including 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.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of your Emergency Condition will be provided regardless of whether the provider is a participating provider. The plan will also cover Emergency Services to treat your Emergency Condition worldwide. However, the plan will cover only those Emergency Services and supplies that are medically necessary and are performed to treat or stabilize your Emergency Condition in a hospital.

Please follow the instructions listed below regardless of whether or not you are in the plan's service area at the time your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that you require treatment for an Emergency Condition, seek immediate care at the nearest hospital emergency department or call 911. Emergency Department Care does not require preauthorization. However, only Emergency Services for the treatment of an Emergency Condition are covered in an emergency department.

   The plan does not cover follow-up care or routine care provided in a hospital emergency department.

2. **Emergency Hospital Admissions.** In the event that you are admitted to the hospital, you or someone on your behalf must notification to the claims processor at the number on your ID card within 48 hours of your admission, or as soon as is reasonably possible.

3. **Payments Relating to Emergency Services Rendered.** The amount the plan pays a Non-Participating Provider for Emergency Services will be the amount the plan has negotiated with the Non-Participating Provider for the Emergency Service or the Non-Participating Provider's charge. However, the negotiated amount will not exceed the

Non-Participating Provider's charge and will be at least the greater of: 1) the amount the plan has negotiated with participating providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the allowed amount for services provided by a Non-Participating Provider (i.e., the amount the plan would pay in the absence of any cost-sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare.

You are responsible for any in-network copayment, deductible or coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance.

4. Emergency Ambulance Transportation.

The plan covers Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a hospital. The plan will, however, only cover transportation to a hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation 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.

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 coinsurance.

The plan also covers emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest hospital where Emergency Services can be performed.

The plan covers Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide.

The plan does not cover non-emergency ambulance transportation.

Urgent Care.

Urgent Care is 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 is typically available after normal business hours, including evenings and weekends. Urgent Care is covered in or out of the plan's service area.

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact the claims processor prior to or after your visit.

2. **Out-of-Network.** The plan covers Urgent Care from a non-participating Urgent Care Center or Physician outside the plan's service area.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

Surgical Services

The plan covers physicians' services for surgical procedures, including 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, anesthesiologist or certified registered nurse anesthetist, 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.

A. Sometimes two (2) or more surgical procedures can be performed during the same operation.

    1. **Through the Same Incision.** If covered multiple surgical procedures are performed through the same incision, the plan will pay for the procedure with the highest allowed amount, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. The plan will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure].
    2. **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, the plan will pay:
        - For the procedure with the highest allowed amount; and
        - 50% of the amount the plan would otherwise pay for the other procedures.

B. Oral Surgery.

The plan covers the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered.
- Surgical medical procedures for temporomandibular joint disorders and orthognathic surgery (applicable to Class 0001).

The plan does not cover orthodontics for cleft palate.

C. Reconstructive Breast Surgery.

The plan covers breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by you and your attending physician to be appropriate. The plan also covers implanted breast prostheses following a mastectomy or partial mastectomy.

D. Other Reconstructive and Corrective Surgery.

The plan covers reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

The plan does not cover kerato-refractive eye surgery (to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis surgery). The plan also does not cover reversal of any elective surgical procedure, reversal of voluntary sterilization or sex change surgery.

E. Assistant surgeon's expenses if:

1. surgery is performed in a hospital where there is no house staff.

2. surgery is performed in a hospital where there is no hospital resident in the specialty involved, certified, or authorized, to assist at surgery.

3. the complexity of the procedure is such that only a *physician* can assist.

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

F. Non-experimental human organ and tissue transplant services to an organ transplant recipient who is covered under this Plan.

The plan covers only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants.

In addition, benefits will be provided for *inpatient hospital* expenses of the donor of an organ for transplant to a covered recipient and for *physician's* expenses for surgical removal of the donor organ if the donor does not have coverage through another group plan. No benefits will be provided for organ selection, transportation and storage costs, or when benefits are available through government funding of any kind, or when the recipient is not covered under this Plan.

The plan does not cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

G. Circumcision.

H. Amniocentesis.

I. Surgical treatment of *morbid obesity* when medically necessary. Criteria used when reviewing for medical necessity includes:

1. body mass index (BMI) is greater than 40 or greater than 35 with associated diagnosis of high blood pressure, diabetes, sleep apnea, or coronary artery disease;

2. over 18 years of age;

3. active in weight reduction program for at least six (6) months with proof of attempt, such as a letter of medical necessity from the primary MD, or log of diets without significant, long-term weight loss achieved;

4. psychological evaluation that indicates the covered person is mentally appropriate for the procedure and has determination and support to succeed;

5. notes from bariatric surgeon that state he or she has reviewed all of this information.

J.. Applicable to Class 0001: Surgical treatment of temporomandibular joint dysfunction (TMJ) and other craniomandibular disorders.

K. Voluntary sterilization.

L. Voluntary termination of pregnancy.

Mental/Nervous Conditions and Substance (Drug or Alcohol) Abuse Treatment

Please refer to the Schedule of Benefits section of this plan for cost-sharing requirements, day or visit limits, and any preauthorization requirements that apply to these benefits.

A. Mental Health Care Services.

1. Inpatient Services. The plan covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar hospital, medical and surgical coverage provided under this plan. 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.

   We also cover 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.

2. 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; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof.

3. 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.

B. Substance Use Services.

1. 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) 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.

2. Outpatient Services. The plan covers outpatient substance use services relating to the diagnosis and treatment substance use disorder, including methadone 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 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 outpatient visits 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 family plan that covers the person receiving, or in need of, treatment for substance use disorder. The plan's 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.

Medical Services

1. *Physician* office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls. The plan does not cover expenses for telephone conversations, charges for failure to keep a scheduled appointment, or charges for completion of medical reports, itemized bills, or claim forms, acupuncture and/or acupressure, dispensing fees for drugs, medicines and supplies received in a physician's office, holistic medical treatment, or hypnosis. The plan also does not cover weight reduction or control, including treatments, instructions, activities, or drugs and diet pills, whether or not prescribed by a physician.

2. Initial physician examination and subsequent physician office visits for prescription of medication for the treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). The plan does not cover education, counseling, or job training for Attention Deficit disorder, Attention Deficit/Hyperactivity learning disorders or behavioral problems whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.

3. *Inpatient physician* visits by the attending or non-attending *physician*.

4. *Second/Third (if medically necessary) Opinions.*

   A. Second Cancer Opinion. The plan covers a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

   B. Second Surgical Opinion. The plan covers a second surgical opinion (or third, if medically necessary) by a qualified physician on the need for surgery.

C. Second Opinions in Other Cases. There may be other instances when you will disagree with a provider's recommended course of treatment. In such cases, you may request that the plan designate another provider to render a second opinion. If the first and second opinions do not agree, the plan will designate another provider to render a third opinion. After completion of the second opinion process, the plan will approve covered services supported by a majority of the providers reviewing your case.

5. Pregnancy and related maternity care for all covered females. Eligible expenses include parent education, training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

   The plan covers services for maternity care provided by a physician or midwife, nurse practitioner, hospital or birthing center. The plan covers prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the New York Public Health Law. The plan will not pay for duplicative routine services provided by both a midwife and a physician. See the Inpatient Services section of this plan for coverage of inpatient maternity care.

   The plan covers the cost of renting one (1) breast pump per pregnancy for the duration of breast feeding.

6. Services to achieve the diagnosis of infertility.

7. The plan covers services for the treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Such coverage is available as follows:

   A. Basic Infertility Services. Basic infertility services will be provided to a member 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, members 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.

B. Comprehensive Infertility Services. If the basic infertility services do not result in increased fertility, the plan covers comprehensive infertility services.

Comprehensive infertility services include:

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

C. Exclusions and Limitations. Then plan does not cover:

- In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs for an ovum donor or donor sperm;
- Sperm storage costs;
- 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 the plan's denial is overturned by an External Appeal Agent.
- Adoption expenses
- Surrogate expenses, including use of a surrogate by a covered individual or services as a surrogate by a covered individual.

All services must be provided by providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

8. The plan covers the following limited dental and oral surgical procedures:

    - Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
    - Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
    - Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
    - Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered.
    - Applicable to Class 0001: Non-surgical treatment of Temporomandibular joint dysfunction (TMJ), prevention of TMJ, craniomandibular disorders, and other conditions of the joint linking the jawbone and skull, muscles, nerves, and other related tissues to that joint:

        a. Intra-oral reversible devices/appliances (encompassing fabrication, insertion, and adjustment).
        b. Physical therapy for chronic myospasms and mandibular hypomobility or hypermobility; such as, ultrasound, massage, and muscle exercise programs.

9. Radiation therapy.

10. Chemotherapy in an outpatient facility or in a health care professional's office. Orally-administered anti-cancer drugs are covered under the Prescription Drug Coverage section of this plan.

11. Dialysis treatments of an acute or chronic kidney ailment.

12. Chiropractic care is covered when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions of this plan. This excludes *maintenance care* and palliative treatment.

13. Podiatric services for treatment of an *illness or injury*, or due to metabolic or peripheral vascular disease.

14. Habilitation/Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a facility or in a health care professional's office. Please refer to the Schedule of Benefits section of this plan for cost-sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

    - Physical therapy received from a qualified *practitioner* under the direct supervisor of the attending *physician,* excluding maintenance care and palliative treatment. Massage therapy or rolfing are not covered.
    - Speech therapy from a qualified practitioner to restore normal speech loss due to an illness, injury or surgical procedure. If the loss of speech is due to a birth defect, any required corrective surgery must have been performed prior to the therapy.
    - Occupational therapy but not to include vocational, educational, recreational, art, dance or music therapy.

15. Cardiac rehabilitation therapy received from a qualified *practitioner* under the direct supervision of the attending *physician,* excluding *maintenance care* and palliative treatment.

16. Home health care provided in your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to your physician's written treatment plan and must be in lieu of hospitalization or confinement in a skilled nursing facility. Home care includes:

    - Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
    - Part-time or intermittent services of a home health aide;
    - Physical, occupational or speech therapy provided by the Home Health Agency; and
    - Medical supplies, Prescription Drugs and medications 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 during a hospitalization or confinement in a skilled nursing facility.
    - Nutritional counseling that is provided by or under the supervision of a registered dietician;

    Please refer to the Schedule of Benefits section of this plan for cost-sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits. Private duty nursing is not covered.

17. *Hospice care* that includes the care and treatment of a covered person who has been certified by the primary attending *physician* as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located.

Benefits are subject to the maximums, if any, as set forth in the Schedule of Benefits. Covered *hospice care*, and bereavement expenses are limited to:

a. room and board for confinement in a *hospice facility*;

b. ancillary charges furnished by the hospice while the patient is confined therein, including rental of *durable medical equipment* which is used solely for treating an *injury* or *illness*;

c. nursing care by a registered *nurse*, a licensed practical *nurse*, or a licensed vocational *nurse* (L.V.N.);

d. home health aide services;

e. home care charges for home care furnished by a *hospital* or *home health care agency*, under the direction of a hospice, including custodial care if it is provided during a regular visit by a registered *nurse*, a licensed practical *nurse*, or a home health aide;

f. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.

g. medical social services by licensed or trained social workers, psychologists, or counselors;

h. nutrition services provided by a licensed dietician;

i. counseling and emotional support services by a licensed social worker or a licensed pastoral counselor;

j. up to 5 bereavement counseling visits by a licensed social worker or a licensed pastoral counselor for the covered person's immediate family following the patient's death.

The plan does not cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

18. Orthoptic therapy.

19. Pulmonary therapy.

20. Respiratory therapy.

21. Allergy testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. The plan also covers allergy treatment, including desensitization treatments, routine allergy injections and serums.

22. Preparation of serum and injections for allergies.

23. Sleep apnea treatment including surgical and non-surgical services.

24. Sleep studies.

25. Diabetic Equipment, Supplies and Self-Management Education.

The plan covers diabetic equipment, supplies, and self-management education if recommended or prescribed by a physician or other licensed health care professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

A. Equipment and Supplies.

The plan covers the following equipment and related supplies for the treatment of diabetes when prescribed by your physician or other provider legally authorized to prescribe:

- Acetone reagent strips
- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Blood glucose kit
- Blood glucose strips (test or reagent)
- Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose reagent strips
- Glucose reagent tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall

designate by regulation as appropriate for the treatment of diabetes.

B. Self-Management Education.

Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. The plan covers education on self-management and nutrition when: diabetes is initially diagnosed; a physician diagnoses a significant change in your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a physician, other health care provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in your home when Medically Necessary.

C. Limitations.

The items will only be provided in amounts that are in accordance with the treatment plan developed by the physician. The plan covers only basic models of blood glucose monitors unless you have special needs relating to poor vision or blindness.

26. Examination for or the purchase or fitting of hearing aids when required as the result of an *injury*.

27. Charges related to a provider discount for covered medical expenses resulting in savings to this Plan.

28. Screening, diagnosis, and treatment of 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 claims processor 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.

A. Screening and Diagnosis. The plan covers assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

B. 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, the plan covers 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; however, the plan will cover the repair or replacement per device type that is necessary due to behavioral issues when deemed medically necessary. Coverage will be provided for the device most appropriate to your current functional level. The plan does not cover delivery or service charges or routine maintenance.

C. 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. The plan 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.

D. 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.

E. 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.

F. 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.

G. 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 Persons 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 coinsurance provisions under this plan for similar services. For example, any copayment, deductible or coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any copayment, deductible or coinsurance for Prescription Drugs will generally also apply to Prescription Drugs covered under this benefit. Please refer to the Schedule of Benefits section of this plan for the cost-sharing requirements that apply to applied behavior analysis services and assistive communication devices.

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 Persons with Developmental Disabilities.

29. Items and services in connection with an approved cancer clinical trial including:

a. otherwise covered physician fees, laboratory expenses, and expenses associated with a hospitalization; and

b. evaluation and treatment of the patient associated with the underlying disease; and

c. the cost of care consistent with the usual standards of care whenever a patient receives medical care associated with an approved cancer clinical trial; and

d. care that would be covered by the Plan if such items and services were provided other than in connection with an approved cancer clinical trial.

An approved cancer clinical trial must include a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets all of the following requirements:

a. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health.
(ii) The Centers for Disease Control and Prevention.
(iii) The Agency for Health Care Research and Quality.
(iv) The Centers for Medicare & Medicaid Services.
(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
(vii) Any of the following if the conditions described in paragraph (2) are met:
(I) The Department of Veterans Affairs.
(II) The Department of Defense.
(III) The Department of Energy.

b. Every policy issued by a medical expense indemnity corporation, a hospital service corporation or a health service corporation which provides coverage for prescribed drugs approved by the Food and Drug Administration of the United States government for the treatment of certain types of cancer shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the food and drug administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:
(i) the American Hospital Formulary Service-Drug Information (AHFSDI);
(ii) National Comprehensive Cancer Networks Drugs and Biologics Compendium;
(iii) Thomson Micromedex DrugDex;
(iv) 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 & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer reviewed professional journal.

c. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

d. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

e. The proposed therapy has been reviewed and approved by the applicable qualified

Institutional Review Board.

f. The available clinical or pre-clinical data indicate that the treatment or intervention provided pursuant to the approved cancer clinical trial will be at least as effective as standard therapy, if such therapy exists, and is anticipated to constitute an improvement in effectiveness for treatment, prevention, or palliation of cancer.

g. The facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.

h. The trial consists of a scientific plan of treatment that includes specific goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of the quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval from one of the federal entities identified above.

i. The trial must:

   i. evaluate a service which is otherwise an Eligible Claims Expense; and
   ii. have a therapeutic intent (i.e., not designed exclusively to test toxicity or disease pathophysiology); and
   iii. enroll diagnosed Participants.

The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

a. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

b. assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

The plan does not cover items and services in connection with a cancer clinical trial including:

i. the costs of the investigational drugs or devices themselves; or

ii. the costs of any non-health service that might be required for a Participant to receive the treatment or intervention (e.g., transportation, hotel, meals, and other travel expenses); or

iii. the costs of managing the research; or

iv. any cost which would not be covered under the Plan's benefits for non-investigational treatments.

Diagnostic X-Ray and Laboratory Services

1. *Diagnostic charges* for x-rays, including PET scans, MRI, nuclear medicine, and CAT scans.

2. X-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

3. Preadmission testing (PAT) ordered by your physician and performed in hospital outpatient facilities prior to a scheduled surgery in the same hospital provided that:

    - The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
    - Reservations for a hospital bed and operating room were made prior to the performance of the tests;
    - Surgery takes place within seven (7) days of the tests; and
    - The patient is physically present at the hospital for the tests.

4. Ultrasounds, prenatal laboratory and pregnancy testing.

5. Genetic testing and counseling.

Equipment, Supplies and Miscellaneous Items

The plan covers the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.

    Durable Medical Equipment is 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; and
    - Appropriate for use in the home.

    Coverage is for standard equipment only. The plan will determine whether to rent or purchase such equipment.

    The plan does not cover equipment designed for your comfort or convenience (e.g., pools, hot tubs, water beds, air conditioners, air purifiers, saunas, humidifiers, dehumidifiers, heating pads, hot water bottles, exercise equipment and any other clothing or equipment which could be used in the absence of an *illness* or *injury*), as it does not meet the definition of durable medical equipment.

2. Braces.

   The plan covers braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. The plan covers replacements when growth or a change in your medical condition make replacement necessary. The plan does not cover the cost of repair or replacement that is the result of misuse or abuse by you.

   Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances, when prescribed by a physician, to replace lost body parts or to aid in their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the physical condition of the covered person.

3. Prosthetics.

   A. External Prosthetic Devices.

      The plan covers covers prosthetic devices (including wigs) 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. Please refer to the Schedule of Benefits section of this plans cost-sharing requirements, day or visit limits, and any Preauthorization or referral requirements that apply to these benefits.

      The plan does not cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

      Eyeglasses and contact lenses are not covered under this section of the plan.

      The plan does not cover shoe inserts.

      The plan covers external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

      Coverage is for standard equipment only.

      The plan covers the cost of the prosthetic device.

   B. Internal Prosthetic Devices.

      The plan covers surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by you and your attending physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

The plan does not cover breast prosthetic implant removals whether inserted for cosmetic reasons or due to a mastectomy are not covered, unless the removal is medically necessary.

4. Medical Supplies

   The plan covers medical supplies that are required for the treatment of a disease or injury which is covered under this plan. The plan also covers maintenance supplies (e.g., ostomy supplies) for conditions covered under this plan. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. The plan does not cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply coverage.

5. Artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition; or, replacement is less expensive than repair of existing equipment.

6. Oxygen and rental of equipment required for its use.

7. Initial prescription contact lenses or eye glasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery* or when required as the result of an *injury*.

8. Sterile surgical supplies after *surgery*.

9. Jobst garments.

10. Medications for Use in the Office. The plan covers medications and injectables (including injectable contraceptives) (excluding self-injectables) used by your provider in the provider's office for preventive and therapeutic purposes. This benefit applies when your provider orders the prescription drug and administers it to you. When prescription drugs are covered under this benefit, they will not be covered under the prescription drug coverage section of this plan.

11. Post mastectomy prosthetic and surgical bra.

12. Applicable to Classes 0T01, 0T02, 0T03, 0T07, 0T08, 0T09: Prescription drug co-pays.

13 Applicable to Classes 0T04, 0T05, 0T06, 0T10, 0T11, 0T12: Prescription drugs and medications that bear the legend "Caution: Federal law prohibits dispensing without a prescription". In addition, drugs and medications must be accompanied by a *physician's* prescription:

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 coinsurance) 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. Also, 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. You may contact BlueCross BlueShield at the number on your ID card.

1. Well-Baby and Well-Child Care**.** The plan covers 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. This benefit is provided to members from birth through attainment of age 19 and is not subject to copayments, deductibles or coinsurance when provided by a Participating Provider.

2. Adult Annual Physical Examinations. 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.

   Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the covered preventive services is available by contacting BlueCross BlueShield.

   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 coinsurance 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 a Participating Provider.

3. Adult Immunizations. The plan covers adult immunizations as recommended by ACIP. This benefit is not subject to copayments, deductibles or coinsurance when provided in

accordance with the recommendations of ACIP and when provided by a Participating Provider.

4. 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 by contacting BlueCross BlueShield. This benefit is not subject to copayments, deductibles or coinsurance 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.

5. Mammograms. The plan covers mammograms for the screening of breast cancer as follows:

   - One (1) baseline screening mammogram for women age 35 through 39; and
   - One (1) baseline screening mammogram annually for women age 40 and over.

   If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, the plan will cover mammograms as recommended by her Provider. However, in no event will more than one (1) preventive screening per Plan Year be covered.

   Mammograms for the screening of breast cancer are not subject to copayments, deductibles or coinsurance 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 the above schedule, and when provided by a Participating Provider.

   Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to copayments, deductibles or coinsurance.

6. Family Planning and Reproductive Health Services. The plan covers family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise covered under the Prescription Drug Coverage section of this document, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to copayments, deductibles or coinsurance 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 a Participating Provider.

   We also cover vasectomies subject to copayments, deductibles or coinsurance.

   We do not cover services related to the reversal of elective sterilizations.

7. Bone Mineral Density Measurements or Testing. The plan covers bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this document. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for Coverage of bone mineral density measurements and testing if you meet any of the following:

   - Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
   - With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
   - On a prescribed drug regimen posing a significant risk of osteoporosis;
   - With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
   - With such age, gender, and/or other physiological characteristics which pose a significant risk for 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.

   This benefit is not subject to copayments, deductibles or coinsurance 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 not include all of the above services such as drugs and devices and when provided by a Participating Provider.

8. Screening for Prostate Cancer. The plan covers an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with 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 not subject to copayments, deductibles or coinsurance when provided by a Participating Provider.

H. Medical Expenses Not Covered

The Plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. The Plan only covers those expenses for services and supplies specifically described as covered in the preceding section. There may be expenses in addition to those listed below which are not covered by the Plan.

General Exclusions

1. Any condition, disability, or expense sustained as a result of being engaged in an activity primarily for wage, profit or gain, and for which the covered person benefits are provided under Worker's Compensation Laws or similar legislation.

2. Professional services performed by a person who is a member of your immediate family or is related to the covered person, such as a spouse, parent, child, brother, sister, or in-law.

3. Services, supplies, or treatment for which there is no legal obligation to pay, or expenses which would not be made except for the availability of benefits under this Plan.

4. Services, supplies, or treatment furnished by or for the United States Government or any other government, unless payment is legally required.

5. Illness, accident, treatment or medical condition arising out of service in the Armed Forces.

6. Services, supplies, or treatment incurred as the result of an auto accident up to the amount of any state required automobile insurance with respect to those expenses.

Additional Exclusions

The following exclusions are in alphabetical order to assist you in finding information quickly; however, you should review the entire list of exclusions when trying to determine whether a particular treatment or service is covered as the wording of the exclusion may place it in a different location than you might otherwise expect.

1. *Cosmetic* or reconstructive *surgery* except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. However, if the policy provides hospital, surgical or medical expense coverage, including a policy issued by a health maintenance organization, then coverage and determinations with respect to cosmetic surgery must be provided pursuant to Part 56 of this Title (Regulation 183).

2. Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.

3. Eyeglasses or lenses, vision therapy or supplies unless specifically mentioned in Covered Medical Expenses.

4. Foot treatment, palliative or cosmetic, including flat foot conditions, supportive devices for the foot, orthopedic or corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

5. Hearing examinations, hearing aids, or related supplies except as specifically mentioned in Covered Medical Expenses.

6. *Hospital* confinement for physiotherapy, hydrotherapy, convalescent care, or rest care.

7. Respite care.

8. Sanitarium, rest, or *custodial care*.

The plan excludes coverage for services that are not listed as being covered.
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ARTICLE V -- PRESCRIPTION DRUG PLAN
Administered by Express Scripts

A. About Your Prescription Drug Benefits

All Prescription Drug benefits provided under this Plan must satisfy some basic terms. The following terms which may apply to your Plan's benefits are commonly included in Prescription Drug benefit plans but often overlooked or misunderstood.

1. Maintenance Medication

   An extended-use medication for which there is a non-emergency ongoing need.

2. Managed Formulary

   A list of approved generic and brand-name prescription and non-prescription drugs.

3. Mail Order Pharmacy

   A pharmacy which has entered into an agreement with the Plan Administrator to provide covered mail order prescription drugs.

4. Participating Retail Pharmacy

   A retail pharmacy which has entered into an agreement with the Plan Administrator to provide you covered prescription drugs.

5. Pharmacy Benefits Manager

   A Pharmacy Benefits Manager (PBM) is a third party administrator selected to process outpatient medication bills. The Pharmacy Benefits Manager has been contracted to process prescription drug claims from participating pharmacies. The Pharmacy Benefits Manager also develops and maintains the formulary.

6. Prescription Drug

   A pharmaceutical substance approved by the United States Food And Drug Administration (USFDA) for the treatment of your condition and dispenses in accordance with labeling guidelines. A prescription drug requires a prescription in order to be sold to you, and the label must bear the statement “Caution – Federal Law Prohibits Dispensing without a Prescription.”

7. Prior Authorization

   A system whereby the prescribing *physician* must contact the Corporate Pharmacy Department for approval prior to the provision of certain prescription drugs covered under the plan.

B. Prior Authorization

Your *physician* is required to obtain prior authorization prior to your purchase of certain medications.

C. Pharmacy Dispensing Limitations

Prescriptions are covered for up to a thirty (30) day supply, or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops, or up to a ninety (90) day supply for certain chronic conditions when authorized by your *physician*. Three (3) co-pays will apply to the purchase of extended cycle oral contraceptives.

The Plan reserves the right to impose additional supply limitations based on relevant medical and/or scientific information available regarding the condition being treated and/or the appropriate medical use of the medication.

Exception: Drugs allowed by New York State law to be dispensed in ninety (90) or one hundred eighty (180) day supply will be dispensed in accordance with the regulation.

One co-pay will apply to each thirty (30) day supply. Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist.

D. Co-Payments

The co-payment amounts are as determined by the individual school. Contact your individual school district to obtain this information.

E. Covered Prescription Drugs

Prescriptions covered under your Plan include all drugs bearing the legend "Caution: Federal law prohibits dispensing without a prescription" except as identified in Prescription Drugs Not Covered. In addition, the following are specifically covered by this Plan when accompanied by a *physician's* prescription:

1. Diabetic medications and supplies.

2. Non-insulin syringes.

3. Contraceptive drugs and devices, which are approved by the Federal Drug Administration (FDA) and require a prescription.

4. Smoking deterrents for those age 18 and over.

5. Prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.

6. Prescription drugs as required under the Patient Protection and Affordable Care Act.

7. Compounded medication of which at least one (1) ingredient is a generic legend drug.

8. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a *physician* or other lawful prescriber.

F. Prescription Drugs Not Covered

1. Non-legend drugs except as specifically mentioned in Covered Prescription Drugs.

2. Charges for the administration or injection of any drug.

3. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed *hospital*, rest home, sanitarium, *skilled nursing facility*, convalescent *hospital*, nursing home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.

4. The plan reserves the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

5. The plan reserves the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an Appeal.

The plan excludes coverage for prescriptions that are not listed as being covered.

G. Mail Order Prescription Drug Program

The mail order prescription drug program is offered when there is an ongoing need for medication. By using this service, you can obtain prescribed medication required on a non-emergency, extended-use basis. The quantity of a prescribed drug ordered through this program can be anything up to a ninety (90) day supply or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops.

The law requires that pharmacies dispense the exact quantity prescribed by the *physician*. So, if your *physician* authorizes the maximum order quantity, the prescription must be for a ninety (90) day supply for you to receive that quantity. For example, if you take one (1) tablet per day, your *physician* must write a prescription for ninety (90) tablets. If you take two (2) tablets per day, your *physician* must write a prescription for one hundred and eighty (180) tablets, etc. If your *physician* authorizes refills, these can be dispensed only when your initial order is nearly exhausted, so be sure to ask your *physician* to prescribe the normal supply, plus refills whenever appropriate.

There will be times when you need a new prescription filled immediately. If you need medication immediately but will be taking it on an ongoing basis, ask your *physician* for two (2) prescriptions. The first prescription should be for up to a thirty (30) day supply that you can have filled at a local pharmacy; the second prescription should be for your ongoing need, which will be dispensed in up to a ninety (90) day supply. Send the larger prescription through the mail service prescription drug program.

ARTICLE VI -- COORDINATION OF BENEFITS (COB)

A. General Provisions

When more than one coverage exists, one plan normally pays its benefits in full and the other plan pays a reduced benefit. If this Plan is the primary plan, it will consider benefits as if it were the only plan. If this Plan is the secondary plan, it may make additional payment for covered expenses after any applicable deductible, but only to bring the cumulative total paid by both plans combined to the amount that this Plan would have paid if it were the only plan.

For example, assume your spouse's employer plan is primary for your dependent children's expenses. If the expense is $150, a claim for this amount must be submitted first with the spouse's employer plan, which determines a benefit of $120 is payable. Next, a claim for the $150 along with proof of payment of $120 from the spouse's plan should be submitted for payment under this Plan. The benefit under this Plan will be determined as if it was the only Plan. If the benefit under this Plan is $120 or less, no additional benefit is payable. If the benefit payable under this Plan is $135, an additional $15 is payable from this Plan.

B. Automobile Coverage

Benefits payable under this Plan will be coordinated with benefits provided or required by any no-fault automobile coverage statute, whether or not a no-fault policy is in effect, and/or any other automobile coverage. This Plan will be secondary to any state mandated automobile coverage for services and supplies eligible for consideration under this Plan.

C. Federal Programs

The term "group health plan" includes the Federal programs *Medicare* and Medicaid. The regulations governing these programs take precedence over the order of determination of this Plan.

D. Order of Benefit Determination – Employee / Spouse

When all other group health plans covering you and/or your spouse contain a coordination of benefits provision, order of payment will be as follows:

1. The plan covering a person as an active employee will be primary over a plan covering the same person as a dependent, a retiree, a laid-off individual or in some other capacity.

2. When a person is an active employee under more than one (1) plan, the plan covering the individual for the longer period of time will be considered primary.

3. The plan covering a person as an employee or a dependent will be primary over the plan providing continuation coverage (COBRA).

E. Order of Benefit Determination – Children

The group health plan covering an individual as a dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

- The plan of the parent who has custody will be primary;
- 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; and
- 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.

F. Order of Benefit Determination - Medicare

If you are entitled to *Medicare* for any reason but chose not to enroll under *Medicare* Parts A and B when entitled, this Plan will process your claims as though *Medicare* Parts A and B had been elected. If the Plan determines that *Medicare* would have been the primary payor, if enrolled, this plan will calculate the amount that Traditional *Medicare* Parts A and B would have paid and coordinate benefits accordingly.

Many factors determine whether this Plan or *Medicare* is the secondary payor for you and your spouse including the number of people employed by your *employer* and disabling *illness* for which an individual is treated. This plan does not discriminate against *Medicare* beneficiaries for whom *Medicare* is the secondary payer. This Plan will not coordinate benefits for prescription drugs for an individual enrolled in a *Medicare* D plan. If you or your dependent enrolls in a *Medicare* D plan, benefits available under this Prescription Drug Plan will be terminated – such termination may result in termination of all Plan coverage.

If you are entitled to *Medicare* and remain actively at work (for an employer which employs more than 20 employees) you or your spouse may choose to remain covered under this Plan without reduction in *Medicare* benefits or you may designate *Medicare* as the exclusive payor of benefits. If you choose *Medicare* as the exclusive payor of benefits, coverage under this Plan will end. If you do not specifically choose *Medicare* as the exclusive payor of benefits, this Plan will continue to be primary. If you are under age sixty-five (65) and your spouse is over age sixty-five (65), he or she can make their own choice.

G. Right To Make Payments To Other Organizations

Whenever payments which should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision.

Amounts paid will be considered benefits paid under this Plan and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

ARTICLE VII -- SUBROGATION

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and the plan has provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, the plan may be subrogated to all rights of recovery against any such party (including your own insurance carrier) for the benefits the plan has provided to you under this plan. Subrogation means that the plan has the right, independently of you, to proceed directly against the other party to recover the benefits that the plan has provided.

Subject to applicable state law, unless preempted by federal law, the plan may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which the plan provided benefits. Under Section 5-335 of the New York General Obligations Law, the plans right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that you did not take any action against the plan or violate any contract between you and the plan. The law presumes that the settlement between you and the responsible party does not include compensation for the cost of health care services for which the plan provided benefits.

The plan requests that you notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by you for which the plan has provided benefits. You must provide all information requested by the plan or its representatives including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request.

ARTICLE VIII -- OTHER IMPORTANT PLAN PROVISIONS

A. Special Election For Employees Age Sixty-Five (65) And Over

If you remain actively at work after reaching age sixty-five (65), you or your spouse may choose to remain covered under this Plan without reduction in *Medicare* benefits or designate *Medicare* as the exclusive payor of benefits. **If you choose to remain covered under this Plan, this Plan will be the primary payor of benefits and *Medicare* will be secondary**. If you choose *Medicare* as primary, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you are under age sixty-five (65) and your spouse is over age sixty-five (65), he or she can make their own choice.

B. Medicaid-Eligible Employees And Dependents

If you or your dependents are Medicaid-eligible, you will be entitled to the same coverage under the Plan as all other employees and dependents. The benefits of this Plan will be primary to those payable through Medicaid.

C. Recovery Of Overpayments

On occasion, a payment will be made to you when you are not covered, for a service that is not covered, or which is more than is proper. When this happens, the plan will explain the problem to you and you must return the amount of the overpayment to the plan within 60 days after receiving notification from the plan. However, the plan shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless the plan has a reasonable belief of fraud or other intentional misconduct.

D. Right To Receive And Release Necessary Information

The Plan may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement Plan provisions. When you request benefits, you must furnish all the information required to implement Plan provisions. Failure to provide requested information may result in denial of benefits.

E. Blue Card Pricing Disclosure

When you obtain health care services from a participating provider outside the geographic area BlueCross BlueShield of Western New York serves, the amount you pay for covered services is calculated on either:

- The billed charges for your covered services, or
- The negotiated price that the on-site BlueCross and/or BlueShield Licensee ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price considered by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any other contingent payments arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices, however, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Participant liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Participant liability calculation methods that differ from the usual Blue Card method noted above in paragraph one of this Exhibit or require a surcharge, BlueCross BlueShield of Western New York would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area BlueCross BlueShield of Western New York serves, if this plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area BlueCross BlueShield of Western New York serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area BlueCross BlueShield of Western New York serves. But in no event will you be entitled to benefits for health care services, whenever you receive them, which are specifically excluded or limited from coverage by this plan.

F. Severability

The provisions of this Plan will be considered severable; therefore, if a provision is deemed invalid or unenforceable, that decision will not affect the validity and enforceability of the other provisions of the Plan.

ARTICLE IX -- CLAIM SUBMISSION PROCESS

A. 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 a participating provider, you will not need to submit a claim form. However, if you receive services from a non-participating provider either you or the provider must file a claim form. If the non-participating provider is not willing to file the claim form, you will need to file it. See the Coordination of Benefits section of this plan for information on how the plan coordinates benefit payments when you also have group health coverage with another plan.

B. Notice of Claim

Claims for services must include all information designated by the claims processor 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 calling the claim processor at the number on your ID card. Completed claim forms should be sent to the address on your ID card.

C. Timeframe for Filing Claims

Claims for services must be submitted to the claim processor for payment within 12 months after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 12-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 (1) year from the time the claim was required to be filed.

D. Claims for Prohibited Referrals

The claims processor 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.

E. 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 section of this plan.

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 plan.

F. Pre-Service Claim Determinations

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If the claims processor has all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), the claims processor will make a determination and provide notice to you (or your designee) within 15 days from receipt of the claim.

   If the claims processor needs additional information, the claims processor will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If the claims processor receives the information within 45 days, the claims processor will make a determination and provide notice to you (or your designee) in writing, within 15 days of receipt of the information. If all necessary information is not received within 45 days, the claims processor will make a determination within 15 calendar days of the end of the 45-day period.

2. Urgent Pre-Service Reviews. With respect to urgent pre-service requests, if the claims processor has all information necessary to make a determination, the claims processor will make a determination and provide notice to you (or your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If the claims processor needs additional information, the claims processor will request it within 24 hours. You will then have 48 hours to submit the information. The claims processor will make a determination and provide notice 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.

G. Post-Service Claim Determinations

A post-service claim is a request for a service or treatment that you have already received. If the claims processor has all information necessary to make a determination regarding a post-service claim, the claims processor will make a determination and notify you (or your designee) within 30 calendar days of the receipt of the claim. If the claims processor needs additional information, the claims processor will request it within 30 calendar days. You will then have 45 calendar days to provide the information. The claims processor will make a determination and provide notice to you (or your designee) in writing within 15 calendar days of the earlier of the receipt of the information or the end of the 45-day period.

ARTICLE X – GRIEVANCE PROCEDURES

A. Grievances

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

B. Filing a Grievance

You can contact the claims processor at the number on your ID card or in writing to file a Grievance. You or your designee has up to 180 calendar days from when you received the decision you are asking for review to file the Grievance.

When your Grievance is received, the claims processor 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.

The claims processor keeps all requests and discussions confidential and will take no discriminatory action because of your issue. The claims processor has a process for both standard and expedited Grievances, depending on the nature of your inquiry.

C. 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 claims processor will decide the Grievance and notify you 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 30 calendar days of receipt of your Grievance.

D. Grievance Appeals

If you are not satisfied with the resolution of your Grievance, you or your designee may file an Appeal in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an appeal.

When the claims processor receives your Appeal, the claims processor will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. The claims processor will decide the Appeal and notify you in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of your Appeal.
All Other Grievances (That are not in relation to a claim or request for a service or treatment.)	30 calendar days of receipt of your Appeal.

ARTICLE XI – UTILIZATION REVIEW

A. Utilization Review

The claim processor reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the Utilization Review process, please call the number on your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

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 plan does not compensate or provide financial incentives to employees or reviewers for determining that services are not Medically Necessary. The plan has developed guidelines and protocols to assist the claim processor in this process. Specific guidelines and protocols are available for your review upon request. For more information, call the number on your ID card.

B. Preauthorization Reviews

1. Non-Urgent Preauthorization Reviews. If the claim processor has all the information necessary to make a determination regarding a Preauthorization review, The claim processor 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 claim processor needs additional information, the claim processor will request it within three (3) business days. You or your provider will then have 45 calendar days to submit the information. If the claim processor receives the requested information within 45 days, the claim processor 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, the claim processor will make a determination within 15 calendar days of the end of the 45-day period.

2. Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if the claim processor has all information necessary to make a determination, the claim processor 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 the claim processor needs

additional information, the claim processor will request it within 24 hours. You or your provider will then have 48 hours to submit the information. The claim processor will make a determination and provide notice to you (or your designee) and your provider by telephone within 48 hours of the earlier of the receipt of the information or the end of the 48 hour period and 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 claim processor 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.

C. Concurrent Reviews

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 claim processor needs additional information, the claim processor will request it within one (1) business day. You or your Provider will then have 45 calendar days to submit the information. We 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 the claim processor does not receive the information, within 15 calendar days 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 claim processor 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 claim processor has all the information necessary to make a determination, the claim processor 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 claim processor needs additional information, the claim processor will request it within 24 hours. You or your provider will then have 48 hours to submit the information. The claim processor 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 we 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 claim processor 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 claim processor 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 claim processor receives a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, the claim processor will not deny coverage for home care services 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 claim processor at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, the claim processor will make a determination within 24 hours of receipt of the request and the claim processor will provide coverage for the inpatient substance use disorder treatment while the determination is pending.

D. Retrospective Reviews

If the claim processor has all information necessary to make a determination regarding a retrospective claim, the claim processor will make a determination and notify you and your provider within 30 calendar days of the receipt of the request. If the claim processor needs additional information, the claim processor will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We 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 the claim processor has all the information to make a decision, the claim processors 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.

E. Retrospective Review of Preauthorized Services

The claim processor may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to the claims processor upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to the claim processor upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to the claim processor;
- The claim processor was not aware of the existence of such information at the time of the Preauthorization review; and
- Had the claim processor 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.

F. Reconsideration.

If the claim processor 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.

G. Utilization Review Internal Appeals

You, your designee, and, in retrospective review cases, your provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an Appeal. The claim processor will acknowledge your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will, if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

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 the claim processor determines 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. You are not eligible for a Utilization Review Appeal if the service you request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating your condition. (Such an Appeal will be treated as a Grievance.) 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 the claim processor 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 Referral Denial. You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when the claim processor determines that they have 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 referral 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 the claims processor 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.

H. First Level Appeal

1. Preauthorization Appeal. If your Appeal relates to a Preauthorization request, the claim processor 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 claim processor 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 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.

    If you are not satisfied with the resolution of your expedited Appeal, you may file a standard internal Appeal or an external appeal.

The claim processors 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 the claim processor denies a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your provider file an expedited internal Appeal of an adverse determination, the claim processor 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 an adverse determination, the claim processor will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

ARTICLE XII – EXTERNAL APPEAL

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 claim processor 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 internal Appeal process. But, you can file an external appeal even though you have not received a final adverse determination through the internal Appeal process if:

    - The claim processor agrees in writing to waive the internal Appeal. The claim processor 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 claim processor 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 claim processor demonstrates that the violation was for good cause or due to matters beyond their control and the violation occurred during an ongoing, good faith exchange of information between you and the claim processor).

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

If the claim processor 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 in paragraph "A" above.

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

If the claim processor 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 in paragraph "A" 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 the plan; 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 We have 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 Referral Denial to a Non-Participating Provider

If the claim processor has denied coverage of a request for a Referral to a Non-Participating Provider because they determine they have 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: certify that the Participating Provider recommended by the claim processor does not have the appropriate training and experience to meet your particular health care needs; and 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. 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 failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

The claim processor will provide an external appeal application with the final adverse determination issued through the internal Appeal process or the written waiver of an internal Appeal. 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 claim processor based the denial, the External Appeal Agent will share this information with the claim processor in order for the claim processor to exercise he right to reconsider their decision. If the claim processor chooses to exercise this right, the claim processor will have three (3) business days to amend or confirm their decision. Please note that in the case of an expedited external appeal (described below), the claim processor does not have a right to reconsider the claim processors 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 claim processor. 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 the claim processor 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 claim processor 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.

G. 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 the claim processors failure to adhere to claim processing requirements.

ARTICLE XIII -- FAMILY AND MEDICAL LEAVE ACT OF 1993

A. Coverage

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), your coverage may continue for a period of up to twelve (12) weeks in any twelve (12) consecutive month period. The FMLA requires any employer with fifty (50) or more employees, as defined by the Act, to maintain health coverage for an employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan. You are considered eligible for FMLA leave if you have been employed by the *employer* for at least twelve (12) months, and have performed at least 1,250 hours of service with the *employer* in the twelve (12) months immediately preceding the start of the leave.

B. Reasons for FMLA Leave

You may continue to be covered under the Plan during an approved FMLA leave for one or more of the following reasons:

1. The birth of a son or daughter, in order to care for that son or daughter.

2. The placement of a son or daughter with you for adoption or foster care.

3. In order to care for your spouse, son, daughter, or parent who has a serious health condition unrelated to service in the line-of-duty in the Armed Forces of the United States.

4. Because of a serious health condition that makes you unable to perform the functions of your position.

5. In order to care for a member of the United States Armed Forces, including a member of the National Guard or Reserves. Military caregiver leave may be approved if it meets the following criteria:

    a. You are the spouse or the next-of-kin (the nearest blood relative of that individual) of a member of the Armed Forces who suffered a serious illness or injury in the line-of-duty while on active duty, and

    b. The Armed Forces member is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary disability retired list and is medically unfit to perform the duties of the member's office, grade, rank, or rating.

6. A *qualifying exigency* due to your spouse, son, daughter, or parent's active duty status, or notification of an impending call to active duty status, in support of a contingency operation.

C. Serious Health Condition

For the purposes of Subsections 3. and 4., a serious health condition is defined as an *illness*, *injury*, impairment, or physical or mental condition that involves any period of incapacity or treatment as an *inpatient* in a *hospital*, hospice, or residential medical care facility; any period of incapacity requiring absence from work, school, or other regular daily activities of more than three (3) calendar days that also involves continuing treatment by or under the supervision of a *health care provider*; or continuing treatment by or under the supervision of a *health care provider* for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three (3) calendar days; and for prenatal care. A *health care provider* means a doctor of medicine or osteopathy who is authorized to practice medicine or *surgery* (as appropriate) by the state in which the doctor practices or others capable of providing health care services as defined by the Act.

D. Amount Of Leave

When an FMLA leave is taken in order to care for your spouse, son, daughter, or parent who has sustained a serious line-of-duty related health condition during service in the United States Armed Forces you may continue to be covered for up to twenty-six (26) weeks in a single twelve (12) consecutive month period. Any other approved FMLA leave is limited to twelve (12) weeks in any twelve (12) consecutive month period.

If you and your spouse are both employed by the *employer* the aggregate amount of FMLA leave may not exceed the maximum period described above in any twelve (12) consecutive months if such leave is taken for the birth of a son or daughter, the placement of a son or daughter with you for adoption or foster care, or in order to care for a parent who has a serious health condition. Your entitlement to leave for a birth or placement for adoption or foster care concludes at the end of the twelve (12) month period beginning on the date of the birth or placement.

E. Reduced Leave Schedule

Reduced leave schedule means a leave schedule that reduces the usual number of hours per week, or per day, that you are employed. Approved leave taken for reasons stated in Subsections 1. and 2. above cannot be taken intermittently or on a reduced leave schedule unless the *employer* and you agree otherwise. Approved leave described in Subsections 3. through 6. may be taken intermittently or on a reduced leave schedule when *medically necessary*.

F. Documentation And Procedures

The *employer* may require that leave taken for reasons stated in Subsections 3., 4., and 5 be supported by a certification letter issued by the treating *health care provider*, as appropriate. Military caregiver leave may require supporting certification from, or on behalf of the United States Department of Defense. If the validity of the certification is doubted, the *employer* can request that you obtain a second opinion, at the *employer's* expense, from a *health care provider* designated by the *employer*. If both certification letters are in conflict, the *employer* can request that you obtain, at the *employer's* expense, a third opinion from a provider jointly approved by you and the *employer*. The opinion of the third provider is binding.

You must notify the *employer* of your intention to take a FMLA leave at least thirty (30) days prior to the date the leave is to begin unless you prove that the need for the leave was not reasonably foreseeable. The *employer* may require you to substitute any existing paid leave, such as vacation leave, personal leave, or family leave, for any part of the unpaid FMLA leave.

Coverage will be continued during a FMLA leave at the same level and under the same conditions that coverage would have been provided if you had remained a member of the eligible group and covered under the Plan. Such continuation may be combined with any time allowed under the Extension of Coverage section of the Plan for coverage continuation in the event of a leave of absence or disability. If the *employer* provides a new health care plan of benefits, or changes health benefits or plans while you are on leave, you are entitled to the new or changed plan or benefits to the same extent as if you were not on leave. You will not be subject to the *waiting period* or the *pre-existing condition* limitation when restored to active service with the *employer* regardless of whether or not you chose to retain health coverage during FMLA leave. The *employer* reserves the right to deny restoration to certain Highly Compensated or Key Employees as determined by the conditions defined in the Act.

You must continue to make any required contribution to the Plan in order for coverage to continue. The *employer's* obligation to maintain health coverage under FMLA leave will cease if your contribution is more than thirty (30) days overdue. Failure to make the required contribution to the Plan will terminate coverage at the end of the period for which you made the last required contribution.

Further, failure to return from FMLA leave for reasons other than the continuation, recurrence, or onset of a serious health condition that entitles you to leave under FMLA, or other circumstances beyond your control, may result in the recovery, by the *employer*, of any contributions made by the *employer* toward the continuation of your coverage. When you fail to return from FMLA leave because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the *employer* from recovering any contribution made toward continuation of coverage, the *employer* may require a certification letter issued by your *health care provider* or the *health care provider* of your son, daughter, spouse or parent, as appropriate, verifying the *medical necessity* for continued leave. The certification letter must be submitted within thirty (30) days of the *employer's* request.

The amount that the *employer* may recover is limited to only the *employer's* share of allowable contributions as would be calculated under COBRA Continuation of Benefits excluding the two (2) percent fee for administrative costs. The *employer* may not recover any contributions for any period of FMLA leave covered by paid leave. The employee who returns to active service for at least thirty (30) calendar days is considered to have "returned to work."

The above is in compliance with the Family and Medical Leave Act of 1993, as amended, and the same as may be further amended from time to time.

ARTICLE XIV -- COBRA CONTINUATION OF BENEFITS
(Consolidated Omnibus Budget Reconciliation Act)

A. Definitions

For purposes of this Continuation Coverage Under COBRA provision, the following definitions apply:

1. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2. "Code" means the Internal Revenue Code of 1986, as amended.

3. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.

4. "Covered Employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan, subject to the provisions set forth in **ARTICLE I – ELIGIBILITY AND PARTICIPATION**. This definition is expansive and includes retirees, independent contractors, self-employed persons and partners of a partnership.

5. "Group Health Plan" means a plan (including a self-insured plan) of, or contributed by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to employees, former employees, the employer, other associated or formerly associated with the employer in a business relationship, or their families.

6. "Qualified Beneficiary" means:

    a. A Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan;

    b. A covered spouse or dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below; or

    c. A newborn or newly adopted child of a Covered Employee who is continuing coverage under COBRA.

7. "Qualifying Event" means the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

    a. Termination of a Covered Employee's employment (other than for gross misconduct) or reduction in his hours of employment;

    b. The death of the Covered Employee;

c. The divorce or legal separation of the Covered Employee from his spouse;

d. A child ceasing to be eligible as a dependent child under the terms of the Group Health Plan; or

e. Your *employer* filing a Chapter 11 bankruptcy petition. Coverage may continue for covered retirees and/or their dependents if coverage ends or is substantially reduced within one year before or after the initial filing for bankruptcy.

8. "Totally Disabled" or "Total Disability" means Totally Disabled as determined under Title II or Title XVI of the Social Security Act.

B. Right To Elect Continuation Coverage

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the 60-day period beginning on the later of:

1. The date of the Qualifying Event; or

2. The date he was notified of his right to continue coverage.

C. Notification Of Qualifying Event

If the Qualifying Event is divorce, legal separation or a dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company of the Qualifying Event within 60 days of the event in order for coverage to continue. You must report the Qualifying Event to the Plan Administrator in writing. The statement must include:

1. Your name;

2. Your identification number;

3. The dependent's name;

4. The dependent's last known address;

5. The date of the Qualifying Event; and

6. A description of the event.

In the case of a request for extension of the COBRA period as a result of a finding of disability by the Social Security Administration, you must also submit the disability determination. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the section below entitled "Total Disability" in order for coverage to continue.

Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

D. Length Of Continuation Coverage

1. A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Group Health Plan for up to 18 months from the date of the Qualifying Event.

   If you are eligible for New York State continuation coverage, your coverage may continue for a total of 36 months.

2. A Qualified Beneficiary who loses coverage due to the Covered employee's death, divorce, or legal separation, and dependent children who have become ineligible for coverage may continue coverage under the Group Health Plan for up to 36 months from the date of the Qualifying Event.

E. Total Disability

1. In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled within 60 days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for dependents who were covered under the Continuation Coverage) for a total of 29 months as long as the Qualified Beneficiary notifies the *employer*:

   a. Prior to the end of 18 months of Continuation Coverage that he was disabled as of the date of the Qualifying Event; and

   b. Within 60 days of the determination of Total Disability under the Act.

   If you are eligible for New York State continuation coverage, your coverage may continue for a total of 36 months.

2. The *employer* will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond 18 months pursuant to this section.

3. If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

   a. The Qualified Beneficiary shall notify the *employer* of this determination within 30 days; and

   b. Continuation Coverage shall terminate the last day of the month following 30 days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

F. Coordination Of Benefits

Benefits will be coordinated with any federal program, automobile coverage or group health plan in accordance with the provisions described in the Article entitled - Coordination of Benefits.

G. Termination Of Continuation Coverage

Continuation Coverage will automatically end earlier than the applicable 18, 29, or 36-month period for a Qualified Beneficiary if:

1. The required monthly contribution for coverage is not received by the Company within 30 days following the date it is due;

2. The Qualified Beneficiary becomes covered under any other Group Health Plan as an employee or otherwise.

3. For Totally Disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such beneficiary is no longer Totally Disabled;

4. The Qualified Beneficiary becomes entitled to *Medicare* benefits; or

5. The Company ceases to offer any Group Health Plans.

H. Multiple Qualifying Events

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is 18 or 29 months, and a second Qualifying Event occurs during the 18- or 29- month period, the Qualified Beneficiary may elect, in accordance with the section entitled “Right To Elect Continuation Coverage”, to continue coverage under the Group Health Plan for up to 36 months from the date of the first Qualifying Event.

I. Continuation Coverage

The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated Covered Employees and their dependents. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add dependents for Continuation Coverage, such dependents must meet the definition of dependent under the Group Health Plan.

J. Carryover Of Deductibles And Plan Maximums

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable deductible and co-payment features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

K. Payment Of Premium

1. The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

    a. The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.

    b. For Qualified Beneficiaries whose coverage is continued pursuant to the section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for Continuation Coverage months 19-29.

    c. Contributions for coverage may, at the election of the Qualified Beneficiary, be paid in monthly installments.

2. If Continuation Coverage is elected, the monthly contribution for coverage for those months up to and including the month in which election is made must be made within 60 days of the date of election.

3. Without further notice from the Company, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within 30 days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage", subsection A. This 30-day grace period does not apply to the first contribution required under subsection B.

4. No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

ARTICLE XV -- PROTECTED HEALTH INFORMATION

This Employee Benefit Plan collects and maintains a great deal of personal health information about you and your enrolled dependents. Federal HIPAA regulations on privacy and confidentiality limit how an Employee Health Plan and its *Plan Administrator* may use and disclose this information. This Article describes provisions that protect the privacy and confidentiality of your personal health information and complies with applicable federal law.

A. Definitions

For purposes of this Article, the following terms shall have the meaning set forth below unless otherwise provided by the Plan:

1. "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in any electronic media.

2. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

3. "Member" means a covered employee or the covered dependents of a covered employee.

4. "*Plan Sponsor*" is Allegany – Cattaraugus Schools.

5. "Plan" is Allegany – Cattaraugus Schools Health Plan.

6. "Plan Documents" means the group health plan's governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to the Allegany – Cattaraugus Schools Health Plan Document.

7. "Protected Health Information" means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify a member. Protected Health Information includes information of persons living or deceased. The following components of a member's information also are considered Protected Health Information:

    a. Names;

    b. Street address, city, county, precinct, zip code;

    c. Dates directly related to a member, including birth date, health facility admission and discharge date, and date of death;

    d. Telephone numbers, fax numbers, and electronic mail addresses;

e. Social Security numbers;

f. Medical record numbers;

g. Health plan beneficiary numbers;

h. Account numbers;

i. Certificate/license numbers;

j. Vehicle identifiers and serial numbers, including license plate numbers;

k. Device identifiers and serial numbers;

l. Web universal resource locators (URLs);

m. Biometric identifiers, including finger and voice prints;

n. Full face photographic images and any comparable images; and

o. Any other unique identifying number, characteristic, or code.

8. "Regulation" means the Health Insurance Portability and Accountability Act of 1996, as amended.

9. "Security Incidents" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. The Plan Sponsor will report a successful Security Incident to the Plan within a reasonable period of time after learning of the successful security incident. Data relating to an unsuccessful attempt may be aggregated and reported to the Plan on a less frequent basis.

10. "Summary Health Information" means information that may be individually identifiable health information, and

    a. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

    b. From which the information described in the regulation has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

B. Permitted And Required Uses And Disclosure Of Protected Health Information

Subject to obtaining written certification, this Plan may disclose Protected Health Information to the *Plan Sponsor*, provided the *Plan Sponsor* does not use or disclose such Protected Health Information except for the following purposes:

1. Performing Plan administrative functions which the *Plan Sponsor* performs for the Plan.

2. Obtaining bids for providing employee coverage under this Plan; or

3. Modifying, amending, or terminating the Plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the *Plan Sponsor* be permitted to use or disclose Protected Health Information in a manner that is inconsistent with the regulation.

C. Conditions Of Disclosure

The Plan, or any employee coverage with respect to the Plan, shall not disclose Protected Health Information to the *Plan Sponsor* unless the *Plan Sponsor* agrees to:

1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

2. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to Protected Health Information.

3. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the *Plan Sponsor*.

4. 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.

5. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with the Regulation.

6. Make available to a Plan participant who requests an amendment to the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with the Regulation.

7. Make available to a Plan participant who requests an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with the Regulation.

8. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Regulation.

9. If feasible, return or destroy all Protected Health Information received from the Plan that the *Plan Sponsor* still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.

10. Ensure that the adequate separation between the Plan and the *Plan Sponsor* required in the Regulation is satisfied.

D. Certification Of Plan Sponsor

The Plan shall disclose Protected Health Information to the *Plan Sponsor* only upon the receipt of a certification by the *Plan Sponsor* that the Plan has been amended to incorporate the provisions of the Regulation, and that the *Plan Sponsor* agrees to the conditions of disclosure set forth in item C. above.

E. Permitted Uses And Disclosure Of Summary Health Information

The Plan may disclose Summary Health Information to the *Plan Sponsor*, provided such Summary Health Information is only used by the *Plan Sponsor* for the purpose of:

1. Obtaining bids for providing employee coverage under this Plan; or

2. Modifying, amending, or terminating the Plan.

F. Permitted Uses And Disclosure Of Enrollment And Disenrollment Information

The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the *Plan Sponsor*, provided such enrollment and disenrollment information is only used by the *Plan Sponsor* for the purpose of performing administrative functions that the *Plan Sponsor* performs for the Plan.

G. Adequate Separation Between The Plan And The Plan Sponsor

The *Plan Sponsor* shall limit access to Protected Health Information to only those employees authorized by the *Plan Sponsor*. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the *Plan Sponsor* performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the *Plan*

Sponsor for non-compliance pursuant to the *Plan Sponsor's* employee discipline and termination procedures.

H. Security Standards For Electronic Protected Health Information

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

2. Plan Sponsor shall ensure that the adequate separation that is required by the Regulation is supported by reasonable and appropriate security measures;

3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

    b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.

This Plan will comply with the requirement of 45 C.F.R. / 164.314 (b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164.

ARTICLE XVI -- DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under Covered Medical Expenses.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Applied Behavior Analysis

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.

Birthing Center

A public or private facility, other than private offices or clinics of *physicians*, which meets the free standing *birthing center* requirements of the State Department of Health in the state where the covered person receives the services.

The *birthing center* must provide: A facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a *physician* or certified nurse midwife at all births and immediate post partum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified *nurse* midwife; arrangements for diagnostic x-ray and lab services; the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for emergency transfers, and maintain medical records on each patient and child.

Calendar year

The twelve (12) month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the *calendar year*.

Claims Processor

BlueCross BlueShield of Western New York

Cosmetic Surgery

A procedure performed primarily to improve appearance which does not meaningfully promote the proper function of the body or prevent or treat an *illness, injury* or disease.

Creditable Coverage

Coverages required to be included as such under Section 701(c) of ERISA, and shall exclude those coverages that are permitted to be excluded under Section 701(c) of ERISA. Solely for purposes of illustration and not in limitation of the foregoing, *creditable coverage* generally includes periods of coverage under an individual or group health plan (including *Medicare*, Medicaid, governmental and church plans) that are not followed by a *significant break in coverage* and excludes coverage for liability, limited scope dental or vision benefits, specified disease and/or other supplemental-type benefits. **Days in a *waiting period* are not *creditable coverage***.

Custodial Care

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Dentist

A person acting within the scope of his/her license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

Diagnostic Charges

The *fee schedule* for x-ray or laboratory examinations made or ordered by a *physician* in order to detect a medical condition.

Durable Medical Equipment

Equipment able to withstand repeated use for the therapeutic treatment of an active *illness* or *injury*. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an *illness* or *injury* and could be purchased without a *physician's* prescription.

Emergency Condition

A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in:

1. 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;

2. Serious impairment to such person's bodily functions;

3. Serious dysfunction of any bodily organ or part of such person; or

4. Serious disfigurement of such person.

Employer

Allegany – Cattaraugus Schools.

Enrollment Date

The first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*.

Experimental/Investigational

Expenses for treatments, procedures, devices or drugs which the *Plan Administrator* determines, in the exercise of its discretion, are *experimental*, *investigational* or done primarily for research. Such treatments, procedures, devices or drugs are excluded under this Plan unless:

Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and, reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnoses; and

Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnoses.

Reliable evidence includes anything determined to be such by the *Plan Administrator*, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authorized by the national medical professional community.

Governmental approval of a service will be considered, but is not necessarily sufficient, to render a service of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition.

Fee Schedule

The *fee schedule* is the calculation of the maximum amount payable toward any claim of benefits. The *fee schedule* is the negotiated price for local participating providers and a participating provider outside the geographic area that the network serves. The *fee schedule* reflects the maximum amount payable toward a covered expense. Participating providers can only bill you for the difference between the benefit paid and the *fee schedule* for any service. Allowed expense for non-participating providers is based on the usual and customary charge in the geographic area where the services or supplies are provided. The usual and customary charge is the charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by *physicians, health care providers* or *dentists*.

General Anesthesia

An agent introduced into the body which produces a condition of loss of consciousness.

Genetic Information

The information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Health Care Provider

A *physician*, *practitioner*, *nurse, hospital* or *specialized treatment facility* as those terms are specifically defined in this section.

Home Health Care Agency

An agency or organization that provides a program of home health care and that:

1. is approved as a *home health care agency* under *Medicare*;

2. is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; or

3. meets all of the following requirements:

a. it is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;

b. it has a full-time administrator;

c. it maintains written records of services provided to the patient;

d. its staff includes at least one registered *nurse* or it has nursing care by a registered *nurse* available; and

e. its employees are bonded and it provides malpractice and malplacement insurance.

Hospice Care

A program approved by the attending *physician* for care rendered in the home, *outpatient* setting or institutional facility to a terminally ill covered person with a medical prognosis that life expectancy is six (6) months or less.

Hospice Facility

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six (6) months or less.

The facility must have an interdisciplinary medical team consisting of at least one (1) *physician,* one (1) registered *nurse,* one (1) social worker, one (1) volunteer and a volunteer program.

A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care,* the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital

The term *hospital* means a short-term, acute, general hospital which:

1. is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;

2. has organized departments of medicine and major surgery;

3. has a requirement that every patient must be under the care of a physician or dentist;

4. provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);

5. if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861 (k) of United States Public Law 89-97 (42 USCA 1395x (k));

6. is duly licensed by the agency responsible for licensing such hospitals; and

7. is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, or a place for convalescent, custodial, educational or rehabilitory care.

Illness

Any bodily sickness, disease or mental/nervous disorder. For the purposes of this Plan, pregnancy will be considered an *illness*.

Injury

A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or accident.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A section, ward, or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate *nurses* or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purposes of providing normal post-operative recovery treatment or service.

Late Enrollee

An individual who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime

The period of time you or your eligible dependents participate in this Plan or the plan sponsored by Allegany – Cattaraugus Schools prior to the restatement date, October 1, 2016.

Maintenance Care

Services and supplies primarily to maintain a level of physical or mental function.

Medical Director

A Physician, compensated by the *Claims Processor*, who provides health care utilization advise to the *Plan Administrator*. In addition, the Medical Director:

- Monitors and evaluates health care utilization including quality of care and safety issues, adherence to clinical guidelines, protocols, etc.

- Provides guidance of case management, utilization management, medical management, treatment plans, quality and safety related to appropriate utilization and review of an adverse benefit determination.

- Establishes best practices and documents appropriate guidelines.

- Reviews and evaluates new applications of existing technology and new medical procedures for medical policy.

Medically Necessary (Medical Necessity)

Any service or supply required for the diagnosis or treatment of an active *illness* or *injury* that is rendered by or under the direct supervision of the attending *physician*, generally accepted by medical professionals in the United States and non-experimental.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended.

Morbid Obesity

A condition in which the body weight exceeds the normal weight by either 100 pounds, or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.

The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Nurse

A person acting within the scope of his/her license and holding the degree of Registered Graduate *Nurse* (R.N.), Licensed Vocational *Nurse* (L.V.N.) or Licensed Practical *Nurse* (L.P.N.).

Open Enrollment Period

A period as defined by the individual district.

Oral Surgery

Necessary procedures for *surgery* in the oral cavity, including pre- and post-operative care.

Outpatient

Treatment either outside a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Physically or Mentally Handicapped

The inability of a person to be self-sufficient as the result of a condition such as, but not limited to, mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition preventing the individual from being self-sufficient or other *illness* as approved by the *Plan Administrator*.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who is legally entitled to practice medicine under the laws of the state or jurisdiction where the services are rendered.

Plan Sponsor

Cattaraugus - Allegany BOCES.

Plan Year

The twelve (12) month period for Allegany – Cattaraugus Schools beginning July 1 and ending June 30.

Practitioner

A *physician* or person acting within the scope of applicable state licensure/certification requirements and/or holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Optician, Certified Nurse Midwife (C.N.M.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist or Registered Respiratory Therapist.

Professional Components

Services rendered by a professional technician (e.g. radiologist, pathologist, anesthesiologist) in conjunction with services rendered at a *hospital, ambulatory surgical center* or *physician's* office.

Qualified Medical Child Support Order

A medical child support order that either creates or recognizes the right of an alternate recipient (i.e., a child of a covered participant who is recognized under the order as having a right to be enrolled under the Plan) or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the Plan.

A "medical child support order" is a judgment, decree or order (including a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law in that state, that provides for child support related to health benefits with respect to the child of a group health plan participant, or required health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or that enforces a state medical child support law enacted under Section 1908 of the Social Security Act with respect to a group health plan.

Qualifying Exigency

An event arising from your spouse, son, daughter, or parent's call to active duty in the United States Armed Forces. Such exigencies are:

1. Short-Notice Deployment

   Leave if your covered family member is notified of a deployment of seven days or less. You may take a leave of up to seven days for any reason related to that deployment. The seven day period begins on the day the covered family member is notified of the short-notice deployment.

2. Military Events

   Leave in order to attend any official ceremony, program or event sponsored by the armed forces, and to attend family support and assistance programs and information briefings sponsored by the military, military service organizations, or the American Red Cross.

3. Child Care / School Activities

   Leave in order to arrange for child care or attend certain school functions of the son or daughter of a covered military family member, including leave to:

   a. Arrange for alternative school or childcare;

   b. Provide childcare on an urgent, immediate need (not regular) basis;

   c. Enroll or transfer a child into a new school or day care facility; and

   d. Attend meetings with school or day care staff regarding discipline, parent-teacher conferences, and school counselors if directly related to the active duty of a covered military family member.

4. Financial And Legal Arrangements

   Leave in order to make or update financial or legal arrangements to address the covered military family member's absence while on active duty/call to active duty, such as preparing or executing a will, powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, and securing military service benefits (Leave is not available for routine matters, such as paying bills.)

5. Counseling

   Leave in order to attend counseling by a non-health care provider (i.e. military chaplain, pastor, or minister, or counseling offered by the military or a military service organization) available when counseling is needed by the employee, the covered military member, or the son or daughter of the covered military member provided that the counseling arises from active duty service or call to active duty.

6. Rest And Recuperation Leave

   Leave in order to spend time with a covered military family member on rest and recuperation leave during a period of deployment. You may take a leave of up to five days during any military family member’s rest and recuperation leave.

7. Post-Deployment Activities

   Leave in order to attend ceremonies incident to the return of the covered military family member, including arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of ninety (90) days following the termination of the covered military member's active duty status, participation in Department of Defense “Yellow Ribbon Reintegration” Program (participation is permitted even if it exceeds the general ninety (90) day limitations period by a few days).

   Additionally, such leave is available to address issues arising from the death of a covered military family member including meeting and recovering the body and making funeral arrangements.

8. Additional Activities

   Upon approval by the *Plan Administrator*, any other activity arising from your covered family member’s call to or active service duty/contingency operation in the United States Armed Forces.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post acute *hospital* and rehabilitative *inpatient* care and is duly licensed

by the appropriate governmental agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part time care services, or an institution which primarily provides treatment of mental/nervous conditions, substance abuse treatment or tuberculosis except if such facility is licensed, certified or approved as a *rehabilitative facility* for the treatment of medical conditions, mental/nervous conditions or substance abuse treatment in the jurisdiction where it is located, or is credited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Respite Care

Respite care rendered through a licensed *hospice facility* for home custodial care which provides relief to an immediate family in caring for the day to day needs of a terminally ill individual.

Retiree

A former employee of Allegany-Cattaraugus Schools who meets the retiree requirements as defined by the individual school.

Second/Third Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the diagnosis of the proposed *surgery* to evaluate alternatives and/or the medical advisability of undergoing a surgical procedure.

Significant Break In Coverage

A period of 63 (or more) consecutive days without *creditable coverage*. Periods of no coverage during an HMO affiliation period or *waiting period* shall not be taken into account for purposes of determining whether a *significant break in coverage* has occurred. For this purpose, an HMO affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

Skilled Nursing Facility/Extended Care Facility/Convalescent Nursing Hospital

An institution that:

1. primarily provides skilled (as opposed to custodial) nursing service to patients;

2. is approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAH) and/or *Medicare*.

In no event shall such term include any institution or part thereof that is used principally as a rest facility or facility for the aged or, any treatment facility for mental/nervous condition or substance abuse treatment.

Special Enrollee

A Special Enrollee i**s** an employee or dependent who is entitled to and who requests special enrollment:

1. within thirty-one (31) days of losing other health coverage because their COBRA coverage is exhausted, they cease to be eligible for other coverage, or employer contributions are terminated;

2. for a newly acquired dependent, within thirty-one (31) days of the marriage, birth, adoption, or placement for adoption; or

3. within sixty (60) days of losing other health coverage through Medicaid or CHIP.

Specialized Treatment Facility

Specialized treatment facilities as the term relates to this Plan include *birthing centers*, *ambulatory surgical facilities*, *hospice facilities*, or *skilled nursing facilities* as those terms are specifically defined.

Spouse

The person to whom the subscriber is legally married, including a same sex spouse.

Surgery

Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision. Surgery includes closed reduction of fractures, dislocation of bones, endoscopic procedures, and any incision or puncture of the skin or other tissue except for inoculation, vaccination, collection of blood, drug administration or injection.

Total Disability (Totally Disabled)

The inability to perform all the duties of the covered person's occupation as the result of an *illness* or *injury*. *Total disability* means the inability to perform the normal duties of a person of the same age.

Waiting Period

A period of continuous, full-time employment before an employee or dependent is eligible to participate in the Plan, or for purposes of determining *creditable coverage*, the *waiting period* under any other health plan. The *waiting period* cannot exceed ninety (90) days.

Year

See *calendar year*.

ARTICLE XVII-- GENERAL INFORMATION

Name and Address of the Plan Sponsor

Cattaraugus-Allegany BOCES
1825 Windfall Road
Olean, NY 14760

Name and Address of the Plan Administrator

Cattaraugus-Allegany BOCES
1825 Windfall Road
Olean, NY 14760

Name and Address of the Person Designated as the Agent for Service of Legal Process

Cattaraugus-Allegany BOCES
1825 Windfall Road
Olean, NY 14760

Claims Processor

Medical Claims:

BlueCross BlueShield of Western New York
P.O. Box 80
Buffalo, NY 14240

Prescription Drug Claims:

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121

Internal Revenue Service and Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 16-6006266.

Plan Year

The twelve (12) month period for Allegany – Cattaraugus Schools beginning July 1 and ending June 30.

Method of Funding Benefits

The funding for the benefits is derived from the funds of the *employer* and contributions made by covered employees. The Plan is not insured.

SIGNATURE PAGE

The effective date of the Allegany – Cattaraugus Schools Health Plan is October 1, 2016.

It is agreed by Allegany – Cattaraugus Schools that the provisions of this document are correct and will be the basis for the administration of the Allegany – Cattaraugus Schools Health Plan.

Dated this 16th day of AUGUST, 2016

BY: Thomas C Potter

TITLE: CHIEF FISCAL OFFICER

WITNESS: Carol Packard

TITLE: Health Benefits Manager