
# STATE-WIDE SCHOOLS COOPERATIVE HEALTH PLAN

## SWSCHP PLAN DOCUMENT
## AND
## SUMMARY PLAN DESCRIPTION

**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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## INTRODUCTION

This Plan Document describes the health care benefits funded by SWSCHP, the State-Wide Schools Cooperative Health Plan.

The purpose of this Plan Document is to explain your rights and responsibilities in working with SWSCHP, which provides for the payment or reimbursement of all, or a portion of, eligible medical expenses.

Please keep it handy for future reference. It is available on the SWSCHP website. www.swschp.org.

Certain provisions of this Plan may be modified by your particular Participating Employer. Examples of those types of variable provisions are:

- The definition of "Employee," which guides your right to eligibility for participation in the Plan;
- The definition of "Waiting Period," which specifies how soon after your employment starts you may participate in the Plan; and
- The contributions (the amount per month or pay period) required, if any, toward the cost of your coverage.

This Plan Document generally provides information regarding the most common of these variable provisions. You may contact your School District Health Benefits Representative for specific information regarding your Participating Employer's policy. Your School District Health Benefits Representative can also explain enrollment choices (individual, family, etc.), Plan options, and other employee benefits available to you.

In addition, as the Plan is amended from time to time, the Plan Administrator will send you information explaining the changes. If those later notices describe a benefit or procedures that is different from what is described here, you should rely on the most recent information.

**Plan Effective Date: January 1, 1986**

**SPD Restated as of: July 1, 2020**

**Plan Year Ends: June 30th**

## CONTACT INFORMATION: FOR HELP OR INFORMATION ABOUT THE PLAN

When you need information, please check this Plan Document first. If you need further help, call the people listed in the following summary:

| FOR INFORMATION ON: | YOU SHOULD CONTACT: |
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| **Eligibility**<br>• Enrollment and General Plan Information | You should contact your School District Health Benefits Representative for information on specifics on when Plan benefits become eligible and for the necessary enrollment forms.<br><br>You may also contact the State-Wide Schools Cooperative Health Plan (SWSCHP) at 1-888-P SWSCHP (779-7247) or on the web at SWSCHP.org for further information. |
| **Hospital and Medical Benefits**<br>• Claims determinations for Post Service Claims<br>• Claim Forms (Out-of-Network Post service claims)<br>• Plan Benefit Information<br>• Medicare Part D Notice of Creditable Coverage<br>• Preservice, Urgent Care and Concurrent Grievances and Appeals of decisions that do not involve medical necessity determinations | To request a claim form, contact your School District Health Benefits Representative.<br><br>When refer to in this Document, the “Hospital and Medical Claims Administrator” refers to Amalgamated Employee Benefits Administrators.<br><br>When referred to in this Document, “Medical Management”, Medical Care Management or the “Medical Management Program” refers to Amalgamated Medical Care Management.<br><br>Submit claims to: SWSCHP<br>P.O. Box # 5035<br>White Plains, New York 10602-5035<br><br>To file a Grievance/Appeal (Non-clinical Issues)<br>Amalgamated Employee Benefits Administrators<br>Attn: Appeals Department<br>P.O. Box 5451<br>White Plains, NY 102-4551<br>Fax 914-367-2981<br><br>For Medical Necessity Appeals, contact:<br>Amalgamated Medical Care Management<br>Attn: Appeals<br>8C Industrial Way<br>Salem, NH 03079<br>ammretrosandappeals@alicaremed.com Fax: 914-367-4152 |

| FOR INFORMATION ON: | YOU SHOULD CONTACT: |
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| **Preferred Provider Organization (PPO) Network - Anthem JAA PPO**<br><br>**Point of Service (POS) Network – Empire Blue Cross Blue Shield**<br>POS Network for all Members residing in the 28 Southern Counties of New York State<br><br>• Medical Network Provider Directory<br>• Additions/Deletions of Network Providers | For help locating a Participating Provider, contact SWSCHP at 1-888-P SWSCHP (779-7247) or on the web at SWSCHP.org for further information.<br><br>Always check before you visit a provider to be sure they are still contracted and will give you the discounted price. **CAUTION:** Use of a **non**-PPO/POS network Hospital, facility or health care provider could result in you having to pay a substantial balance on the provider's billing (see definition of "balance billing" in the Defined Terms section of this Plan Document). Your lowest out-of-pocket costs will occur when you use In-Network PPO/POS providers. |
| **Medical Management Program**<br>• Precertification of Admissions and Medical Services<br>• Utilization Review and Case Management<br>Preservice (including Urgent Care and Concurrent) and Post Service Grievances and Appeals of decisions (including External Appeals) that involve medical necessity determinations. | Amalgamated Medical Care Management<br>8C Industrial Way<br>Salem, NH 03079<br>Phone: 1-888-779-7247 SWSCHP.org |
| **Prescription Drug Plan/Pharmacy Benefits Manager (PBM)**<br>• ID Cards<br>• Retail Network Pharmacies<br>• Mail Order (Home Delivery) Pharmacy<br>• Prescription Drug Information<br>• Formulary of Preferred Drugs<br>• Precertification of Certain Drugs<br>• Direct Member Reimbursement (for Non-network retail pharmacy use)<br>• Specialty Drug Program: Precertification and Ordering<br>• Submit claims and appeals | When use in this Document, "the PBM" refers to CVS Caremark.<br><br>CVS Caremark<br>844-260-5889<br>www.caremark.com<br><br>Mail Order Address:<br>CVS Caremark X0272<br>P.O. Box 2110<br>Pittsburgh, PA 15230-2110<br><br>If you need to submit a claim or to file a Grievance/Appeal, send it to:<br>CVS/Caremark<br>PO Box 52136<br>Phoenix, AZ 85072-2136 |
| **COBRA Administrator**<br>• Information About Coverage<br>• Adding or Dropping Dependents<br>• Cost of COBRA Continuation Coverage<br>• COBRA Premium payments<br>• Second Qualifying Event and Disability Notification | You should contact your School District Health Benefits Representative at your Participating Employer. |

| FOR INFORMATION ON: | YOU SHOULD CONTACT: |
|---|---|
| **Executive Director and HIPAA Privacy Officer and HIPAA Security Officer**<br>• Request a HIPAA Notice of Privacy Practice | Peter Mustich<br>Executive Director<br>State-Wide Schools Cooperative Health Plan<br>12 Metro Park Road<br>Suite 208<br>Colonie, NY 12205-1139<br>1-800-814-6265 |
| **If you are dissatisfied with how the Plan has handled a claim or appeal or need to contact the New York Department of Financial Services:** | Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:<br>New York State Department of Financial Services<br>Consumer Assistance Unit<br>One Commerce Plaza<br>Albany, NY 12257<br>Website: www.dfs.ny.gov |
| **If you need assistance filing a Grievance or Appeal:** | Contact the state independent Consumer Assistance Program at:<br>Community Health Advocates<br>633 Third Avenue, 10th Floor<br>New York, NY 10017<br>Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org<br>Website: www.communityhealthadvocates.org |

## DEFINED TERMS

Key words and phrases used in this Plan Document are capitalized and listed below; along with the definition or explanation of the manner in which the term is used in this Plan. Terms that apply to the Prescription Drugs are define in that section.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender, unless the context indicates otherwise.

**Active Employee** refers to the status of you, the Employee, prior to your retirement, and other than when you are disabled.

**Acupuncture** is the technique for treating disorders of the body by passing long, thin needles through the skin to specific points.

**Acute** is a short duration of the onset of symptoms, or a change in the Member's condition that would require prompt medical attention.

**Allowable Expense** is a health care service or expense, including Deductibles, Coinsurance or Copayments, that is covered in full or in part by any of the plans covering a Member (this term is further discussed in the COB section of this Plan Document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

**Allowed Amount** means the maximum amount the Plan allows as payment for eligible Medically Necessary Covered Services or supplies.

The Allowed Amount is determined by the Plan to be:

**With respect to an In-Network/Participating Provider** (PPO/POS), the Negotiated Rate set forth in the agreement between the participating network health care provider/facility and the PPO/POS network (also known as the Network Rate). For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim.

**With respect to an Out-of-Network/Provider**, Allowed Amount means the scheduled amount the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Out-of-Network providers or the negotiated fee, if any, with the Provider. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

The Plan determines the Allowed Amount based on the 70$^{th}$ percentile of Fair Health Schedule.

***With respect to Emergency Services in an Out-of-Network Emergency Room***, Allowed Amount means the highest of Medicare, the median of the Network rate or the 80$^{th}$ percentile of Fair Health Schedule.

If the health care provider's/facility's actual billed charge is less than what is listed above, actual billed charge is the allowed charge.

The Plan will not always pay benefits equal to or based on the health care or provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "Allowed Amount" amount for health care services or supplies.

**Any amount in excess of the "Allowed Amount" does not count toward the Plan's annual Out-of-Pocket Maximums.** Members are responsible for amounts that exceed the Allowed Amount by this Plan.

**Ambulance/Pre-Hospital emergency medical services** mean the prompt evaluation and treatment of an emergency medical condition and/or non-air-borne transportation of the patient to a Hospital. Where the patient utilizes non-air-borne emergency transportation, reimbursement will be based on whether a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (1) placing the health of the person affected with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (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.

**Ambulatory Surgical Center** is a facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis, has continuous Physician and nursing care by Registered Nurses when patients are there and does not provide for overnight stays.

**Appeal** is a request for the Plan to review a Utilization Review decision or a Claim/Grievance request.

**Autism Spectrum Disorder** means, for purposes of administering the "autism spectrum disorder" benefit as described in the *Schedule of Benefits*, 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.

**Balance Billing** is a bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Amount and what the provider actually charged (the billed charges). Amounts associated with balance billing are not covered by this Plan, even if the Plan's Out-Of-Pocket Maximum has been reached. Amounts exceeding the Allowed Amount do not count toward the Plan's Out-Of-Pocket Maximum and may result in balance billing to you. Out-of-Network Health Care Providers commonly engage in balance billing. This means a Member may be billed for, and be responsible for, any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid balance billing by using In-Network providers. In-Network providers are not allowed to Balance Bill for Covered Services. Where the Plan is able to negotiate with an Out-of- Network provider, however, the provider may accept the Plan's payment (less any applicable Coinsurance, Deductible or Copayment) as payment in full and, in that event, you will not be balanced billed.

**Benefit Days** is a day of care that is used to count against any benefit limit in this Plan based upon days. For example, each day that you are an inpatient in a Hospital counts as one benefit day. Each day that you are a patient in a skilled nursing facility counts as one-half benefit day. Therefore, 20 days in a skilled nursing facility counts as 10 benefit days towards the 365-day limit on Benefit Days.

**Biofeedback** is a training program designed to develop an individual's ability to control his or her autonomic (involuntary) nervous system.

**Birthing Center** is a free-standing facility or a separate area of a Hospital which has permanent facilities equipped and operated mainly for childbirth, which provides continuous service by Physicians, Registered Nurses, or mid-wife Nurse Practitioner when a patient is in the center. The center must be licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

**Calendar Year** means the 12-month period beginning January 1st and ending December 31st.

**Chemical Dependence** is another term for Substance Abuse.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and refers to temporary continuation of health care coverage.

**Coinsurance** means the portion of Eligible Medical Expenses for which the patient have financial responsibility, calculated as a percent of the Allowed Amount for the service. See the subsection entitled "Coinsurance" contained in the "Out-of-Network/Non-Participating Medical Expense Benefits Cost Sharing" section for further details.

**Commission on Accreditation of Rehabilitation Facilities (CARF)** is an independent, nonprofit accreditor of health and human services in the following areas that pertain to health plans: Aging Services, Behavioral Health, Child and Youth Service, Employment and Community Services, Vision Rehabilitation Services, Medical Rehabilitation include DME, prosthetics, orthotics and supplies and Opioid Treatment Programs.

**Copayment** (Copay) means the fixed amount applicable to certain services for which the patient has financial responsibility. See the subsection entitled "Copayment" contained in the "In-Network/Participating Medical Expense Benefits Cost Sharing" section for further details.

**Cost-Sharing** means the amount you must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

**Corrective Appliances** The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or device), and Prosthetic appliance (or device).

**Covered Person** is any Participant/Employee, Retiree or covered Dependent who has properly enrolled for coverage under the Plan and is actually covered under this Plan. Also referred to as a Member.

**Covered Service** is a service paid for, arranged, or authorized for Covered Person by the Plan under the terms and conditions of the Plan if deemed Medically Necessary.

**Custodial Care** is care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel.

**Deductible** means the amount for which the patient is responsible, before benefits are calculated and the Plan begins to pay for Covered Services. See the sub-section entitled "Deductible"

contained in the “Out-of-Network/Non- Participating Medical Expense Benefits Cost Sharing” section for further details.

**Dependent** is any one of the following:

- An Employee's spouse, to whom the Employee is legally married.
- An Employee’s Domestic Partner (and Dependent Children of Domestic Partners), provided they meet the requirements described in the Eligible Dependents subsection in the Eligibility section of this Plan Document.
- Except as provided below, for the purposes of this Plan, a Dependent Child is any of the Employee’s/Participant’s children listed below who are under the age of 26 (whether married or unmarried):
- **Son or daughter** (proof of relationship and age will be required).
- **Stepson or stepdaughter** (proof of relationship and age will be required).
- **Legally adopted child or child placed for adoption** with the Employee/Participant (proof of adoption or placement for adoption and age will be required). Placed for adoption means the assumption and retention by the Employee/Participant/Retiree of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement for adoption ends upon the termination of such legal obligation.
- **Legal Guardianship** pursuant to a court order.
- A child named as an “alternate recipient” under a Qualified **Medical Child Support Order**.
  - Except as provided below with respect to a disabled child, coverage will terminate for a Dependent Child at the end of the month in which the child attains age 26.
  - A spouse of a Dependent Child is not eligible for coverage under the Plan.
  - In addition to Dependent Children defined above, an unmarried child, who has reached the age at which dependent coverage would otherwise terminate, is covered if incapable of self-sustaining employment because of any of the following reasons:
    - Mental illness as defined in New York State Mental Hygiene Law; or
    - Developmental Disability as defined in the New York State Mental Hygiene Law; or
    - Mental retardation as defined in the New York State Mental Hygiene Law; or
    - A physical handicap.

    For coverage to be based on these conditions, the condition must have occurred prior to the age at which Dependent coverage would otherwise terminate. The child's disability must be certified by a Doctor. The Plan has the right to verify whether such a child continues to be incapacitated. Coverage ceases when such a child is no longer incapacitated.

    Divorced Spouses are **excluded** as Dependents of the Employee.

**Det Norske Veritas** Germanischer Lloyd Healthcare Inc. **(DNV GL Healthcare):** A national accreditation program that provides hospital with an accreditation option that integrates the ISO

9001 standards (international quality standards that define minimum requirements for a qualify management system).

**Disabled/Disability** means the inability of a Covered Person to be self-sufficient as the result of a physically or mentally disabling injury, illness, or condition (such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, or psychosis) and the Covered Person is permanently and totally Disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a Physician, and accepted by the Plan, as a permanent and continuing condition.

**Doctor or Physician** for the purpose of this Plan Document shall include a licensed physician, osteopath, dentist or podiatrist.

**Durable Medical Equipment** is equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose, not generally used in the absence of an injury or illness; not disposable or non-durable, and appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric Hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device), and Prosthetic appliance (or Device).

**Emergency Condition** is 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 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.

**Emergency Department Care** is Emergency Services you get in a Hospital emergency room.

**Emergency Services** means medical screening that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Condition and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability; no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta). Emergency Services are not subject to prior authorization requirements.

**Employee** is an employee of one of the Participating Employers in this Plan, and who is eligible for coverage under the Plan.

**Essential Health Benefits** means health benefits as defined under federal and new York state law to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management.

**Exclusions** are the health care services that this Plan does not pay for or cover.

**Experimental and/or Investigational.** The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational.

A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Medical Management Program, any of the following conditions were present with respect to one or more essential provisions of the service or supply;

1. The service or supply is described as an alternative to more conventional therapies on the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;

2. The service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

3. There is either an absence of medical or scientific literature on the subject, or a preponderance of such literature published in the United States, written by experts in the field, where recognized medical, dental or scientific experts classify the service or supply as Experimental and/or investigational, or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and FDA approval has not been granted at the time the service or supply is prescribed or provided, or when a current investigational new drug or new device application has been submitted and filed with the FDA.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources available at the time the service or supply was performed, provided or considered for Precertification under the Plan's Medical Management Program:

1. Medical or dental records of the Covered Person;

2. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;

3. Authoritative peer reviewed medical or scientific writings published in the United States regarding the prescribed service or supply for the treatment of the person's diagnosis, including, but not limited to, "United States Pharmacopeia Dispensing Information" and "American Hospital Formulary Service";

4. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; the National Institute of Health (NIH); the Center for Disease Control (CDC); the Office of Technology Assessment; the published screening criteria of national insurance companies such as Aetna and CIGNA, or Milliman Care Guidelines (or the American Dental Association (ADA) with respect to dental services or supplies);

5. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply; or

6. The latest edition of "The Medicare National Coverage Determinations Manual."

Notwithstanding the above, the Plan will not consider Experimental and will cover the routine costs of approved clinical trials, as well as reasonable and necessary supplies and services used to diagnose and treat complications arising from participation in all clinical trials, as outlined below. Such coverage shall not be subject to Utilization Review. In order to be covered under this provision, you must be:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and

- Referred by a Participating Provider who has concluded that your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when you do not have cancer or other life-threatening disease or condition, will be subject to the Utilization Review and External Appeal sections of this Plan Document.

The Plan does not cover: the costs of the investigational drugs or devices; the costs of non-health services required for you to receive the treatment; the costs of managing the research; or costs that would not be covered under this Plan.

An "approved clinical trial" means a Phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;

- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or

- A drug trial that is exempt from having to make an investigational new drug application.

To determine how to obtain a Precertification of any procedure that might be deemed Experimental and/or Investigational, including costs for clinical trials, see the Medical Management Program section of this Plan Document.

**External Appeal Agent** is an entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

**Facility** is a Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33); a Substance Use Disorder or Mental

Health Facility (as defined in this section) or facility certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility).

**Family** is the Covered Employee and his or her family members who are covered as Dependents under the Plan.

**Genetic Counseling** means counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman, to allow the patient to make an informed decision.

**Genetic Information:** Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

**Genetic Testing:** Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

**Gene Therapy:** Therapy that involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or turning off genes that cause medical problems. To be covered under the Plan, the Gene Therapy must be approved by the FDA and intended to treat a specific disease and will be reviewed on a case-by-case basis.

**Grievance** is a complaint that a Covered Person communicates to the Plan or an appeal request that does not involve a Utilization Review determination.

**Health Care Practitioner, Professional, or Provider** for the purpose of this Plan Document shall include a licensed acupuncturist; physical therapist; occupational therapist; speech therapist; speech language pathologist or audiologist; chiropractor; optometrist; psychiatrist; certified and registered psychologist; social worker as defined elsewhere in this section; nurse-midwife licensed pursuant to Article 140 of the New York Education Law; certified nurse anesthetist; Physician's assistant or nurse practitioner, as defined in the New York Education or Public Health Laws or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance law requires to be recognized who charges and bills patients for Covered Services. If you receive care from a Health Care Provider outside of New York State, such Health Care Providers must be licensed or certified under standards similar, in the sole judgment of the Plan Administrator or its designee, to those used in New York State by a state agency in the state where the care is provided. All Health Care Providers must practice only within the scope of their license or certification. A nurse-midwife must be in a collaborative relationship with a Physician. A certified nurse anesthetist, a Physician's assistant or a nurse practitioner must practice in accordance with state law.

**Home Health Care Agency** is an agency that is either:

1. A Hospital licensed and/or certified to provide home health services under the New York Public Health Law or similar statutory or regulatory authority in the state where home care services are rendered; or

2. A home health service or agency licensed and/or certified to provide home health services under either the New York Public Health Law or similar statutory or regulatory authority in the state where home care services are rendered.

**Home Health Care Plan** must meet these tests:

1. A formal written plan issued by the patient's attending Physician to be reviewed periodically; and

2. It must certify that the home health care is in place of Hospital confinement; and

3. It must specify the type and extent of home health care required for the treatment of the patient.

**Home Health Care Services and Supplies** include:

1. Part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.);

2. Part-time or intermittent home health aide services provided through a Home Health Care Agency, not including general housekeeping services;

3. Physical, occupational or speech therapy when provided by the Home Health Service or Agency;

4. Medical supplies, including drugs and medication prescribed by a Doctor to the home care patient, but only to the extent such items would be covered for Inpatient care in a Hospital or a Skilled Nursing Facility; and

5. Laboratory services by or on behalf of the Home Care Agency or Hospital.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Organization, or supervised by a Physician.

**Hospice Care is** care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

**Hospice Unit** is a freestanding facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is a short-term acute care general institution which:

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

2. is not a school, college or camp infirmary;

3. Has organized departments of medicine and major surgery;

4. Has a requirement that every patient must be under the care of a Physician or dentist; and

5. provides 24-hours a day nursing service by or under the supervision of registered professional nurses (R.N.);

6. 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 42 U.S.C. Section 1395x(k); and

7. Is duly licensed by the agency responsible for licensing such Hospitals; and

8. is not, other than incidentally a place:

    a. of rest;

    b. for the aged or nursing home or similar institution;

    c. for drug addicts;

    d. for alcoholics;

    e. a place for the treatment of tuberculosis;

    f. for convalescent, custodial, educational, or rehabilitory care; or

    g. a hemodialysis center.

This definition shall apply even though the term “Hospital” may have a different meaning in other legal contexts. Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

**Hospitalization** means care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

**Hospital outpatient care** in a hospital is care that does not require stay.

**Illness or Sickness** is a bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person’s previous condition. Pregnancy of a covered Employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan.

**Incurred Date** is the date a charge for a covered expense shall be deemed to be incurred. The Incurred Date shall be the latest of the following to occur:

- the date a purchase is contracted;
- the date delivery is made; or
- the actual date a service is rendered.

**Infertility** is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve months but no more than a 24-month period of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months but no more than a 24-month period of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five years of age or older. Earlier evaluation and treatment may be warranted based on an individual's medical history or physical findings.

**In-Network/Participating Providers** are Providers who have agreed to accept payment according to a set Schedule of Benefits as full payment.

**Injury** is any damage to a body part resulting from trauma from an external source.

**Inpatient** refers to confinement for which room and board is charged by a Hospital or other approved Health Care Facility.

**Inpatient Services** refers to services provided in a Hospital or other approved Health Care Facility during the period when charges are made for room and board.

**Intensive Care Unit** is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "Coronary Care Unit" or an "Acute Care Unit." It has:

- facilities for special nursing care not available in regular rooms and wards of the Hospital;
- special life-saving equipment that is immediately available at all times;
- at least two beds for the accommodation of the critically ill; and
- at least one Registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** is a nonprofit organization based in the United States that accredits over 20,000 healthcare organizations and programs in the country.

**Medically Necessary**

1. A medical service or supply will be determined to be “Medically Necessary” or “Medical Necessity” by the Plan if it:
    - is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it ; and

- is determined by the Plan to be necessary in terms of generally accepted American medical standards; and

- is determined by the Plan Administrator or its designee to meet all of the following requirements:

    - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and

    - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and

    - It is an "Appropriate" service or supply given the patient's circumstances and condition; and

    - It is a "Cost-Efficient" supply or level of service that can be safely provided to the patient; and

    - It is safe and effective for the illness or injury for which it is used.

2. A medical service or supply will be considered to be "Appropriate" if:

    - It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition; or

    - It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

3. A medical service or supply will be considered to be "Cost-Efficient" if it is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

The following items are considered not to be Medically Necessary:

1. The fact that your Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.

2. A Hospitalization or confinement to a Health Care Facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

3. A medical service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

4. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services, will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

5. A medical service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Health Care Practitioner or if it is furnished mainly for the

personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Health Care Practitioner, Hospital or Health Care Facility.

6. Expenses for and related to travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Person (except for Emergency Ambulance) or family member of a Covered Person are not considered to be Medically Necessary.

7. Except as specifically outlined under the Hospice Care section of this Plan, services or expenses that cannot reasonably be expected to lessen the patient's disability or to enable the patient to live outside of an institution.

**Medical or Health Care Facility** means a Hospital; a facility that treats one or more specific ailments; or any type of Skilled Nursing Facility.

**Medical Emergency** See the definition of Emergency Condition.

**Medicare** is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended and as it may be amended in the future.

**Member** is any Employee/Participant, Retiree or Dependent who is eligible for coverage and has properly enroll in the Plan as described in the *Enrollment Section*. When used in this document, "Member" refers to any Covered Person.

**Mental Health Condition** is an illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual and it is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

**Mental Health Care** means medically necessary care rendered by an eligible practitioner or approved facility and which, in the opinion of the Plan, is directed predominantly at treatable behavioral manifestations of a condition that the Plan determines: (a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

**Mental Health Facility.** A facility is defined as the following:

- ***Inpatient Facility.*** 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,

  - 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.

In other states, Facilities include similarly state licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Plan.

***Outpatient Facility.*** 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. In the absence of a similarly licensed or certified Facility that provides the same level of treatment, must be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or Det Norske Veritas Healthcare, Inc. (DNV Healthcare).

**Mental Health Provider** means a licensed psychiatrist or psychologist, a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional cooperation or university facility practice corporation thereof

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Nondurable Medical Supplies** are goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device), and Prosthetic appliance (or Device). Only those Nondurable Medical Supplies identified in the Schedule of Medical Benefits are covered by this Plan.

**Orthotic (Appliance or Device)** is a type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of this Plan, this definition does **not** include Dental Orthotics. See also definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies, and Prosthetic Appliance (or Device).

**Out-of-Network/Non-Participating Providers** are providers who have not agreed to accept payments according to a set schedule of allowances as payment in full.

**Out-of-Pocket Limit** means the most you pay during a calendar year in cost-sharing before the Plan begins to pay 100% of the Allowed amount for covered services for In-Network benefits. For Out-of-Network benefits, the out-of-pocket limit is the yearly out-of-pocket Coinsurance maximum that the Plan requires you to pay towards Your Out-of-Network health care, in addition to the annual Deductible and/or any non-covered services. See the sub-section entitled "Maximum Out-of-Pocket Expenses" contained in the "Out-of-Network/Non-Participating Medical Expense Benefits Cost Sharing" section for further details.

**Outpatient Care** is treatment performed in a Hospital on a basis other than Inpatient. Outpatient Care includes:

1. services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted on an Inpatient basis; and

2. services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Participant** is an Employee or Retiree who has satisfied the eligibility requirements and has properly enrolled in the Plan as described in the *Enrollment Section* and is therefore covered under this Plan. When used in this document, "Participant" refers to the eligible Employee or Retiree.

**Participating Employer** refers to the School Districts participating in SWSCHP.

**Plan** is the State-Wide Schools Cooperative Health Plan, also referred to as SWSCHP.

**Plan Year** is the period July 1st to June 30th.

**Pregnancy** is childbirth and conditions associated with Pregnancy including complications.

**Preauthorization** is a decision by the Plan that receipt of a Covered Service, procedure, treatment plan, device or Prescription drug is Medically Necessary. See the Medical Management section for a list of benefits that require preauthorization.

**Prescription drug** is a medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

**Pre-Service Claim** is a request for benefits under this Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care.

**Primary Payer** means the Plan that will determine the medical benefits that will be payable to You first.

**Primary Care Physician** is a Family Physician, Physician of Internal Medicine, General Practitioner, Pediatrician, or OB/GYN.

**Prophylactic Surgery** is a surgical procedure performed for the purpose of: (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on Genetic Information or Genetic Testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

**Prosthetic Appliance (or Device)** is a type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies, and Orthotic appliance (or Device).

**Provider** is a Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are covered under this Plan Document that is licensed, registered, certified or accredited as required by state law.

**Rehabilitation Therapy** is physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions sections of this Plan Document to determine the extent to which Rehabilitation Therapies are covered.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**

3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for Passive Rehabilitation are commonly taught to the family/caregivers to employ on an Outpatient basis with the patient when and until such time as the patient is able to achieve Active Rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

**Retiree** is an Employee who has retired in accordance with the conditions set forth by a Participating Employer and is eligible for Retiree benefits under this Plan.

**Schedule of Benefits** is the section of this document that describes the cost-sharing (Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits), preauthorization requirements and other limits on Covered Services.

**Secondary Payer** means a plan that will determine your medical benefits after the Primary Payer.

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**Skilled Nursing Facility (SNF)** is an institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by the Plan to meet the standards of any of these authorities.

**Social Worker** is an individual who is performing covered services within the lawful scope of practice; is certified under New York Education Law Article 154; and, in addition, has:

1. Three or more years of supervised post degree experience in psychotherapy. For the purposes of this Plan, the experience must be in the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior that are intellectually, socially, or emotionally maladaptive, under supervision, satisfactory to the State Board of Social Work, in a facility licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of mental, nervous, or emotional disorders or ailments; or

2. Three or more years post degree experience in psychotherapy under the supervision, satisfactory to the State Board of Social Work, of a Psychiatrist; a Certified and Registered Psychologist; or a Social Worker qualified for reimbursement under Section 4303(n) of the New York Insurance Law; or

3. A combination of the experience, specified in paragraphs "1" and "2" totaling three years, satisfactory to the State Board of Social Work.

The Social Worker's name must appear on the list of all Certified Social Workers who meet these qualifications as maintained by the State Board of Social Work.

**Specialist** is a Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

**Spell of Illness or Injury** begins separately on the first day the Member is admitted to a Hospital, Birthing Center or Skilled Nursing Facility; or the Member receives Home Health Care. A Spell of Illness ends when the Member has not been confined in any Hospital, Birthing Center or Skilled Nursing facility, or received Home Health Care, for at least 90 consecutive days. An admission due to an accident will be considered a separate and distinct Spell of Illness or Injury.

**Substance Use Disorder Facility**. A facility is defined as the following:

- ***Inpatient Facility***. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Addiction Services and Supports ("OASAS").

  Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and Part 817.

- ***Outpatient Facility***. 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. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider.

Applicable to both inpatient and outpatient Facilities, in other states, Facilities are those that are licensed or certified by a similar state agency and which are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO), Det Norske Veritas Healthcare, Inc. (DNV Healthcare) or the Commission on Accreditation of Rehabilitation Facilities (CARF) or a national accreditation organization recognized by the Plan as alcoholism, substance abuse or chemical dependence treatment programs.

**Substance Abuse Disorder Provider** means a licensed Provider including an OASAS credentialed Provider, and 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.

**Total Disability (Totally Disabled)** is a physical state of a Participant resulting from an illness or injury which wholly prevents:

1. The Participant from engaging in any business or occupation and from performing any and all work for compensation or profit; or

2. The Dependent of a Participant from performing the normal activities of a person of like age and sex in good health.

**Urgent Care** is a health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity where prompt medical attention is appropriate even though health and life are **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections. Urgent Care may be rendered in a Physician's office or Urgent Care Facility.

**Urgent Care Claim** See the Claim Filing and Appeal Information section for the definition.

**Urgent Care Facility** is licensed facility other than a Hospital that: is licensed or legally operating as an Urgent Care Facility; primarily provides minor and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open; and includes x-ray and laboratory equipment and a life support system.

**Utilization review** is the review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

**You, Your** when used in this Plan Document, these words refer to the Employee who is covered by the Plan, but do not refer to any Dependent of the Employee.

## ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

### Eligibility for Active Employees

**Initial Eligibility:** Your (the Employee's) eligibility for benefits and the effective date of your SWSCHP membership is determined by your Participating Employer in accordance with its eligibility requirements. Contact your School District Health Benefits Representative for information on the eligibility requirements that pertain to your Participating Employer and to determine your effective date.

**Eligible Dependents:** If you elect coverage for yourself, your eligible Dependents are also eligible for the same benefits as you as of the latter of the day you become eligible for your own coverage or the day you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if:

1. You submit a completed written enrollment form. Enrollment forms can be obtained from your School District Health Benefits Representative;

2. Coverage is in effect for you on that day; and

3. You provide the Plan's required proof of Dependent status and pay any required contribution for coverage of the Dependent(s), as applicable to your Participating Employer's requirements. A Dependent may not be enrolled for coverage unless you are also enrolled. Specific proof of Dependent status is required.

Your Eligible Dependents include:

- ***Your Spouse.*** Your spouse, including a legally separated spouse, is eligible. This Plan recognizes marriages between same-sex partners legally performed in New York and other jurisdictions.

  If you are divorced or your marriage has been annulled, your former spouse is not eligible even if a court orders you to maintain coverage. If your marriage ends, you must notify your School District Health Benefits Representative within 60 days of the date the divorce or the annulment is finalized. Coverage will end the date the divorce or annulment is finalized. Documentation must be provided. Your spouse may be eligible to continue coverage under COBRA, provided you notify your School District Health Benefits Representative within 60 days.

- ***Domestic Partner and Dependent Children of Domestic Partners***. You may cover your same or opposite sex domestic partner as your Dependent. A domestic partner, for eligibility under SWSCHP, is one with whom an eligible employee shares a residence, is involved in a lifetime relationship, financially interdependent, is 18 years of age or older, unmarried and not related in any way that would bar marriage and neither one is legally married to anyone else or in another domestic partnership. To enroll a domestic partner, you must have been in a partnership for a minimum period of 12 months prior to requesting coverage and be able to provide proof of residency and four (4) proofs of financial interdependence or if you are registered domestic partners and provide proof of registration. You will be required to submit an affidavit affirming domestic partnership status along with certain other required documentation. If registered as Domestic Partners, the 12-month requirement for the proof is waived, but you must still provide four (4) proofs of financial interdependence.

To cover your domestic partner and his/her child, the standard SWSCHP provisions for adding a Dependent apply. Contact your School District Health Benefits Representative for information on eligibility and enrollment procedures for domestic partners and children of domestic partners.

Individuals who qualify as a domestic partner, as that term is defined in this Plan, may be eligible to enroll for coverage when they complete the necessary enrollment forms. Coverage for the Domestic Partner will be the same as if covering a spouse and any Dependent child; however, such coverage will generally result in imputed income for the employee. Questions on or information about any such imputed income should be directed to your School District Health Benefits Representative.

- ***Dependent Child(ren).*** Any of the Employee's/Participant's children under the age of 26 (whether married or unmarried), including a son or daughter, stepson or stepdaughter, legally adopted child or child placed for adoption with the employee/participant/retiree (proof of adoption or placement for adoption may be requested).

  Coverage will continue past the end of the month in which a child attains age of 26 for an unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law), or physical handicap and who became so incapable prior to attainment of the age at which Dependent coverage would otherwise terminate and who is chiefly Dependent upon you for support and maintenance, while your coverage remains in effect and your Dependent child remains in such condition. In order to be eligible, you have 31 days from the date of your Dependent child's attainment of the termination age to submit proof of your Dependent child's incapacity.

  Except as provided with respect to a Disabled child, coverage shall terminate for a Dependent child at the end of the month in which the child attains age 26.

**Right of Young Adults through Age 29 to Elect Coverage**

Your child may be eligible to purchase his or her own individual coverage through this Plan through the age of 29 if he or she: 1) is under the age of 30; 2) is unmarried, 3) is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; 3) lives, works or resides in New York State or Plan's Service Area; and 4) is not covered by Medicare. The child may purchase coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

Your child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;

2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Plan receives notice of election and premium payment; or

3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the Plan receives notice of election and premium payment.

Contact your School District Health Benefits Representative for more information. A spouse or child of a Dependent child is not eligible for coverage under the Plan. Foster children are not eligible for coverage under the Plan.

**Proof of Dependent Status**

Specific documentation to substantiate Dependent status will be required by the Plan and includes:

- Spouse/Marriage: copy of the certified marriage certificate.
- Child/Birth: copy of the certified birth certificate listing the Participant as the parent.
- Adopted child or child placed for adoption: court order papers signed by the judge.
- Stepchild: copy of the certified birth certificate listing your (the Employee's) spouse as the parent, and your (the Employee's) and the child's natural parent's marriage certificate.
- Disabled Dependent Child: Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent child.
- Qualified Medical Child Support Order (QMCSO): Valid QMCSO document or National Medical Support Notice.

**Qualified Medical Child Support Orders (QMCSO) (Special Rule for Enrollment)**

This Plan will provide benefits in accordance with a National Medical Support Notice. In this document, the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a Dependent even though the child may not meet the plan's definition of Dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the Employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. All QMCSO should be directed to your School District Health Benefits Representative and the Representative will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

**For Information:** For information (free of charge) regarding the procedures for administration of QMCSOs, contact your School District Health Benefits Representative.

## Enrollment Procedures and Changing Your SWSCHP Coverage

### *Enrollment Procedure*

There are three opportunities to enroll for coverage under this Plan: Initial Enrollment, Special Enrollment and Late Enrollment. Proper enrollment is required for coverage under this Plan. If you request enrollment within the required time limit but proper enrollment, including the necessary paperwork, has not been completed, claims will not be able to be considered for payment until all such paperwork has been completed and submitted to your School District Health Benefits Representative. An individual who has not properly enrolled by requesting enrollment in a timely manner has no right to any coverage for Plan benefits or services under this Plan.

In order to enroll, you must contact your School District Health Benefits Representative. Note that the Open Enrollment procedure can differ from this process and if so, the procedure on how to enroll during Open Enrollment will be announced by your School District Health Benefits Representative at the beginning of the Open Enrollment period.

### Declining Coverage

You may pass up the opportunity to enroll in (decline) coverage under this Plan for yourself and/or your Dependents, but to do so you must follow the process for declining coverage set out by your Participating Employer, which may include submitting a completed written portion of the enrollment form that pertains to declining coverage. Any such form should be completed and returned to your School District Health Benefits Representative. Remember that a Dependent may not be enrolled for coverage unless you (the Employee) are also enrolled. If, at a later date, you want the coverage you declined for yourself, you may enroll only under the Special Enrollment provisions (when applicable) or during the Plan's Open Enrollment provisions described later in this section. Enrollment forms may be obtained from your School District Health Benefits Representative.

### Initial Enrollment

You must enroll no later than 30 days after the date on which you are eligible for coverage by submitting a completed written enrollment form (that may be obtained from your School District Health Benefits Representative), providing proof of Dependent status (as appropriate) and paying any required contributions for coverage. If you want Dependent coverage, you must enroll your

eligible Dependents at the same time. The effective date of your SWSCHP membership is determined by your Participating Employer in accordance with its eligibility standards. Consult your School District Health Benefits Representative to determine your effective date.

***Late Enrollment*:** If you do not enroll yourself, or if you do not enroll any of your Eligible Dependents during the Initial Enrollment period, you may enroll late, but benefits will not become effective until the first day of the third month following the month in which the request was made, unless coverage can be effective sooner due to loss of eligibility under another plan or contract or under the Open Enrollment provisions of this Plan or you may qualify for Special Enrollment or in the case of a newborn child, see the Special Enrollment provisions below.

**Special Enrollment**

***Newly Acquired Spouse and/or Dependent Child(ren)***

If you are enrolled for individual coverage under this Plan and if you acquire a Spouse by marriage, or if you acquire any Dependent Child(ren) by birth, adoption or placement of adoption, you may request enrollment for yourself and/or your newly acquired Spouse and/or any Dependent Children) no later than 30 days after the date of marriage, birth, adoption or placement for adoption. If you, the Employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a newly acquired Dependent.

Effective date for Newborns: Newborns are covered from the moment of birth if you are enrolled in family coverage. You must notify your School District Health Benefits Representative within 30-days of the child's birth. If you have individual or two-person coverage at the time your child is born, you must notify your School District Health Benefits Representative of your desire to change to family coverage within 30 days of the birth.

If you wish to change to family coverage but fail to notify your Participating Employer within 30 days of the child's birth, you may enroll your child late but coverage will become effective on the next premium due after the change request was made, unless coverage can be effective sooner due to loss of eligibility under another plan or contract or under the Open Enrollment provisions of this Plan.

Adopted newborns are covered from the moment of birth if you have family coverage or switch to family coverage as described above and if the following conditions are met:

- You (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the Hospital after birth; and
- You file a petition pursuant to section 115-C of the New York State Domestic Relations Law within 30 days of the infant's birth.
- Adopted newborns are NOT covered from the moment of birth if:
- You fail to switch to family coverage;
- One of the child's natural parents has coverage available to cover the newborn's initial Hospital stay. SWSCHP coverage will begin as soon as the Employee takes physical custody of the adopted newborn upon the adopted newborn's release from the Hospital; or
- A notice of revocation of the adoption has been filed, or one of the natural parents revokes their consent to the adoption.

If SWSCHP pays benefits to cover the adopted newborn and any of the above occurs, SWSCHP shall be entitled to recover any sums paid for care of the adopted newborn.

Effective Date for Spouses: New Spouses will be covered retroactive to the date of marriage, provided you enroll them within 30 days of the date of the marriage. Otherwise, you will be subject to the late enrollment provisions (see the prior page).

**Loss of Other Coverage**

If You did not request enrollment under this Plan for yourself, your Spouse, and/or any Dependent Child(ren) within 30 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy including COBRA Continuation Coverage, certain types of individual insurance, Medicare, or other public program; and You, your Spouse and/or any Dependent Child(ren) lose coverage under that other group health plan or health insurance policy; you may request enrollment for yourself and/or your Spouse and/or any Dependent Child(ren) within 30 days after the termination of their coverage under that other group health plan or health insurance policy, if that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a Special Enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was "exhausted"; or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals.

Proof of loss of coverage is required by this Plan.

COBRA Continuation Coverage is "exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact) in connection with that COBRA Continuation Coverage. Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 36-month period of COBRA Continuation Coverage has expired.

However, you may not avail yourself of this opportunity for Special Enrollment for yourself or any Dependent unless, when coverage under this Plan was previously offered, you indicated in writing

that the reason you, your Spouse and/or your Dependent Child(ren) declined coverage was because you or they had coverage under another health insurance policy or plan.

You and your Dependents may also enroll in this Plan if you (or your eligible Dependents):

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

- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your Dependents) are determined to be eligible for such premium assistance.

**Open Enrollment**

Open Enrollment is offered under this Plan every six months in the fall and spring during which eligible employees may add or drop Eligible Dependents. Enrollment forms and information may be obtained from your School District Health Benefits Representative. No Dependent may be covered unless You are covered. All relevant parts of the enrollment form must be completed and the form must be submitted before the end of the Open Enrollment period to your School District Health Benefits Representative along with proof of Dependent status (as requested).

Open enrollment is held in November with coverage effective January 1st of the following year and in May with coverage effective July 1st.

**Payment for Your Coverage**

For more detailed information regarding eligibility and enrollment as well as any required contributions, contact your School District Health Benefits Representative.

**Effective Date of Benefits**

The effective date of your Plan membership is determined by your Participating Employer in accordance with its eligibility standards. You should consult with your School District Health Benefits to determine your effective date.

**When Coverage Ends**

Employee coverage shall automatically terminate immediately upon the earliest of the following dates:

- Date of Termination of the Employee's employment; or
- Date the Employee's employment contract ends; or
- The Employee fails to make any required contribution for coverage. If a payment, required by the Participating Employer is not made, the coverage will end on the last day of the period for which a payment required by the Participating Employer was made; or
- The Plan is terminated, or with respect to benefits of the Plan, date of termination pursuant to the notice provisions of Section 430(j)(3) of the New York Insurance Law; or
- The Employee enters the Armed Forces (the military) on full-time active duty; or
- The Employee dies.

**Dependent Termination**

The Dependent coverage of an Employee shall automatically terminate immediately upon the earliest of the following dates:

- Date the Dependent ceases to be an eligible Dependent as defined in the Plan; or
- Date of termination of the Employee's coverage under the Plan; or
- Date the Employee ceases to be in a class of Employees eligible for Dependent coverage; or
- Date the Employee fails to make any required contribution for Dependent coverage; or
- Date the Dependent dies (In the event of Dependent termination due to the death of an Employee, the Dependent may be eligible to continue benefits as a survivor. See "Survivor Benefits" under the "Miscellaneous Provisions" section of this Plan Document); or
- If a payment required by the Participating Employer is not made, the coverage will end on the last day of the period for which a payment required by the Participating Employer was made for Dependents under a QMCSO; or
- The expiration of the period of coverage stated in the QMCSO; or
- The Employee ceases to make any contributions required for coverage for Spouse or Dependent Child(ren); or
- The date the Dependent enters the Armed Forces on full-time active duty.

If coverage terminates for any reason, any claim which is incurred before your coverage ends will not be affected.

In the event of termination, the Dependent may be eligible for continuation of coverage in limited circumstances which are explained in the "Continuation Options" section of this Plan Document.

**Notice to the Plan**

You, your Spouse, or any of your Dependent Children must notify the Plan preferably within 30 days but no later than 60 days after the date a:

- Spouse ceases to meet the Plan’s definition of Spouse (such as in a divorce);
- Dependent Child ceases to meet the Plan’s definition of Dependent (such as the Dependent child reaches the Plan’s limiting age or the Dependent Child ceases to have any physical or mental disability).

**Failure to give this Plan a timely notice** (as noted above) will cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage.

**When the Plan Can End Your Coverage for Cause**

Your Participating Employer will make any determination that involves termination of coverage for cause. Your Employer may end your coverage retroactively and/or the coverage of any of your Covered Dependents for cause 30 days after it gives you written notice of its finding that:

1. You or your Covered Dependent made a fraudulent statement, a material misrepresentation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan, including failure to provide complete, updated and accurate information on a timely basis regarding your marital status, employment status of a spouse or child, or the existence of other coverage; or

2. You or your Covered Dependent allowed anyone else to use the identification card that entitles you or your Covered Dependent to coverage, services or benefits under the Plan; or

3. You or your Covered Dependent altered any prescription furnished by a Physician.

If your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your Covered Dependent performed or permitted the acts described above. In addition, your coverage may be suspended during the 30 day-notice period.

Coverage for you and/or your Dependents may also be terminated retroactively due to non- payment of premiums (including COBRA premiums).

**Leave of Absence (Special Circumstances) Family and/or Medical Leave (FMLA)**

If you have completed 12 months of employment, you are entitled by law to up to 12 weeks each year of unpaid Family or Medical Leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. Your Participating Employer is responsible for determining and granting the leave and will notify the Plan Administrator when you take a Leave.

The Plan will continue benefits for the employee on the same basis as prior to the beginning of the leave. You will be responsible for making any required employee contributions. While you are officially on such a Family or Medical Leave, you can keep benefit coverages for yourself and your Dependents in effect during that Family or Medical Leave period by continuing to pay any required contributions.

Whether or not you keep your coverage while you are on Family or Medical Leave, if you return to work promptly at the end of that Leave, your benefit coverage will be reinstated without any additional limits or restrictions imposed on account of your Leave. This is also true for any of your Dependents who were covered by the Plan at the time you took your Leave. Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that Leave will apply to you and your Dependents in the same way they apply to all other employees and their Dependents.

To find out more about Family or Medical Leave and the terms on which you may be entitled to it as well as paying applicable premiums while you are on Leave, contact your Participating Employer's Human Resources Department.

## Continuation of Coverage if You Temporarily Serve in the Armed Services

An Employee who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services. If the employee elects USERRA temporary continuation coverage, the employee (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the date the employee stopped working.

If the employee goes into active military service for up to 31 days, the employee (and any eligible Dependents covered under the Plan on the day the leave started) can continue healthcare coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

**Duty to Notify the Plan:** The Plan will offer the employee USERRA continuation coverage only after SWSCHP has been notified by the Participating Employer in writing that the employee has been called to active duty in the uniformed services and provides a copy of the orders. The employee must notify the Participating Employer as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Questions regarding your entitlement to an approved leave of absence and to the continuation of medical coverage should be referred to your Participating Employer.

## Reservists Supplementary Continuation

An affected individual called to active duty may elect to continue his or her group coverage, including family coverage, under the Plan by making a written request and paying to the Plan up to 100% of the premium for the coverage. If an affected individual does not elect continuation rights, Plan coverage is suspended while the affected individual is on active duty. (It should be noted that an employer may treat affected individuals as active employees to maintain coverage under the employer's group plan.)

Continuation is not available for those who become covered or could be covered by Medicare or other group coverage (except for that available to active duty person of the uniformed services). Affected individuals who return to work after active duty are entitled to resume participation under the employer's plan without the imposition of limitations or conditions.

However, limitations may be imposed with respect to conditions that arose during active duty and are determined by the Secretary of Veterans Affairs to have been incurred in the line of duty. In addition, if there was a waiting period in place at the time of call to active duty which had not been satisfied, the waiting period balance may be imposed. For affected individuals who opted for suspension of Plan coverage and return to employment, coverage is retroactive to the effective date

of termination of active duty. For affected individuals who do not return to employment upon return to civilian status, the reservist is entitled to the standard continuation rights provided by this Plan.

**Eligibility for Retirees**

You are eligible for Retiree benefits provided by the Plan in accordance with your participating School District's rules. Please note that any employee of a participating School District who was not enrolled in a participating School District plan at the time of retirement is not eligible to request enrollment at a later date. Eligibility to continue coverage in retirement will be forfeited. Enrollees who retired with HMO coverage are eligible to request coverage in SWSCHP at a later date. The criteria and procedures indicated in Change of Option should be followed.

## HOSPITAL AND MEDICAL BENEFITS

The Plan provides benefits for Medically Necessary Eligible Medical Expenses either on an In-Network or Out-of-Network basis. You may obtain health care services from Participating (In-Network) or Non-Participating (Out-of-Network) Health Care Providers as described in this section. Your out-of-pocket expenses differ, depending on whether you use Participating Provider or a non-Participating Provider. If you use the services of a Participating/In-Network health care provider, you will be responsible for paying less money out of your own pocket as benefits provided by Participating/In-Network providers are generally subject to a Copayment and accept the Plan's payment as payment in full after the Copayment. However, the choice is always yours as to what type of provider to use.

### Participating/In-Network and Non-Participating/Out-of-Network Providers

The Plan offers Covered Persons the use of "In-Network" or "Out-of-Network" providers for Medical Expense benefits. The networks will be indicated on your Plan identification card. Services rendered by "In-Network" providers are subject to the applicable Copayments. Services rendered by "Out-of-Network" providers are subject to the applicable Deductible, Copayment and/or Coinsurance as well as to Balance Billing on billed charges that exceed the Allowed Amounts. Specific benefit levels are shown in the *Schedule of Benefits* (in the following section of this Plan Document).

A summary of the Plan's Cost-Sharing provisions (Deductibles, Coinsurance, Copayments and Annual Out-of-Pocket Maximums) are described in the section entitled "Participating/In-Network and Non-Participating/Out-of-Network Providers and Cost-Sharing". Please refer to the *Schedule of Preventive Services* and the *Schedule of Benefits* for details on how and when specific cost-sharing provisions apply.

## UTILIZATION REVIEW/MEDICAL MANAGEMENT

### Introduction

Medical Care Management or Medical Management is a program which offers clinically based care management programs designed to promote optional health outcomes and manage health care costs through patient advocacy, support, health information and education by medical professionals.

Medical Management is a patient-centered approach to care management to help Covered Persons obtain quality healthcare and services in the most appropriate setting and to help ensure that better clinical and financial outcomes can be achieved while maintaining high levels of patient satisfaction. The Medical Care Management Program is an established quality leader in the health care arena with four separate URAC accreditations and includes Utilization Management, Case Managements, 24/7 Nurse Help Line and Independent Review Services. Please see the *Contact Information* chart at the beginning of this Plan Document for information on how to reach Medical Care Management.

#### MEDICAL MANAGEMENT

The benefits available to you under this Plan are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by the Plan. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided. See the Defined terms section for a description of Medical Necessity.

#### *Medical Management Process*

The Medical Management process includes the following components:

Pre-Certification and Medical Review

To be covered at the highest level of benefit and to ensure better clinical and financial outcomes, the Plan requires that certain care, services and procedures be pre-certified before they are provided. While the Covered Person is responsible for obtaining the Pre-certification, the Provider may obtain it on behalf of the Covered Person. Pre-certification requests are submitted on your behalf to the Utilization Review Agent by a specialty Physician, designated PCP, other PCP, or other healthcare provider. Provider offices have been provided with materials and education regarding this referral process and your Plan identification card includes instructions. Depending on the request, the Utilization Review Agent may contact the requesting provider to obtain additional clinical information to support the need for the pre-certification request and to ensure that the care, service and/or procedure meet Plan criteria. Please note that precertification is not required when another carrier/plan is primary and have paid benefits primarily (see the Coordination of Benefits Section for details).

**The following services require pre-certification**:

- Acupuncture
- Bone Density Test if you do not meet the criteria listed under *Preventive Benefits Section G*
- Dialysis
- Durable Medical Equipment and prosthetics (rentals or purchases over $500)
- Home Health Care (Includes Home Infusion Therapy and Visiting Nurse Services)
- Hospice Care

- In-Patient Admissions (Medical, Mental Health and Substance Used Disorder)
- MRI/MRA/PET/CTA/Spect Scans (CTs do not require pre-cert)
- Enteral and Parenteral Nutritional Supplements
- Oncology Care/Services (Chemotherapy and Radiation Therapy)
- Organ/Bone Marrow Transplants
- Private Duty Nursing, home health care and nursing visits
- Skilled Nursing Facility
- Residential Facilities for Mental Health and Substance Use Disorders (note that residential facilitates are not covered for any other types of treatment)
- Surgery and/or Surgical Procedures ( except for surgeries done in the doctor's office)
- Therapies and rehabilitation including Physical, Speech, and Occupational Therapy, and Physiotherapy
- Temporomandibular Joint TMJ Procedures
- Genetic Testing (except for testing required under the ACA Preventive services)
- Gene Therapy. Please note that no benefits will be provided for Gene Therapy if you do not contact Medical Management prior to receiving the therapy.
- All Comprehensive, Advanced Infertility Services and Certain Basic Infertility services as outlined in the Schedule of Medical Benefits,.
- Biofeedback

**The following services require medical review**:

- Infusion Therapy
- Cardiac Rehabilitation (therapy) after the 36th visit in a calendar year
- Pain Management (Epidural Steroid Injections, Trigger Point Injections, Nerve Blocks/Occipital Nerve Blocks, Botox for Migraines and Intra-articular Injections (Hylagan Steroids))
- Acne Treatment
- Therapies and rehabilitation including Applied Behavioral Therapy and Chiropractic after the 12th visit and before the 13th visit for the same diagnosis/episode of care
- UV Treatments (PUVA)
- Sleep studies that are physician attended
- Intensive Outpatient and Partial Hospitalization Program
- Support Stockings are limited to two (2) pairs during any 6-month period

**Penalties for not obtaining pre-certification:**

A non-notification penalty is the amount you must pay if notification of the service is not provided prior to receiving a service. A penalty in the amount of the lesser of $250 or 50% of the benefit

otherwise payable will be applied per incident if a Covered Person receives services but did not obtain the required pre-certification for the above services.

Time of Notice

The pre-certification notifications must be made to Medical Management within the following timeframe:

- At least four (4) business days, before a scheduled (elective) Inpatient Hospital admission or surgery when your Physician recommends inpatient Hospitalization;
- Upon being identified as a potential organ or tissue transplant recipient.
- Five (5) to seven (7) business days prior to ambulatory surgery or ambulatory/outpatient care/ procedures and for all other services and supplies which require pre-certification; or
- Within 48-hours after admission for an Emergency Condition. Please be aware that while you do not have to precertify Emergency Room Visits, you must call to pre-certify any subsequent admission to the hospital within 48-hours of admission.
- Within 48-hours for a hospital stay for maternity that exceeds 48-hours for a vaginal delivery or 96-hours for a cesarean section.

***** If notification is outside of the parameters listed above, precertification penalties will apply. *****

Utilization Review

Medical Management includes an independent utilization review process to determine whether healthcare services provided to Covered Persons are Medically Necessary. Utilization Review is supported by a team of nurses and physicians. If you request an appeal, it will be conducted by an independent review panel made up of over 200 board-certified physicians and specialists who are available to review adverse determinations (otherwise know as a denial of benefits).

**See the section on Claims and Appeals at the end of this Plan Document for information on timing of reviews, including Pre-service, Urgent, Concurrent and Retrospective/Post-Service reviews.**

Appeal of Adverse Determinations by Utilization Review Agents

A Covered Person, the Covered Person's designee and, in connection with retrospective adverse determinations, a Covered Person's health care provider, may appeal an adverse determination rendered by a utilization review agent. **See the "Medically Necessary Appeals" subsection in the Claims and Appeals section for information on how to file an appeal of an adverse determination.**

Concurrent Review

The Medical Management program will regularly monitor a Hospital stay, other institutional admission, or ongoing course of care for any Covered Person, and examine the possible use of alternative facilities or forms of care. Medical Management staff communicates regularly with attending Physicians, the Utilization Management staff of such facilities, and the Covered Person and/or family, to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). Such concurrent review, and authorization for Plan coverage of Hospital days,

are conducted in accordance with the utilization criteria adopted by the Plan and Medical Management.

Pre-Certification involving Specialty and Infusion Drugs

Specialty and infusion drugs can be administered in a doctor's office, at an infusion center, in a patient's home or by the patient him or herself (self-administered). When you are prescribed one of these types of medications, Medical Management makes determinations as to whether treatments and services are Medically Necessary including if the place of service is appropriate and the PBM makes determinations as to whether a drug that is prescribed in appropriate and covered under the Plan's formulary and criteria.

If a physician wishes to administer a Specialty or Infusion Drug in an office setting or you will self-administer the medication, you will have to contact both Medical Management and the PBM to request pre-certification. Medical Management will make a determination as to Medical Necessity and place of service and you will ALSO need to contact the PBM to pre-certify the prescription drug. The determinations are NOT interchangeable and just because one component is pre-certified and covered does not mean that the other will be covered in the absence of a specific determination. In addition, you are required to utilize the CVS Specialty Pharmacy in order to fill the prescription. If you do not use the CVS Specialty Pharmacy for Specialty Drugs, you will be responsible for 100% of the cost of the drug. See the *Prescription Drug Program* section for details on how this program works and the requirements for pre-certification under the Prescription Drug Program.

Case Management

Case Management is ongoing, proactive coordination of a Covered Person's care in cases where the medical condition is, or is expected to become catastrophic, or chronic, or when the cost of treatment is expected to be significant. Examples of conditions that could prompt case management intervention include but are not limited to, cancer, chronic obstructive pulmonary disease, multiple trauma, spinal cord injury, stroke, head injury, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, high-risk pregnancy, and premature birth.

Case Management is a collaborative process designed to meet a Covered Person's health care needs and maximize their health potential, while effectively managing the costs of care needed to achieve these objectives. The Case Manager will consult with the Covered Person, the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care that provide the most appropriate health care and services in a timely, efficient and cost-effective manner.

If the Case Manager, Covered Person, and the Plan Administrator all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, the Plan Administrator may alter or waive the normal provisions of this Plan to cover such alternative care, at the benefit level determined by the Plan Administrator.

In developing an alternative plan of treatment, the Case Manager will consider:

- The Covered Person's current medical status;
- The current treatment plan;
- The potential impact of the alternative plan of treatment;
- The effectiveness of such care; and

- The short-term and long-term implications this treatment plan could have.

The Plan Administrator retains the right to review the Covered Person's medical status while the alternative plan of treatment is in process, and to discontinue the alternative plan of treatment with respect to medical services and supplies that are not covered benefits under the Plan if:

- The attending Physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment;
- The goal of the alternative care of treatment has been met; or
- The alternative plan of care is not achieving the desired results or is no longer beneficial to the Covered Person.

**Blue Distinction/Center of Excellence**

The Blue Distinction Centers for Specialty Care℠ is a program administered by the Blue Cross and Blue Shield Association that identifies quality providers of bariatric surgery, cardiac care, and transplant services nationwide. Each Center has been selected through a rigorous evaluation of clinical data that provides insight into the facility's structures, processes, and outcomes of care.

The Center of Excellence designation is awarded by Anthem to those programs meeting the participation requirements for Anthem's transplant network and all other future specialty networks developed by Anthem. Each Center has been selected through a rigorous evaluation of clinical data that provides insight into the facility's structures, processes, and outcomes of care.

**General Provisions for Medical Management**

A. Authorized Representative

The Covered Person is ultimately responsible for ensuring that all pre- certifications are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual pre-certification process will be executed by the Covered Person's Physician(s) or other providers on behalf of the Covered Person. By enrolling in this Plan, the Covered Person authorizes the Plan and its designated service providers (including Medical Management, the third party administrator, and others) to accept HealthCare Providers making referral and pre-certification submissions, or who otherwise have knowledge of the Covered Person's medical condition, as their Authorized Representative in matters of Medical Management. Communications with and notifications to such HealthCare Providers shall be considered notification to the Covered Person.

B. "Emergency" admissions and procedures

Any Hospital admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the patient's health is considered an emergency for purposes of the utilization review notification and this does not require pre-certification. However, notice must be given within 48 hours of an emergency admission.

C. Maternity Admissions

A notice regarding admissions for childbirth should be submitted to Medical Management in advance, preferably 30 days prior to expected delivery. However, this notice is not required. The Plan and the Medical Management Program process comply with all state and federal regulations regarding utilization review for maternity admissions. The Plan will not restrict

benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. If an admission exceeds 48 hours for a normal delivery or 96 hours for a cesarean section, notice must be given within 48 hours.

D. Medical Management is not a guarantee of payment of benefits

The Medical Management process does not provide a guarantee of payment of benefits. Approvals of referral and pre-certification notices for specialty visits, procedures, Hospitalizations and other services, indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan but other limitations or exclusions may apply. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

E. Result of not following the Medical Management Process

Failure to comply with the Medical Management "process of care" may result in reduction or loss in benefits as follows:

The reductions in benefits applicable for not obtaining pre-certification are described in the "Pre-Certification of Certain Procedures" earlier in this section. This subsection specifies the applicable penalties. Please note that charges you must pay due to any penalty for failure to follow the Medical Management Process do not count toward satisfying any Deductible, Coinsurance or Out-of-Pocket Limits of the Plan.

If a claim for benefits does not meet the definition of Medical Necessity or is considered Experimental or Investigation by Medical Management, benefits will be denied in whole or part.

F. Protection from Surprise Bills.

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

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
  - A participating Physician is unavailable at the time the health care services are performed;
  - A non-participating Physician performs services without your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

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

- You were referred by a participating Physician to a Non-Participating Provider without your explicit written consent acknowledging that the referral is to a Non-Participating Provider and

it may result in costs not covered by the Plan. For a surprise bill, a referral to a Non-Participating Provider means:

- Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;

- The participating Physician sends a specimen taken from you in the participating Physician's office to a non-participating laboratory or pathologist; or

- For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under the 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 Plan's website at www.swschp.com for a copy of the form. You need to mail a copy of the assignment of benefits form to the Hospital and Medical Claims Administrator at the address found in the Contact List in the front of this document or on your ID card and to your Provider.

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

G. Delivery of Covered Services Using Telehealth.

The Plan pays for Covered Services delivered using telehealth including, but not limited to, the services from providers who participate in the telehealth program known as LiveHealth Online. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Plan that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by the Plan's telehealth providers to deliver Covered Services to you while your location is different than your Provider's location. See the next section for details on the Plan's program.

Early Intervention and Individualized Education Program Services

The Plan will not exclude Covered Services solely because they are Early Intervention or Individualized Education Program services for infants and toddlers under three years of age or for children ages three to eighteen years old who have a confirmed disability or an established developmental delay. Additionally, if Early Intervention or Individualized Education Program services are otherwise covered under this Plan, coverage for Early Intervention or Individualized Education Program services will not be applied against any maximum annual or lifetime dollar limits if applicable. Visit limits and other terms and conditions will continue to apply to coverage for Early Intervention or Individualized Education Program services. However, any visits used for Early Intervention or Individualized Education Program services will not reduce the number of visits otherwise available under this Plan.

**Authorization to a Non-Participating Provider**

If the Plan does not have a Participating Provider that has the appropriate training and experience to treat your condition, an authorization to an appropriate Non-Participating Provider will be approved. Your Participating Provider or you must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of you or another treating Provider. If the authorization is approved, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Medical Management in consultation with your PCP, the Non-Participating Provider and you or your authorized representative. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will covered as an out-of-network benefit if available.

## ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses which are considered Covered Services for which you are covered are called "Eligible Medical Expense." Eligible Medical Expenses are determined by the appropriate Claims Administrator (see the Claims and Appeals section for a listing of the Plan's Claims Administrators), and are limited to those that are:

1. **"**Medically Necessary," but only to the extent that the charges are "Allowed Amounts" (as those terms are defined in the Defined Terms section of this Plan Document); and

2. Services or supplies that are specifically listed as Covered Service by the Plan and <u>not</u> excluded from coverage (as provided in the Exclusions section of this Plan Document);

3. Not in excess of any benefit limitations described in the *Schedule of Benefits* section of this Plan;

4. For the diagnosis or treatment of an injury or illness (except where Preventive services are payable by the Plan as noted in the Schedule of Preventive Services in this Plan Document);

5. Received while you are covered by the Plan.

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. All the Cost-Sharing amounts for which you are responsible for Medical benefits are outlined in this section. Information on how Prescription Drug benefits may be subject to Cost-Sharing are outlined in the Prescription Drug Benefits section following this section.

### Non-Eligible Medical Expenses

The Plan will not reimburse you for any expenses that are not Covered Services/Eligible Medical Expenses (and are not specifically listed as Eligible Medical Expenses in the Schedule of Benefits or elsewhere in this Plan Document). That means you are responsible for paying the full cost of all expenses that are determined not to be Medically Necessary, determined to be in excess of the Allowed Amount, not covered by the Plan, or payable on account of a penalty because of failure to comply with the Plan's Medical Management requirements as described in the preceding section of this Plan Document.

### Accessing Care and Level of Benefits under the Plan

Whenever you need care, you are free to choose care from a Participating (In-Network) Provider or a Non-Participating (Out-of-Network) Provider. However, your Out-of-Pocket expenses differ, depending on whether you use Participating Provider or a Non-Participating Provider. If you use the services of a Participating Provider, you will be responsible for paying less money out of your own pocket, benefits provided by Participating Providers are generally subject to a Copayment only and Participating Providers accept the Plan's payment as payment in full after any applicable Copayment. For Non-Participating Providers, you are generally subject to the Deductible and Coinsurance and, in addition, may be balanced billed for amounts over and above the Allowed Amount (the amount the Plan will pay for a certain service or supply). See the Defined Terms of this Plan Document for a definition of the Allowed Amount and Balance Billing.

Before you obtain services or supplies, you can find out whether the Plan will provide In-Network or Out-of-Network Benefits for those services or supplies and find a Participating Provider via the State-Wide Schools Cooperative Health Plan website at SWSCHP.org or by calling SWSCHP at 1 (888) P SWSCHP (779-7247). You will be able to find out the following information about the Plan's Network:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

This Plan does not have a gatekeeper, usually known as a Primary Care Physician ("PCP") feature. Although you are encouraged to receive care from your PCP, you do not need a referral from a PCP before receiving Specialist care.

You do not need prior authorization from the Fund or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Fund's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan.

**Remember,** because providers are added to and dropped from the Network periodically throughout the year, you should contact the Provider each time **BEFORE** you seek services.

## PARTICIPATING /IN-NETWORK AND NON-PARTICIPATING PROVIDERS AND COST-SHARING

### Participating/In-Network Providers

Participating/In-Network Providers are those eligible Providers who have agreed to accept payment directly from the Plan, in accordance with the Schedule of Benefits, as payment in full (less any applicable Copayment) for Eligible Medical Expense. Charges for covered services are paid directly to the Provider by the Plan in accordance with the Schedule of Benefits. You do not have to pay (apart from your Copayment) the Participating Provider for most covered services or submit a claim form. Any exceptions to this provision are detailed in the *Schedule of Benefits* portion of this Plan Document. In some instances, a Copayment must be paid, and/or a maximum reimbursement limit is applied.

### LiveHealth Online

Your coverage includes online physician office visits and include a visit with the physician using the internet via a webcam with online chat of voice functions. Services are provided by board certified, licensed Primary Care Providers. Online visits are not for specialist care. Common types of diagnosis and conditions treated online include:

- Cough
- Sore throat
- Upper Respiratory Infections
- Fever
- Routine child health issues
- Sinusitis
- Headaches
- Influenza
- Bronchitis
- Urinary Tract Infections

**Member Access.** To begin the online visit, log onto www.livehealthonline.com and establish an online account by providing some basic information about you and your insurance plan. Before you connect to a Physician, you will be asked to identify: the kind of condition you want to discuss with the Physician, your local pharmacy, provide information for the credit care you want your cost sharing for the visit to be billed to, agree to the terms of use, and select an available Physician. If you are not in New York State when you seek an online visit, you will need to check to be sure an online Physician is available in the state you are in because online physicians are not available in every state.

The visit with the Physician will not start until you provide the above information and click "connect." The visit will be documented in an electronic health record. You may access your records and print them, and may email or fax them to Your Primary Care Physician.

Note about Covered Services. Online visits are not meant for the following purposes:

- To get reports of normal lab or other test results;
- To request an office appointment;
- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a specialist Doctor
- To request Preauthorization for a benefit under your health Plan; or
- To ask the Physician to consult with another Physician.

- For Behavioral Health/Mental Health.

In addition, if you receive a prescription, it should be filled in accordance with the Prescription Drug Benefits Program section of this document.

**Non-Participating/Out-Of-Network Providers**

Non-Participating/Out-of-Network refers to providers who are not contracted with the network. A Non-Participating Provider is one who has not entered into an agreement with the Plan to accept payment in accordance with the Schedule of Benefits for Eligible Medical Expenses under the Plan. You are responsible for paying a Non-Participating Provider's charges. To receive reimbursement for such charges, you must file a claim with the Plan. You share in the payment of charges. Unless otherwise noted, you are responsible for an annual Deductible and for a percentage of Eligible Medical Expenses in excess of the Deductible or a Copayment. The fees charged by the Non-Participating Provider may exceed the amount reimbursed by the Plan. Non- participating providers may bill you a non-discounted amount for any balance that may be due, beyond the Allowed Amount payable by the Plan, also called Balance Billing.

When you receive Covered Services from a Non-Participating Provider, the Plan will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services received. Sometimes, applying these rules will change the way that the Plan will pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. Following are a few examples of when the Plan will apply payment rules to a claim is when:

- Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. The Plan will make one (1) inclusive payment in that case rather than a separate payment for each billed code.

- You have surgery that involves two (2) surgeons acting as “co-surgeons”. Under the payment rules, the claim from each Provider should have a “modifier” on it that identifies it as coming from a co-surgeon. If the Plan receives a claim that does not have the correct modifier, it will change it and make the appropriate payment.

- You receive services from a Health Care Professional who is not a Physician, such as a physician’s assistant. Under the payment rule, the Allowed Amount for a physician’s assistant or other Health Care Professional who is not a Physician will be less than the Allowed Amount for a Physician.

***Copayment/Copay Applicable to In-Network Medical and Hospital Benefits and Out-of-Network Hospital Benefits***

The Copayment is the fixed amount applicable to certain services for which you have financial responsibility. The Plan’s Copayments are listed specifically for each benefit where applicable in the *Schedule of Benefits*. Copayments generally apply to In-Network and Out-of-Network Hospital (both Inpatient and Outpatient Hospital facility) and In-Network Medical Eligible Expenses.

For Out-of-Network benefits, Copayments cannot be used to satisfy the Out-of-Network Deductible or Out-of-Pocket Limit and will continue to be your responsibility even after you reach your Out-of-Network Out-of-Pocket Limit. When Copayments apply, there are generally no Deductibles or Coinsurance, unless the Plan specifically provides otherwise as listed in the *Schedule of Benefits*.

When there is a Copayment amount shown in this *Schedule of Benefits*, it is paid for each Provider per service date. Physician charges (sometimes called the technical component) are usually considered separately from the facility charge. Any Outpatient Copayments listed for Outpatient Hospital Benefits in the *Schedule of Benefits* do not apply if the patient is admitted to the same Hospital from the Outpatient department. In order for the service to be covered under the provision for Outpatient Hospital Benefits, it must:

- Usually be provided by the Hospital;
- Must be given by an employee of the Hospital;
- Must be billed and payable to the Hospital; and
- The Hospital must retain the money collected for the service.

When the Allowed Amount for a service is less than the applicable Copayment, you are responsible for the lesser amount.

***Deductible Applicable to Out-of-Network Medical Benefits (and In-Network Non-Emergency services in an Emergency Room)***

The Deductible is the amount you must pay each calendar year before the Plan pays benefits. The amount applied to the Deductible is the lesser of billed charges or the amount considered an Allowed Amount under this Plan. The Deductible only applies to Eligible Medical Expenses that are received from Out-of-Network/Non-Participating Providers for medical (non-Hospital) services and In-Network Non-Emergency services in an Emergency Room. It does not apply to any Hospital (Inpatient and Outpatient Hospital facility expenses), In-Network benefits (except Non-Emergency services in an Emergency Room), or Coinsurance. Expenses for these benefits accumulate toward the annual Deductible.

For Non-Participating/Out-of-Network providers, each calendar year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are received by the Plan. Deductibles under this Plan are accumulated on a calendar year basis. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses, explained on the first page of this section do not count toward the Deductibles. Once you meet the annual Deductible, the Plan will begin to pay benefits for Out-of-Network Providers for medical benefits.

There are two types of Deductibles, Individual and Family. The Individual Deductible is the maximum amount one Covered Person has to pay toward Eligible Medical Expenses before Plan benefits begin and is currently $1,000 per individual. The Family Deductible is the maximum amount that a family of three or more Covered Persons is responsible for paying toward Eligible Medical Expenses before Plan benefits begin and is currently $3,000 per family.

***Coinsurance Applicable to Out-of-Network Medical Benefits and In-network Non-emergency Services Furnished in an Emergency Room***

Coinsurance is how you and the Plan will split the cost of certain Eligible Medical Expenses, after the Deductible is met. The Coinsurance is the portion of Eligible Medical Expenses for which you have financial responsibility, represented as a fixed percentage. Generally, the Plan pays 70% of the Allowed Amount for Out-of-Network providers and In-network non-emergency services provided in an emergency room. You are responsible for the 30% balance, known of as Coinsurance.

***Maximum Out-of-Pocket Limit***

The Maximum most you pay during a Plan Year in Cost-Sharing (Copayment, Coinsurance and Deductible) before the Plan begins to pay 100% of the Allowed Amount for Covered Services. This Out-of-Pocket Limit never includes "Out-of-Pocket Expenses You Always Pay", listed below.

Please note that the Plan maintains separate Out-of-Pocket Limits for In-Network and Out-of-Network benefits. The In-Network and Out-of-Network Out-of-Pocket Limits are NOT interchangeable. This means you may not use any portion of an In-Network Out-of-Pocket Limit to meet an Out-of-Network Out-of-Pocket Limit and vice versa. However, Out-of-Network copayment applied toward Emergency Services performed in an Out-of-Network Emergency Room will apply toward the In-Network Out-of-Pocket Limit on Cost-Sharing.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits the plan from imposing an annual Out-of-Pocket Limit on medical/surgical benefits and a separate annual Out-of-Pocket Limit on mental health and substance use disorder benefits. Expenses for mental health and substance use disorder benefits count toward the applicable Out-of-Pocket Limit in the same manner as those for medical expenses.

**In-Network Out-of-Pocket Limit.** The Out-of-Pocket Limit is $3,250 for any individual covered under this Plan and $6,500 for any family covered under this Plan. This Out-of-Pocket Maximum includes only Hospital and Medical costs. The Plan also maintains a separate Out-of-Pocket Limit for Prescription Drug benefits. These amounts can be found in the Prescription Drug section of this Plan Document. The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.

**Out-of-Network Out-of-Pocket Limit.** Each Calendar Year, after an individual or family has incurred a maximum Out-of-Pocket cost for Coinsurance of $3,250 for any individual or $9,500 for a family, no further Coinsurance will apply to Out-of-Network covered Eligible Medical Expenses. This amount does not include the Deductible or any Copayment amounts. Once you meet the Out-of-Pocket Limit, the Plan will pay 100% of Eligible Out-of-Network Medical Expenses, except for the Plan Deductible, Copayments (including those for Prescription Drugs) and the "Out-of-Pocket Expenses You Always Pay", listed below, that are incurred during the remainder of the calendar year after the Out-of-Pocket Limit has been reached.

**Out-of-Pocket Expenses You Always Pay**: This Plan rarely pays benefits equal to all the medical expenses you may incur. You are responsible for paying for certain expenses for medical services and supplies yourself. Under the Plan, each year, you will be responsible for paying the following expenses out of your own pocket and these expenses do not accumulate to meet the Out-of-Pocket Limits:

1. Premiums.

2. All charges in excess of the Allowed Amount determined by the Plan. (See the definitions of Allowed Amount and Balance Billing in the Defined Terms section of this Plan Document.)

3. All charges in excess of any limitation of the Plan or for benefits specifically excluded under the Plan.

4. Any additional other amounts or penalties you have to pay because you failed to comply with pre-certification requirements of the Medical Management Program described in that section of this Plan Document.

### Appeals Rights

You have the right to appeal a claim that is denied in whole or part. See the "Claims and Appeals" section for information on filing an appeal. This section also details the process for how to file a claim.

## HEALTH AND WELLNESS BENEFITS

### Preventive Services Benefits

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided for the following services on an **in-network** basis with no cost-sharing (meaning, no Deductibles, Coinsurance, or Copayments) for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Health Resources and Services Administration (HRSA) Guidelines, including the American Academy of Pediatrics *Bright Futures* guidelines.

However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Cost-Sharing (the Out-of-Network Copayments, Deductible and/or Coinsurance) applies if services are provided by a Non-Participating Provider.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under ACA. In that case, the Plan will determine whether a particular benefit is covered under Preventive Services benefits.

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 the Plan at the number on your ID card or visit the Plan's website for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP. You may also contact the Plan and have a copy of the list mailed to you upon request. You may also access the list on Healtcare.gov as follows: https://www.healthcare.gov/coverage/preventive-care-benefits/.

### Rules When Preventive Services Are Provided as Part of an Office Visit Vary by Billing

If a preventive item or service is billed separately from an office visit, the Plan may impose cost-sharing requirements with respect to the office visit (but not the preventive item or service).

Medical Management requirements will still apply to Preventive Services.

### Office Visit Coverage

Preventive Services are paid for based on the Plan's Schedule of Benefits for the individual services. The following conditions apply to payment for In-Network office visits under the Preventive Services benefit. Out-of-Network office visits are subject to the Cost-Sharing applicable to Out-of-Network benefits.

- If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.

- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.

- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit. For example, if a Covered Person has a cholesterol-screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol-screening test, the Plan will charge a Copayment for the office visit but not for the lab work.

**Preventive Benefits**

A. ***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 recommended by ACIP are also covered.

   This benefit is provided to Members from birth through attainment of age 21 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider. Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider.

B. ***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, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. 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. Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider.

C. ***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.

Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider. Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider.

D. ***Well-Woman Examinations.*** The Plan covers well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. 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.

   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. Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider.

E. ***Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.*** The Plan covers mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

   - One (1) baseline screening mammogram for Covered Individuals age 35 through 39;
   - Upon the recommendation of the Covered Individual's Provider, an annual screening mammogram for Covered Individuals age 35 through 39 if Medically Necessary; and
   - One (1) screening mammogram annually for Members age 40 and over.

   If a Covered Individuals of any age has a history of breast cancer or a first degree relative has a history of breast cancer, The Plan covers mammograms as recommended by the Member's 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 by a Participating Provider. The Plan also covers additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs.

   Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider. Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider.

F. ***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 Plan;
   - patient education and counseling on use of contraceptives and related topics;
   - follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and
   - sterilization procedures for women.

Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider. Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider.

The Plan also covers vasectomies subject to Copayments, Deductibles or Coinsurance.

The Plan does not cover services related to the reversal of elective sterilizations.

G. ***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 Plan Document. Bone mineral density measurements or tests, drugs or devices includes 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 qualify for coverage if you meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or 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. Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider.

H. ***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. Cost-Sharing (the Out-of-Network Deductible and Coinsurance) applies if services are provided by a Non-Participating Provider.

**Preventive Services Coverage Limitations and Exclusions**

1. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate Preventive Services codes. Services provided for diagnostic reasons are

covered under the applicable Plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the Covered Person had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

2. Services covered under Preventive Services benefits are not also payable under other portions of the Plan.

3. Immunizations are not covered, even if recommended by the CDC, if the recommendation is because some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.

4. Examinations, screenings, tests, items or services are not covered when they are Investigational or Experimental, as determined by the Plan.

5. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes, unless otherwise covered by the terms of this Plan:

    a. When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

    b. When related to judicial or administrative proceedings;

    c. When related to medical research or trials; or

    d. When required to maintain employment or a license of any kind.

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

## SCHEDULE OF BENEFITS

| Inpatient Hospital Benefits – Facility Charge | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| **Inpatient Acute Care General Hospital Services and Certified Birthing Center (Facility Charges)** for 365 days of care in each Spell of Illness.☎ | 100% of Allowed Amount after $200 Copayment per admission | |
| Charges made by a Hospital for a semi-private room, board and general nursing care, up to but not exceeding any limitations or exclusions stated herein for the following:<br>• Semiprivate room and board.<br>• General, special and critical nursing care;<br>• Meals and special diets.<br>• Use of Operating, Recovery, and Cystoscopy Room and equipment Laboratory and Pathology Examinations<br>• Use of Intensive Care, Special Care or Cardiac Care Units and use of Cartographic Equipment.<br>Basal Metabolism Tests<br>• Diagnostic and therapeutic items, such as prescribed 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.<br>• Blood, Blood products, and plasma except when a volunteer blood replacement program is available to the patient.<br>• Use of Transfusion equipment.<br>• Dressing and Plaster Casts.<br>• Supplies and the use of equipment in connection with Oxygen, Physiotherapy, Chemotherapy, Electrocardiographs, Electroencephalographs, X-Ray Examinations, Radiation Therapy and Radioactive Isotopes, Laboratory and Pathological examinations.<br>• Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.<br>• Anesthesia Supplies, equipment and administration by a Hospital staff employee<br>• Ambulance service when supplied by the admitting Hospital<br>• Treatment of a Mental Health or Substance Use Disorder by Licensed Health Care Provider.<br>• Short-term physical, speech and occupational therapy.<br>• 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 patient and attending Physician.<br>• Any additional Medically Necessary medical services and supplies which are provided while a registered bed patient and which are billed by the Hospital | Once 365-days are exhausted for one Spell of Illness (as explained in the "Defined Terms" section of this Plan Document) benefits continue to be payable at 100% of Allowed Amount<br>A Spell of Illness is explained in the "Defined Terms" section of this Plan Document. | Once 365-days are exhausted for one Spell of Illness (as explained in the "Defined Terms" section of this Plan Document), benefits are payable at 70% of Allowed Amount after Deductible |
| | **☎Pre-certification is required for all Inpatient Admissions. When you see this symbol☎, it means the service must be pre-certified. Failure to pre-certify will result in the lesser of $250 or 50% of the benefit otherwise provided. See the Utilization Review/ Medical Management section of this Plan Document for details on how pre-certification works.**<br>• Expenses must be recommended and approved by a Physician for the diagnosis of and/or treatment of an illness or injury.<br>• The services must be provided by an employee of the Hospital, and the Hospital must bill for and retain the money collected for the services.<br>• A Medically Necessary private room is covered.<br>• A separate $200 Copayment will apply if the patient is discharged to a new facility after a covered inpatient Hospitalization. | |

SCHEDULE OF BENEFITS

| Inpatient Hospital Benefits – Facility Charge | Inpatient Hospital Benefits – Facility Charge | Inpatient Hospital Benefits – Facility Charge |
|---|---|---|
| **Inpatient Stay for Maternity Care☎**<br>The Plan will pay for Inpatient maternity care in a Hospital for the mother and Inpatient newborn care in a Hospital for the infant, if covered under this Plan, for at least 48 hours following any delivery other than a caesarean section delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The Plan will also cover any additional days of such care that are deemed 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 pay for a home care visit. This additional home care visit will not be counted against any benefit limit established for home care elsewhere in this Plan. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. This home care visit will not be subject to any Deductibles, Copayments or Coinsurance payments.<br>• Nursery charges for the routine care of a healthy newborn baby during its initial Hospital confinement include a maximum of three (3) Physician/Pediatrician visits per confinement.<br>• The Plan also covers fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis. | **☎ Precertification is required for admissions that exceed 48-hours for delivery (or 96-hours for C-sections).** | |
| **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, the Plan 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 Document until the External Appeal Agent renders a decision in the Plan's favor.<br><br>The Plan will reimburse Non-Participating Providers for this end of life care as follows:<br>1. At a rate that has been negotiated between the Plan and the Provider.<br>2. If there is no negotiated rate, the Plan will reimburse Acute care at the Facility's current Medicare Acute care rate.<br>If it is an alternate level of care, the Plan will reimburse at 75% of the appropriate Medicare Acute care rate. | **☎Pre-certification is required**<br>100% of Allowed Amount after $200 Copayment per admission<br><br>Once 365-days are exhausted for one Spell of Illness (as explained in the "Defined Terms" section of this Plan Document) benefits continue to be payable at 100% of Allowed Amount<br>A Spell of Illness is explained in the "Defined Terms" section of this Plan Document. | Once 365-days are exhausted for one Spell of Illness (as explained in the "Defined Terms" section of this Plan Document) benefits continue to be payable at 100% of Allowed Amount<br>A Spell of Illness is explained in the "Defined Terms" section of this Plan Document. |

| Inpatient Hospital Benefits – Facility Charge | Inpatient Hospital Benefits – Facility Charge | Inpatient Hospital Benefits – Facility Charge |
|---|---|---|
| **Inpatient Mental Health Disorder** ☎<br>The Plan covers inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Plan. The Plan also covers inpatient mental health care services relating to the diagnosis and treatment of mental health conditions 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 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment that are JCAHO, CARF or DNV Healthcare accredited Mental Health Facilities as defined in this Plan Document. | ☎ **Precertification is required***<br>***Pre-cert is not allowed if patient is under 18 years of age**<br>The Copayment for an admission for rehabilitation or residential treatment is waived during a continuous period of treatment if a $200 Copayment was charged for a preceding Inpatient admission for treatment for the same Spell of Illness. | |
| **Inpatient Substance Use Disorder – Including Detoxification and Rehabilitation**☎<br>The Plan covers inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. The Plan also covers services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission, CARF or DNV Healthcare accredited Substance Abuse Facilities as defined in this Plan Document. | ☎ **Precertification is required***<br>***Pre-cert is not required for In-network, In-state** Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports ("OASAS")<br>The Copayment for an admission for rehabilitation is waived during a continuous period of treatment if a $200 Copayment was charged for a preceding Inpatient admission for detoxification or other treatment for the same Spell of Illness. | |
| **Inpatient Skilled Nursing Facility (SNF)/Rehabilitation** ☎<br>The Plan covers inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in an inpatient rehabilitation facility.<br><br>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 Document). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by Medical Management.<br><br>Benefits provided include:<br>• *A semi-private room*. The Plan will pay an amount equal to the facility's most common charge for a semi-private room. Covered individual is responsible the excess portion of the charge for a private room, unless a private room is Medically Necessary;<br>• *Skilled nursing service*. Nursing care must be given or supervised by a Registered Nurse;<br>• *Physical, Occupational and Speech Therapy*;<br>• *Medical Social Services*; and<br>• *Drugs, biologicals, supplies, appliances and equipment* furnished for use in the facility and which the facility ordinarily provides to inpatients. | ☎ **Precertification is required**<br><br>100% of Allowed Amount<br><br>Two (2) SNF days equal one (1) benefit day<br><br>Applies toward the 365 benefit days per Spell of Illness maximum<br><br>**The Plan will not pay for benefits in a Skilled Nursing Facility if the Covered Person is eligible to receive primary benefits from Medicare.** | |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Hospital Outpatient Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Emergency Room - Facility charge for Emergency Medical Condition**<br>Benefits are payable for Emergency Services provided in Hospital emergency rooms when the patient is suffering from an Emergency Condition as defined in the "Defined Terms" section of this Plan Document. Coverage only includes those Emergency Services and supplies that are Medically Necessary and preformed to treat or stabilize the patient's Emergency Condition in a Hospital emergency room.<br>Emergency Condition may include, but is not limited to, the following conditions:<br>• Severe chest pain<br>• Severe or multiple injuries<br>• Severe shortness of breath<br>• Sudden change in mental status (e.g., disorientation)<br>• Severe bleeding<br>• Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis<br>• Poisonings<br>• Convulsions | $75 Copayment, then 100% of Allowed Amount<br><br>The $75 Copayment is waived if the patient is admitted from the ER to the Hospital. **Precertification is required within 48-hours of emergency admission.** | $75 Copayment, then 100% of greater of:<br>(1) Network Fee (if more than one amount is negotiated, the median of the amounts);<br>(2) Allowed Amount for Emergency Services provided by an out-of-network provider; or<br>(3) Medicare allowance.<br><br>The $75 Copayment is waived if the patient is admitted from the ER to the Hospital. **Precertification is required within 48-hours of emergency admission.** |
| **Emergency Care Visit – Physician's charge for Emergency Care in an Emergency Room** | $30 Copayment, then 100% of Allowed Amount | $30 Copayment then 100% of greater of:<br>(1) Network Fee (if more than one amount is negotiated, the median of the amounts);<br>(2) Allowed Amount for Emergency Services provided by an out-of-network provider; or<br>(3) Medicare allowance. |
| **Observation services in a Hospital.**<br>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 for up to stays that span two midnights. | $75 copayment , then 100% of Allowed Amount (this Copayment will be in addition to the Emergency Room Copayment) | |
| **Non-Emergency Care in an Emergency Room (facility and/or Physician charge)**<br>Treatment received in an emergency room of a Hospital that is classified as non-emergency care or for services that are provided in conjunction with an Emergency Room visit that are not considered Emergency Services for an Emergency Medical Condition as defined in the "Defined Terms" section of this Plan Document and are NOT Medically Necessary and performed to treat or stabilize the patient's Emergency Medical Condition in a Hospital emergency room. | 70% of Allowed Amounts after Deductible | |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Hospital Outpatient Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Urgent Care Facility or Hospital Outpatient Clinic** | \$30 Copayment, then 100% of Allowed Amount | 70% of Allowed Amount after Deductible |
| **Ambulance and Pre-Hospital Medical Services**<br>***Pre-Hospital Emergency Medical Services*** means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a hospital when such services are provided by an ambulance service issued a certificate under the New York Public Health Law.<br><br>Separate charges for paramedic intercept are not covered by the Plan except if no charges are submitted for the ambulances services. If both organizations bill, the Plan will pay the greater of the two changes up to the Allowed Amount.<br><br>***Emergency Ambulance Transportation***. In addition to Pre-Hospital Emergency Medical Services, the Plan also covers emergency ambulance transportation by a licensed ground ambulance service to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat the Emergency Condition.<br><br>***Non-Emergency Ambulance Transportation***.<br>The Plan covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:<br>• From a non-participating Hospital to a participating Hospital;<br>• To a Hospital that provides a higher level of care that was not available at the original Hospital;<br>• To a more cost-effective Acute care Facility; or<br>• From an Acute care Facility to a sub-Acute setting.<br><br>Benefits payable under the Plan do not include transfers of patients between Hospitals or health care facilities by an ambulance service (unless the transfer meets the definition of Emergency as defined in the Defined Terms section of this Plan Document). No coverage is provided for non-ambulance transportation, such as ambulette, van or taxicab. | 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. In the absence of negotiated rates, the Plan will pay a Non-Participating Provider the Allowed Amount for Pre-Hospital Emergency Medical Services, which will not be excessive or unreasonable.<br><br>\$50 Copayment, then 100% of Allowed Amount | \$50 Copayment, then 100% of Allowed Amount<br><br>Out-of-Network Ambulance services are not subject to Deductible or Co-insurance. |
| **Preadmission Testing (within 14 days of admission) – (Facility charge)**<br>Laboratory tests, x-rays and other Medically Necessary tests performed in an Outpatient facility of a Hospital prior to a scheduled Hospital admission as a planned preliminary to admission as an Inpatient for surgery in the same Hospital when ordered by a Physician or other health care provider provided that:<br>• The tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;<br>• The tests must be Medically Necessary;<br>• A bed and operating room must have been reserved before the tests are done;<br>• The patient must be physically present at the Hospital when the tests are performed; and<br>• The surgery must occur within 14 days of these tests. | 100% of Allowed Amount | |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Hospital Outpatient Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Home Health Care Service and Supplies ☎**<br>Benefits are available for Home Care visits as described in the Defined Terms section of this Plan Document. Benefits are provided for Home Care if the Covered Person is under the care and treatment of a Physician or other Health Care Provider and, in the absence of Home Care, would require Hospitalization or a stay in a Skilled Nursing Facility. This care must be provided pursuant to a Physician or other Health Care Provider's written treatment plan. Care must be provided by:<br>• A Hospital licensed and/or certified to provide Home Health services under the Public Health Law of the State of New York or similar statutory or regulatory authority of another state; or<br>• A Home Health service or agency licensed and/or certified to provide Home Health services under either the Public Health Law of the State of New York or similar statutory or regulatory authority of another state.<br><br>The benefits provided under Home Care are as follows:<br>• Part-time or intermittent home nursing care given you by or under the supervision of a Registered Nurse (R.N.);<br>• Part-time or intermittent home health aide services which consist primarily of caring for you;<br>• Physical, occupational, speech therapy, respiratory therapy or infusion therapy provided you by the Home Health agency;<br>• Medical supplies, drugs, or medicines, and Laboratory services prescribed by a Physician or other Health Care Provider for you while you are receiving Home Care. These items are covered only to the extent such items would be covered, if you were in an In-patient in a Hospital or a Skilled Nursing Facility; and<br>• Laboratory services for which you would be covered if you were an Inpatient in a Hospital. | **☎ Pre-certification is required**<br><br>• Limited to 365 benefit days (applies toward the 365 benefit days per Spell of Illness maximum), however, a minimum 40 visits per calendar year are provided without regard to the 365-day Spell of Illness maximum<br>• Three (3) visits equal one benefit day<br>• Each visit by a member of a home care team equals one home care visit<br>• Four hours of a home aide service equals one (1) home care visit<br><br>100% of Allowed Amount | |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Hospital Outpatient Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Hospice Care☎**<br>Hospice Care benefits provided by a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If this care is provided outside New York, the Hospice organization must have an operating certificate similar to those issued in New York by a State Agency in the state where Hospice Care is provided.<br><br>The Plan will pay for Hospice Care during the period when the Hospice has accepted the Covered Person for its program if the attending Physician certifies that the Covered Person has six (6) months or less to live. Coverage is provided for up to 210 days of Hospice care. While the Covered Person in their care, coverage will be provided for the following benefits:<br><br>• Bed patient care either in a designated Hospice unit or in a regular Hospital bed;<br>• Day care services provided by the Hospice organization;<br>• Home Care and out-patient services which are provided by the Hospice and for which you are charged. The Services may include at least the following:<br>- Intermittent nursing care by a Registered Nurse, Licensed Practical Nurse, or Home Health aide;<br>- Physical, Speech, Occupational and/or Respiratory Therapy<br>- Social service;<br>- Nutritional services;<br>- Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms;<br>- Medical supplies;<br>- Drugs and medications prescribed by a Physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary. No payment will be made when the drug or medication is of an Experimental nature, unless directed pursuant to external appeal.<br>- Medical care provided by the Hospice Physician;<br>- Bereavement services provided to your family during your illness, and until one year after death. | **☎ Pre-certification is required**<br><br>100% of Allowed Amount | |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Physician and Other Health Care Provider Services**<br>• **Medical Office Visits:** Professional fees when provided by a Physician or other Health Care Professional for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls; and allergy testing and treatment (including allergy testing, including injections and scratch and prick tests to determine the existence of an allergy, and allergy treatment including desensitization treatments, routine allergy injections and serum, one Copayment applicable per visit).<br>• **In-Hospital/Facility Physician's Care/Medical Visits in a Hospital:** Physician or other Health Care Provider's medical services if they are given in a Hospital while Covered Individual is an Inpatient. Separate payments for visits in connection with surgery or maternity care are not made because the scheduled amount of the payment for surgery or maternity care provided includes payments for such visits.<br>• **Outpatient Consultation:** One in each specialty per calendar year, for each condition being treated.<br>• **Special Consultations:** Physician or other Health Care Provider referrals to specialist for a consultation. A consultation consists of an evaluation of a medical condition and professional advice on how to proceed with care.<br>• **Inpatient Consultation**: One in each specialty per confinement for each condition being treated. Consultations are not covered for the fields of:<br>– Pathology;<br>– Roentgenology; or<br>– Anesthesiology.<br>• **Telehealth Visits**. Covered Services via telehealth including online internet consultations between you and Providers including but not limited to visits with LiveHealthOnline Providers (the Plan's telemedicine program for medical conditions) that are not an Emergency Condition. See page 41 for a description of the Plan's program.<br>• **Retail Health Clinics**. Basic health care services provided to you on a "walk-in" basis at retail health clinics normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses. | $30 Copayment per Provider per visit, then 100% of Allowed Amount | 70% of Allowed Amount after Deductible |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| **Preventive Care** (see the Preventive Care description earlier in this section for details on these benefits). The Plan covers the following benefits:<br><br>• Well Child Visits and Immunizations*<br>• Adult Annual Physical Examinations*<br>• Adult Immunizations*<br>• Routine Gynecological Services/Well Woman Exams*<br>• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer*<br>• Sterilization Procedures for Women*<br>• Bone Density Testing*<br>• Screening for Prostate Cancer<br>• All other preventive services required by USPSTF and HRSA* | 100% of Allowed Amount<br><br>*Applicable cost-sharing may apply when preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. | 70% of Allowed Amount after Deductible |
| **Surgical and Maternity Care Benefits/Health Care Provider Fees ☎**<br>The amount of payment for surgery includes payment for the necessary related care by your Physician or other Health Care Provider before and after operation. One payment covers the operation and the care before and after the operation. | **☎ Pre-certification is required for Inpatient and Outpatient procedures. Pre-certification is not required for procedures performed in an office setting or for maternity care (see the Medical Management section for information when pre-certification is required).** | |
| • **Surgery/Surgeon ☎**<br>Surgical procedures, including operative and cutting procedures; procedures for the treatment of a sickness or injury; closed reduction of fractures and dislocations of bones; endoscopic procedures; incisions, or punctures of the skin including all usual and necessary before and after care. All procedures must be performed by a medical professional licensed to perform surgery and be for the treatment of a condition, illness, or injury.<br>Payment for surgical procedures is subject to the following limitations:<br>• If multiple covered surgical procedures are preformed through the same incision, the Plan will pay for the major procedure with the highest Allowed Amount and one-half (50%) of the payment otherwise payable for the secondary procedure except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. Any additional procedures will be reimbursed at one quarter (25%) of the payment otherwise payable for the lesser procedures. 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<br>• If Covered multiple surgical procedures are performed during the same operative session but through different incisions, the Plan will pay:<br>- For the procedure with the highest Allowed Amount; and<br>- 50% of the amount that would otherwise be payable for the other procedures.<br>• When an operative procedure is performed in two or more steps or stages, which make up the entire procedure, payment is limited to the amount which the Plan would pay for such operative procedures if they were not performed in steps or stages. | $30 Copayment per Provider per visit | 70% of Allowed Amount after Deductible |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| • **Assistant Surgeon**<br>The Medically Necessary assistance by another Physician or other Health Care Provider during the course of an operation, to the Physician or other Health Care Provider who performs the operation. The Plan will pay the assisting Physician for 20% of the Allowed Amount for the surgical procedure performed. Please note: Benefits are only allotted for qualified licensed providers acting within the scope of their licenses. (Please refer to "Doctor or Physician" and "Health Care Practitioner or Provider" in the Defined Terms section of this Plan Document for a complete listing.) In addition, any reductions applicable for the primary or co-surgeon that are listed above will also be applied to the assistant surgeon as applicable. The allowed amount for a Physician assistant will be payable at 10% of the Allowed Amount for the Physician. | $30 Copayment per Provider per visit | 20% of Allowed Amount payable at 70% after Deductible |
| • **Anesthesia**<br>The administration of necessary anesthesia and related procedures given with surgical or obstetrical services. The medical professional providing the anesthesia cannot be the operating Physician or his surgical assistant. | $30 Copayment per Provider per visit | 70% of Allowed Amount after Deductible |
| • **Maternity (including fees of nurse midwife)**<br>Maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. The Plan covers prenatal care, 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 does not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services row for information about inpatient maternity care.<br>The Plan covers breastfeeding support, counseling and supplies, including the cost of rental of (up to purchase price of) one (1) breast pump per pregnancy or, if greater, one (1) per calendar year for the duration of breast feeding. | $30 Copayment per visit for other than prenatal services required under the Preventive Benefits<br><br>$0 Copayment for prenatal services required under the Preventive Benefits including breastfeeding support | 70% of Allowed Amount after Deductible |
| • **Reconstructive Breast Surgery:** ☎<br>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 the attending Physician and patient to be appropriate. The Plan also covers implanted breast prostheses following a mastectomy or partial mastectomy. | $30 Copayment per Provider per visit | 70% of Allowed Amount after Deductible |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| • **Other Reconstructive and Corrective Surgery:** ☎<br>Cover reconstructive and corrective surgery other than reconstructive breast surgery is only covered when it is:<br>- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;<br>- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or<br>- Otherwise Medically Necessary.<br>Notwithstanding the above, reconstructive or corrective surgery for surgeries or procedures that are not Covered Services are not covered under any circumstances. | $30 Copayment per Provider per visit | 70% of Allowed Amount after Deductible |
| • **Family Planning and Reproductive Health Services**<br>• See the Preventive Care row for information on benefits for women's family planning and reproductive services.<br>• Voluntary sterilization (vasectomy) for men.<br>No benefits are provided for reversal of elective sterilization. | $30 Copayment per Provider per visit | 70% of Allowed Amount after Deductible |
| • **Voluntary or Elective Abortion** | $30 Copayment per Provider per visit | 70% of Allowed Amount after Deductible |
| **Outpatient Surgery Facility Charge**<br>Facility charge (services and supplies provided by the Facility) on the day of surgery, provided that it is consistent with and related to the surgery performed. The Plan will not pay for the follow-up care or visits, including the removal of sutures, since these services are normally included in the fee for the surgery. | | |
| • ***Freestanding/Ambulatory Facility/Surgical Center Charge*** | 100% of Allowed Amount, No Copayment | 70% of Allowed Amount after Deductible |
| • ***Hospital Outpatient Facility Charge*** | $75 Copayment | |
| **Gene Therapy** ☎<br>The Plan covers gene therapy that has been determined to be non-experimental and non-investigational. You must contact Medical Management prior to receiving any gene therapy in order to assess if the proposed therapy meets the strict FDA-approved indications for use of the therapy, would be considered Medically Necessary and will be covered by the Plan. No benefits will be provided for such treatment/therapy if you do not contact Medical Management prior to receiving the therapy. | **☎ Pre-certification is required**<br>See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., supply, diagnostic tests, office visits, facility charges) | See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits, facility charges) |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Transplants☎**<br>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 for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome the Plan covers Hospital and medical expenses, including donor search fees, of the Member-recipient. Transplant services required when a member serves as an organ donor are only covered if the recipient is a Member.<br>• The transplant must be performed to replace an organ or tissue of the Covered Person. However, no coverage is provided for a transplant procedure that is considered Experimental in nature, unless directed pursuant to external appeal.<br>• The Plan does not cover charges incurred in obtaining donor organs, including:<br>– travel expenses;<br>– lodging, meals, or other accommodations for donors or guests;<br>– donor fees in connection with organ transplant surgery; or<br>– routine harvesting (unless provided by an In-Network provider and included in the negotiate rate)<br>– removing the organ from the donor; and<br>– transportation of the organ to the place where the transplant is to occur (unless provided by an In-Network provider and included in the negotiate rate)<br>• The Plan does not cover the medical expenses of a non-Member acting as a donor or for donor expenses covered under another health plan or program. | **☎ Pre-certification is required**<br>See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits, facility charges) | See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits, facility charges) |
| **Infertility Treatment**<br>The Plan covers services for the diagnosis and treatment (surgical and medical) of Infertility (see definition of "Infertility" in the Defined Terms section of this Plan Document.) | | |
| **Basic Infertility Services**. Basic infertility services will be provided to a Covered Person who is an appropriate candidate for infertility treatment. In order to determine eligibility, the Plan will use guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine and the State of New York.<br><br>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. The Plan will not discriminate based on your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit. | | |

| SCHEDULE OF BENEFITS | | |
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| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Basic infertility** services that do not require Precertification include the following:<br>• Initial evaluation<br>• Semen analysis<br>  - Sperm Identification, Sperm Isolation, Sperm Washing for Artificial Insemination<br>  - Sperm Isolation: complex prep for insemination or diagnosis with semen<br>  - Sperm Isolation: simple prep for insemination or diagnosis with semen analysis<br>• Laboratory evaluation<br>• Evaluation of ovulatory function<br>• Postcoital tests<br>• Blood tests | See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits) | |
| **Basic Infertility** services (requiring Pre-certification) include the following. ☎<br>• Endometrial biopsy<br>• Pelvic ultrasound<br>• Hysterosalpingogram<br>• Sono-hysterogram<br>• Testis biopsy<br>• Medically appropriate treatment of ovulatory dysfunction<br>• Intrauterine Insemination (IUI)<br>Additional tests may be covered if determined to be Medically Necessary | ☎ **Pre-certification is required**<br>See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits) | |
| **Comprehensive Infertility Services☎.** If the basic infertility services do not result in increased fertility, the Plan covers comprehensive infertility services as follows:<br>• Ovulation induction and monitoring;<br>• Pelvic ultra sound;<br>• Hysteroscopy;<br>• Laparoscopy; and<br>• Laparotomy.<br>The Plan also covers standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Latrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes. | ☎ **Pre-certification is required**<br>See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits) | |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
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| **Advanced Infertility Services**☎ The Plan covers the following advanced infertility services for four (4) cycles per lifetime:<br>• Assisted Embryo Hatching, rnicrotechnique<br>• Culture and Fertilization of oocoryte<br>• Follicle Puncture for oocryte retrieval<br>• ZIFT - Zygote Intrafallopian Tube Transfer<br>• GIFT-Gamete Intrafalopian Tube Transfer<br>• ICSI-Intracytoplasmic Sperm Injection<br>• IVF-In-vitro Fertilization<br>• Preparation of Embryo for transfer<br>• Cryopreservation and storage of sperm, ova, and embryos [in connection with in vitro fertilization<br>A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer. | ☎ **Pre-certification is required**<br>See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits). | |
| **Second Surgical Opinion Consultation**<br>A second surgical opinion from a board certified surgeon on any elective, non-emergency surgery. If the surgeon requires x-rays, laboratory tests or other electronic diagnostic medical procedures to render an opinion, the Plan will also make payment for these services.<br>If your Physician or other Health Care Provider makes a recommendation of the need for elective surgery as the form of treatment for your illness, you will usually be referred to a surgeon who confirms the need for an operation. This Physician or other Health Care Provider provides you with your first surgeon's opinion, since your Physician or other Health Care Provider is not, in most cases, a surgeon and usually is not considered a specialist for purposes of a second opinion.<br>You may then seek a second surgeon, who is board certified specialist in the related field of your illness, to obtain your second surgeon's opinion. If the Physician or other Health Care Provider giving the second surgical opinion subsequently performs the operation, the Plan will pay this surgeon for the covered surgical services; however, the Plan will not pay for the opinion rendered. | 100% of Allowed Amount | 70% of Allowed Amount, Deductible does not apply |
| **Second Cancer Opinion**<br>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. You may obtain a second opinion from a Non-Participating Provider on an in-network basis. | 100% of Allowed Amount | 100% of allowed amount after $30 Copayment; Deductible does not apply |

| SCHEDULE OF BENEFITS | | |
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| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Outpatient Private Duty Nursing Care☎**<br>This service must be performed by a medical professional acting within the scope of his or her license. The services cannot be rendered by someone living in your home, or by a person of the Covered Person's immediate family. | **☎ Pre-certification is required**<br>• The first 48 hours per calendar year are not covered.<br>• The Plan does not cover the assistance in activities of daily living or custodial care or companionship or any other service that can be given by a less skilled person, such as a Home Health Aide.<br>• This service is covered only if it is determined that such a nurse is Medically Necessary to manage medical problems of acutely ill patients.<br>• Coverage is limited to a maximum payment of $30/hour for participating and non-participating care.<br>• There is no coverage available for private duty nursing on an Inpatient basis. | |
| | $30 Copayment per Provider per visit up to a maximum Allowed Amount of $30 per hour. | 70% after Deductible up to maximum Allowed Amount of $30 per hour |
| **Visiting Nurse Services☎**<br>Services of a visiting nurse for part-time or intermittent nursing care in your home. A Physician or other Health Care Provider must prescribe the visiting nurse service, and you may not receive visiting nurse services at the same time as Home Health Care. | **☎ Pre-certification is required** | |
| | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Diagnostic Procedures and Testing☎**<br>Diagnostic procedures and diagnostic testing, service and materials including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and high tech/advanced imaging services (MRI, PET CAT, and Computerized Tomography Angiography (CTA) scans and SPECT/nuclear medicine). These tests must be consistent with the condition for which patient is being treated. These tests need not be performed by a Physician or other Health Care Provider, but they must be ordered by a Physician or other Health Care Provider. | **☎ Pre-certification is required for High Tech/Advanced Imaging Services including MRI, MRA, PET, CTA Scans and SPECT/Nuclear Medicine** | |
| • ***Outpatient Freestanding Facility (Non-Hospital and Non-Office setting*** | | |
| • Quest Laboratories and US Imaging for High Tech/Advanced Imaging Services and ACA Preventive Services | 100% of Allowed Amount | Not Applicable |
| • All Other Diagnostic Procedures and Testing other than High Tech/Advanced Imaging Services | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| • All other High Tech/Advanced Imaging Services | $75 Copayment per visit | |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| • ***Hospital Outpatient Facility***<br>Benefits are payable for diagnostic x-ray and laboratory tests if the tests are:<br>• Necessary for the treatment and diagnosis of your illness or injury,<br>• Ordered by a Physician or other Health Care Provider, and<br>• Performed in the patient's presence at the Outpatient department of a Hospital.<br>Includes administration of Deferral for Cooley's Anemia | *Diagnostic Procedures and Testing other than High Tech/Advanced Imaging Services:* $50 Copayment per visit<br><br>*High Tech/Advanced Imaging Services:* $75 Copayment per visit | |
| **Outpatient Treatment for Mental Health Disorders**<br>Outpatient mental health care services to treat a Mental Health Condition, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Mental Health Facilities as defined in Definitions section of this Plan Document. | ☎ **Pre-certification is required for the following:**<br>• Applied Behavioral Analysis (ABA) Therapy | |
| • **Office visits and professional services** | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| • **Psychological Testing** | 100% of Allowed Amount | 70% of Allowed Amount after Deductible |
| • **Freestanding Facility Charge**<br>• **Hospital Outpatient Facility Charge** | $30 Copayment per day | 70% of Allowed Amount after Deductible |
| • **Shock Therapy:** Benefits for shock therapy treatments performed in or out of a Hospital. ☎ | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Outpatient Treatment for Substance Use Disorders**<br>Outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, counseling, and medication-assisted treatment.<br>• For outpatient services provided in a facility setting, coverage is limited to Facilities listed in the Defined Terms section of this document. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider.<br>• 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. | | |
| • **Mental Health and Substance Abuse Outpatient Therapy** | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| • **Freestanding Facility Charge**<br>• **Hospital Outpatient Facility Charge** | $30 Copayment per day | 70% of Allowed Amount after Deductible |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Dialysis☎**<br><br>Benefits are provided for hemodialysis for treatment of acute or chronic kidney ailment. Treatment must be ordered by your Physician or other Health Care Provider and Medically Necessary for the treatment of illness or injury. | **☎ Pre-certification is required**<br><br>It is important that individuals with end stage kidney/renal disease promptly apply for Medicare coverage, regardless of age. See the Coordination of Benefits section that discusses what this Plan pays when you are also Medicare-eligible. Please note that this Plan will pay secondary benefits after the 30-month Coordination Period to the extent allowed by the Law. Therefore, it is important that you enroll in Medicare as soon as you are diagnosed. | |
| • ***Outpatient Freestanding Facility (Non-Hospital setting) and Physician/Health Care Provider (Professional Fees) and Medicare-Certified Dialysis Center***<br>Hemodialysis or peritoneal dialysis administered under the direction of a Physician in an outpatient free-standing facility or Medicare-Certified Dialysis Center. | 100% of the Allowed Amount | 70% of Allowed Amount after Deductible |
| • ***Outpatient Hospital Facility***<br>Hemodialysis or peritoneal dialysis administered under the direction of a Physician in a Hospital or Outpatient Hospital facility. | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Radiation Therapy☎**<br>When ordered by a Physician or other Health Care Provider for the treatment of a condition, illness or injury, by:<br>• X-ray;<br>• Radium; or<br>• Radioactive isotopes. | **☎ Pre-certification is required** | |
| • ***Outpatient Freestanding Facility and Physician/Health Care Provider (Professional Fees)*** | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| • ***Hospital Outpatient Facility Charge*** | 100% of Allowed Amount | |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| **Chemotherapy ☎**<br>Benefits are provided for:<br>• parental;<br>• injection/infusion;<br>• perfusion;<br>• oral; or<br>• intercavity chemotherapy.<br>In no event will benefits be provided for Experimental chemotherapy or investigative anti-neoplastic drugs under this Plan, unless directed pursuant to external appeal.<br>Orally-administered anti-cancer drugs are covered under the Prescription Drug Coverage section of this Plan (as Specialty Drugs). | **☎ Pre-certification is required** | |
| • ***Outpatient Freestanding Facility (Non-Hospital setting) and Physician/Health Care Provider (Professional Fees)*** | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| • ***Hospital Outpatient Facility Charge***<br>• Services and medications for non-Experimental cancer chemotherapy; and<br>• Cancer hormone therapy | 100% of Allowed Amount<br>No benefits are provided under this category for oral chemotherapy, subcutaneous injection or intramuscular injections. | |
| **Infusion Therapy ☎**<br>The Plan provides benefits for at home infusion therapy when Infusion therapy which is the administration of drugs using specialized delivery systems. 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. | **☎ Pre-certification is required** | |
| • ***Home Infusion*** | 100% of Allowed Amount | 70% of the Network Allowance after Deductible |
| • ***Outpatient Freestanding Facility (Non-Hospital setting) and Physician/Health Care Provider (Professional Fees)*** | $30 Copayment | 70% of the network allowance after Deductible |
| • ***Hospital Outpatient Facility Charge*** | 100% of Allowed Amount | |
| **Biofeedback ☎**<br>Biofeedback when administered by a Physician or other medical professional. | **☎ Pre-certification is required**<br>Up to 31 visits per calendar year | |
| | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Rehabilitation Therapy, including Physical, Occupational and Speech Therapy☎**<br>Services of a licensed, professional physical therapist; treatment must be ordered by a Physician or other Health Care Provider and be Medically Necessary for the treatment or diagnosis of the illness or injury.<br>The therapy must be Active Rehabilitation as defined in the Defined Terms section of this Plan Document and:<br>• reasonable;<br>• expected to result in significant clinical improvement of condition; | **☎ Pre-certification is required**<br>• No therapy is payable for Recreational or Leisure Therapy.<br>• Any conditions that do not show significant clinical improvement after three months of therapy are not covered. | |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
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| • intended to improve or restore bodily functions within a reasonable and generally predictable period of time; and<br>• not be solely to prevent further deterioration or maintain a current condition.<br>**See the Autism benefit description for details on how benefits are paid for ABA Therapy.** | • There is no coverage for long term therapy or therapy that is considered Custodial or for Maintenance or Passive Rehabilitation.<br>• If additional visits are necessary after the initially authorized visits are completed, an updated treatment plan documenting the progress to date must be filed with and approved by the Medical Management Program. | |
| • ***Outpatient Freestanding Facility (Non-Hospital setting) and All Physician/Health Care Provider (Professional Fees)*** | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| • ***Outpatient Hospital after Related Surgery*** ☎<br>The therapy must be prescribed by a Physician or other Health Care Provider and commence within 6 months of a related surgery, or date of discharge for related In-patient hospitalization. In either case, no payment will be made for physical therapy given after 365-days from the date of discharge or surgery. | $30 Copayment per visit | |
| **Cardiac Rehabilitation** ☎<br>Benefits for Outpatient or Out-of-Hospital Medically Necessary Cardiac Rehabilitation are available if rehabilitation follows a specific set of symptoms or diagnosis including, but not limited to the following:<br>• Heart Attack;<br>• Cardiac Surgery; or<br>• Stroke. | **☎ Pre-certification is required**<br>• Limited to 36 visits per Episode of Care (Outpatient Hospital or out-of-Hospital setting combined)<br>• No coverage is provided for Cardiac Rehabilitation rendered as a preventive measure. | |
| | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Physiotherapy** ☎<br>Services of a licensed physiotherapist. | **☎ Pre-certification is required** | |
| | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Respiratory Therapy**<br>Pulmonary Rehabilitation is available to those individuals with a chronic respiratory disorder (e.g. emphysema, COPD) who are able to actively participate in a Pulmonary Rehabilitation program that is likely to improve their respiratory condition. | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Chelation therapy**<br>Covered in limited circumstances as may be Medically Necessary; for example, for the treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron. | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Foot Care and Podiatry Services (routine foot care not covered)**<br>The services of a Podiatrist when following surgery. **However, routine foot care is not considered a covered benefit**. Routine care of the feet consists of, but may not be limited to, services in connection with the following:<br>• corns;<br>• calluses;<br>• flat feet;<br>• fallen arches;<br>• weak feet;<br>• chronic foot strain; or | $30 Copayment per visit | 70% of Allowed Amount after Deductible |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
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| • symptomatic complaints of the feet. | | |
| **Chiropractic Care☎**<br>Chiropractic care when preformed by a Doctor of Chiropractic (chiropractor) or Physician, 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.<br>Any laboratory tests will be covered in accordance with the terms and conditions of this Plan. | **☎ Pre-certification is required**<br>$30 Copayment per visit | **☎ Pre-certification is required**<br>70% of Allowed Amount after Deductible |
| **Acupuncture☎**<br>Acupuncture services rendered by a Health Care Provider licensed to provide such services. If the services are being rendered outside of New York State, the practitioner must meet all the necessary local license requirements of that state. Benefits are payable for needle acupuncture (manual or electroacupuncture) when determined to be Medically Necessary for the management of pain of the following indications ONLY:<br>• Chronic low back or neck pain (Maintenance treatment, where the patient's symptoms are neither regressing or improving, is considered not Medically Necessary); *or*<br>• Migraine headache; *or*<br>• Nausea of pregnancy; *or*<br>• Pain from osteoarthritis of the knee or hip (adjunctive therapy); *or*<br>• Postoperative and chemotherapy-induced nausea and vomiting; *or*<br>• Postoperative dental pain; *or*<br>• Temporomandibular disorders (TMD)<br>The Plan excludes acupuncture that is not Medically Necessary or considered to be Experimental and/or Investigational, for example, for the maintenance of a condition or diagnosis; smoking cessation; or weight loss. All treatment must be reviewed by Medical Management and acupuncture treatment will not be considered Medically Necessary if the covered individual does not demonstrate meaningful improvement in symptoms. Maintenance treatment, where the Covered Person's symptoms are neither regressing nor improving, is not considered Medically Necessary, subject to external appeal. | **☎ Pre-certification is required**<br>The maximum payment is $75 for office visit and treatment combined.<br>$30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **PUVA (Psoralen & Ultraviolet Radiation Light Therapy) ☎**<br>PUVA (Psoralen and Ultraviolet Radiation Light Therapy) for the treatment of psoriasis and certain skin disorders. | ***☎ Pre-certification is required.***<br>Limited to treatment of psoriasis and certain skin disorders<br>$30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Diabetic Education/Self-Management**<br>Coverage includes diabetes self-management education and diet information provided in connection with Medically Necessary visits upon the diagnosis of diabetes, a significant change in the patient's symptoms, the onset of a condition necessitating changes in self-management or where re-education or refresher education is Medically Necessary, as determined by the Plan. When such education is provided as part of the same office visit as diagnosis | • Education must be provided in a group setting when practicable.<br>• The Plan will also pay for Home Visits when Medically Necessary.<br>100% of Allowed Amount | 70% of Allowed Amount after Deductible |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| or treatment of diabetes, payment for the office visit shall include payment for the education. Education will be provide in home when Medically Necessary.<br><br>Education is covered when provided in accordance with the following:<br>• By a Physician or Other Health Care Provider authorized to prescribe under Title 8 of the New York Education law, or their staff during an office visit; and<br>• Upon the Referral of a 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<br>• Education will also be provided in your home when Medically Necessary when you are homebound or otherwise not able to leave your house due to mobility or immunocompromising condition. | | |

| SCHEDULE OF BENEFITS | | |
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| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Diabetic Supplies/Equipment**<br>The following equipment and supplies when recommended or prescribed for the treatment of diabetes by a Physician or other Health Care Provider or other provider authorized under Title 8 of the Education Law to prescribe (Authorized Provider):<br>• Acetone regent strips and tablets;<br>• Alcohol or peroxide by pint and wipes;<br>• Blood glucose kits, strips and monitors and blood glucose monitors and cartridges for legally blind, control solutions and strips for home blood glucose monitor;<br>• Testing strips for glucose monitors and visual reading and urine testing strips;<br>• Data management systems;<br>• Disposable insulin and pen cartridges<br>• Drawing-up devices for visually impaired;<br>• Glucagon for injection to increase blood glucose concentration;<br>• Glucose reagent strips and tape;<br>• Injection aids and injector (Busher) Automatic<br>• Insulin, syringes, injection aids, cartridges for the legally blind;<br>• Insulin pumps and appurtenances, and insulin infusion devices and equipment for use of pump;<br>• Lancets;<br>• Oral agents and anti-diabetic agents for controlling blood sugar;<br>• Syringe with needle;<br>• Urine testing products for glucose and ketones; and<br>• Additionally Medically Necessary equipment and supplies, as may be required by the New York State Department of Health. | $30 Copayment | 70% of Allowed Amount after Deductible |

| SCHEDULE OF BENEFITS | | |
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| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| **Durable Medical Equipment☎**<br>The rental of durable medical equipment required for temporary therapeutic use prescribed by a Physician or Health Care Practitioner which is:<br>• Designed and intended for repeated use;<br>• Primarily and customarily used to serve a medical purpose;<br>• Generally not useful to a person in the absence of disease or injury; and<br>• Appropriate for use in the home.<br><br>Coverage is for standard equipment only. Such equipment must be Medically Necessary for the treatment of illness or injury. The Plan will pay for the rental of such equipment unless it is determined that purchase of the equipment would be less expensive. In the case of purchased equipment, coverage is provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement. The Plan does not cover the cost of repair or replacement that is the result of misuse or abuse or equipment designed for comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of Durable Medical Equipment.<br><br>Expenses for Corrective Appliances and Durable Medical Equipment to the extent they exceed the cost of standard models of such appliances or equipment. | **☎ Pre-certification is required for all rentals and purchases over $500**<br>100% of Allowed Amount | 70% of Allowed Amount after Deductible |
| **Prosthetics☎**<br>Coverage for standard equipment only for:<br>• External prosthetic devices (including wigs and breast prostheses following a mastectomy) 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.<br>• Internal prosthetics including 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 the patient's attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.<br>• 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. | ***☎ Pre-certification is required***<br>100% of Allowed Amount | 70% of Allowed Amount after Deductible |
| **Contact Lenses/Eyeglasses following cataract surgery**<br>One set of prescription eyeglasses or contact lenses and one eye examination following cataract surgery. No other expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies are paid for under this Plan. | 100% of Allowed Amount | 70% of Allowed Amount after Deductible |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
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| **Wigs (due to hair loss following cancer treatments and due to burns)**<br>Wigs are only covered for severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). The Plan does not cover wigs made from human hair unless a Covered Person is allergic to all synthetic wig materials. Maximum benefit - $375 per Lifetime | 100% of Allowed Amount | 70% of Allowed Amount after Deductible |
| **Nondurable Medical/Surgical Supplies**<br>Medical supplies ordered by a Physician or other Health Care Provider, not otherwise covered by this Plan, for use in connection with your illness, condition or injury.<br>To be covered by the Plan, the supply must be:<br>• primarily and customarily used to serve a medical purpose;<br>• generally not useful to a person in the absence of an illness or injury; and<br>• appropriate for use in the home.<br><br>Includes such items as: dressings; casts; splints; lancets; mastectomy bras; ostomy supplies; and oxygen (if not billed with a concentrator or portable tank); but does not include common first aid supplies. | $30 Copayment | 70% of Allowed Amount after Deductible |
| **Support Stockings**<br>Coverage is provided for support stockings when Medically Necessary and prescribed by a Physician. Conditions warranting the use of support stockings include, but are not limited to, the following:<br>• Varicose veins;<br>• Phlebitis; or<br>• Postoperative care following leg surgery | Limited to two (2) pairs of support stockings during any 6-month period | |
| | 100% of Allowed Amount | 70% of Allowed Amount after Deductible |
| **Oxygen☎**<br>Oxygen and the use of the equipment necessary for its administration. The use of oxygen must be ordered by a Physician or other Health Care Provider and be Medically Necessary under the terms of this Plan. | ☎ ***Pre-certification is required*** | |
| | 100% of Allowed Amount if billed with an oxygen concentrator or portable tank<br><br>$30 Copayment if billed as a stand-alone non-durable supply | 70% of Allowed Amount after Deductible |
| **Therapeutic Injections☎** | ☎ ***Pre-certification is required*** | |
| | $30 Copayment | 70% of Allowed Amount after Deductible |
| **Nutritional Supplements for Phenylketonuria and Related Disorders** | $30 Copayment– up to a 90-day supply | 70% of Allowed Amount after Deductible |

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| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| **Enteral Formulas and Modified Solid Food Products**☎<br>Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to:<br>• Inherited amino-acid or organic acid metabolism;<br>• Crohn's Disease<br>• Gastroesophageal reflux; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and<br>• Multiple severe food allergies including but not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.<br>Coverage is also provided for modified solid food products that are low in protein or which contain modified protein or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions. | ☎ ***Pre-certification is required*** | |
| | $30 Copayment – up to a 90-day supply | 70% of Allowed Amount after Deductible |
| **Blood Services**<br>Blood transfusions, which includes the cost of blood, blood plasma, and blood plasma expanders; or other blood derivatives if participation in a volunteer blood replacement program is not available to you. | 100% of Allowed Amount | 70% of Allowed Amount after Deductible |
| | Autologous and directed blood donations and storage are not covered. | |
| **Hearing Aid/Exam**<br>• ***External Hearing Aids*** required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. The Plan covers a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. Hearing Aid benefits are limited to a maximum payment of $600 per covered individual per 48-month period. | $30 Copayment | 100%; Deductible does not apply. |
| • ***Cochlear Implants***☎<br>Bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:<br>– Craniofacial anomalies whose abnormal or absent ear canals preclude the use of wearable hearing aid; or<br>– Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.<br>Repair and/or replacement is only covered for malfunctions. | ☎ ***Pre-certification is required*** | |
| | $30 Copayment | 70% of Allowed Amount after Deductible |

## SCHEDULE OF BENEFITS

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| **Dental Care**<br>Charges for the care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:<br>1. 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<br>2. Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly<br>3. Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.<br>4. 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.<br>5. Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| | Limited to dental and oral surgical procedures needed due to Accidental injury or congenital disorders. | |
| **TMJ Treatment ☎**<br>Temporomandibular Joint Pain Dysfunction Syndrome (TMJ) is, in this Plan, considered to result from disease of or injury to the temporomandibular joint. This joint is a hinge joint that controls the movement of the lower jaw.<br><br>No benefits will be paid for treatment that is dental in nature. For example, grinding the surface of the teeth; orthodontic treatment such as braces or wires; or changes of vertical dimension, including crowns. | **☎ Pre-certification is required** | |
| | $30 Copayment per visit | 70% of Allowed Amount after Deductible |
| **Autism Spectrum Disorder ☎**<br>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 Medical Management to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder.<br>1. Screening and Diagnosis. Assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.<br>2. Assistive Communication Devices. 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 the Covered Person is unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide 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. | **☎ Pre-certification is required**<br>See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits).<br><br>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. | |

| Medical Benefits | In-Network Benefits | Out-of-Network Benefits |
|---|---|---|
| Software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device are covered. Installation of the program and/or technical support is not separately reimbursable. Medical Management will determine whether the device should be purchased or rented.<br><br>Repair, replacement fitting and adjustments of such devices is covered 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. Coverage will be provided for the device most appropriate to the Covered Person's current functional level. The Plan does not cover delivery or service charges or routine maintenance.<br><br>3. Behavioral Health Treatment. Counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual when provided by a licensed Provider. Includes 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.<br><br>4. Psychiatric and Psychological Care. 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.<br><br>5. Therapeutic Care. 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.<br><br>6. Pharmacy Care. 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 are covered under the Prescription Drug Program subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits of this Plan. See the Prescription Drug Program for cost-sharing.<br><br>The Plan does not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Plan for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist. | | |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Medical Benefits** | **In-Network Benefits** | **Out-of-Network Benefits** |
| Nothing in this Document shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities. | | |
| **Radial Keratotomy** | Not covered | Not covered |
| **Vision Therapy** | Not covered | Not covered |

## PRESCRIPTION DRUG BENEFITS PROGRAM

The Prescription Drug Benefits portion of your Plan is a separate coverage from the Medical Benefits. However, in addition to the exclusions indicated in this section that specifically apply to prescription drug benefits, all provisions and limitations of the Plan will apply to this coverage. Covered expenses paid under this portion of the Plan will not be a benefit under any other portion or coverage of the Plan. The Plan's Prescription Drug Program is administered by the pharmacy benefits manager (or "PBM") whose name and contact information can be found in the Contact Information found at the beginning of this Document.

Following are definitions that pertain to this section and will help you to understand the benefits available under the Prescription Drug Program.

- ***Prescription Drug*:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

**Tier Status:** Drug Tier" means a group of prescription drugs that correspond to a specified cost sharing tier in your Plan. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug and are described below. The tier status of a Prescription Drug may change periodically and is subject to periodic review and modification (generally quarterly, but no more than six (6) times per calendar year). These changes may occur without prior notice to you. However, if you have a prescription for a drug that is being moved to a higher tier or is being removed from the Plan's Formulary, you will be notified at least 30 days before the change is effective. You may determine whether a particular Prescription Drug is on the Plan's formulary by contacting the PBM. Information can also be found on the PBM's website or the Plan's website (please see the Contact Information chart at the front of this Plan Document for applicable contact information).

- ***Generic Drug*** is defined by its official chemical name and is an equivalent to a brand name medication. All drugs, including generics, must meet the same U.S. Food and Drug Administration (FDA) standards for quality, strength, purity, effectiveness, stability, and safety. Generic Drugs are the least costly drugs both to the Plan and to you, the Member. Generic drugs are generally classified as Tier I drugs.

- ***Brand-Name Drug***: A Prescription Drug that is manufactured and marketed under a trademark or name by a specific drug manufacturer. Brand name medications can only be produced and sold by the company that holds the patent for the drug. Brand-name drugs are generally classified as Tier II (Formulary Preferred Brand-Name Drugs) or Tier III (Formulary Non-Preferred Brand-Name Drugs).

    - ***Formulary Preferred Brand-Name Drug*:** A formulary is a list of brand-name drugs that are covered by the Plan. The list is determined by a medical committee of pharmacists and physicians appointed by Plan's pharmacy benefit manager. The pharmacy benefits manager chooses which drugs to include on the formulary based on each drug's effectiveness, safety and cost. These drugs are considered *Tier II drugs* and have a higher cost-sharing than generic drugs but a lower cost-sharing than Non-Preferred brand name drugs.

    - ***Formulary Non-Preferred Brand Name Drugs*** are those drugs that are not on the Preferred list. These drugs are considered *Tier III drugs* and are subject to a higher cost-share and will generally result in the highest out-of-pocket costs.

- **Non-Formulary Drugs** are not covered unless authorized for Medical Necessity. If approved, the drug will be subject to the applicable CVS Caremark Tier but will generally be subject to the Tier III cost-sharing.

**How to Obtain Your Prescription Drugs**

There are different types of prescriptions – those to treat acute illness and those for chronic conditions (known as maintenance drugs) and medications used to treat complex conditions know as specialty medications - as well as different ways to obtain prescription medication - from Retail, Mail Order or Specialty pharmacies. How all this works as well as your Cost Sharing is described on the following pages.

**Prescription Drug Copayments and Out-of-Pocket Limit**

Prescriptions are filled or checked by a registered pharmacist regardless of how you choose to purchase them. The prescription drug program includes a formulary feature. A formulary is a list of carefully selected medications that have been selected based on their clinical effectiveness and opportunity for cost savings to the Plan. Under the formulary program, the Plan requires a lower Copayment incentive for formulary medications, and a higher Copayment for non-formulary medications. Refer to the Formulary Member Guide (available from the PBM) for commonly prescribed formulary medications and alternatives to non-formulary medications. You will be required to pay a Copayment when you receive a prescription. The Copayment is a set dollar amount you pay for the prescription while the Plan pays the rest (or most of the rest) of the cost of that prescription. Once you reach the Out-of-Pocket Limit for eligible Prescription Drug costs during the Calendar Year, the Plan will pay 100% of your eligible Prescription Drug cost for the remainder of the Calendar Year (December 31st). The applicable Copayments and Out-of-Pocket Limits are shown in the chart below. Please note that if the cost of the Prescription Drug is lower than the applicable copayment, you will only be responsible for the cost of that drug.

| Tier/Plan Provision | Short-Term Medicines CVS Caremark Retail Pharmacy Network | Long-Term Medicines CVS Caremark Mail Service Pharmacy or CVS Designated Pharmacy Locations |
|---|---|---|
| **Tier I Drugs which generally include Generic Medicines** Always ask your doctor if there is a generic option available. It could save you money. | $7.50 for a generic medicine before the refill limit<br><br>$15 for a generic medicine after the retail limit* | $15.00 for a generic medicine |
| **Tier II: Formulary Preferred Brand-Name Medicines**<br>If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list. | $30 for a preferred brand-name medicine before refill limit*<br><br>$60 for a preferred brand-name medicine after refill limit* | $60 for a preferred brand-name medicine |
| **Tier III: Formulary Non- Preferred Brand-Name Medicines**<br>Drugs that are not on the Plan's preferred list will cost more. | $50 for a non-preferred brand-name medicine before refill limit*<br><br>$100 for a non-preferred brand-name medicine before refill limit* | $100 for a non-preferred brand-name medicine |
| **Refill Limit**<br>*After one initial fill plus one refill at a retail pharmacy, you will be responsible for a Copayment that is double the usual Copayment. | One initial fill plus one refill for long-term medicines. | Not applicable |
| **Supply of Medication**<br>See the "Supply Limits" section on page 85 for important qualifications. | Up to a 30-day supply | Up to a 90-day supply |
| **Specialty Medicines**<br>Must be filled through a CVS Specialty Pharmacy (except for certain limited distribution drugs as indicated by CVS Caremark)<br>Limited to a 30-day supply | Not available | $16.67 for a 30-day supply of specialty medicines |
| **Maximum Out-of-Pocket Limit** | $3,600 per individual / $7,200 per family on prescription medicines | |

## Retail Pharmacy

***Participating Pharmacies.*** The Plan's PBM has established a network of pharmacies through which you may fill prescriptions. If you use one of the PBM's participating pharmacies, your out-of-pocket costs may be lower than if you use a Non-Participating Pharmacy. You can visit www.caremark.com to locate participating pharmacies.

For service, simply present your SWSCHP identification card and a valid prescription at any Participating Pharmacy for service. The pharmacy is usually able to check eligibility online and may not ask for your ID card but you should bring it should you be asked. The Participating Pharmacy will dispense a prescription in a quantity not to exceed a 30-day supply and collect the applicable Copayment (as described on the next page). You will generally be asked to sign a log (paper or electronic) to verify that you picked up the medication. While a pharmacy can usually check eligibility

online through the PBM, if you purchase a prescription at a Participating Pharmacy without your ID card or if your eligibility cannot be verified, you might need to pay for the prescription and submit a claim to the PBM for direct reimbursement. You will not have to fill out any claim forms at a retail Participating Pharmacy, as Participating Pharmacies will submit the claim with required information electronically to the PBM on your behalf.

***Non-Participating Pharmacies***. If you use a Non-Participating Pharmacy, you will have to pay the full retail price for prescription drugs and then submit a claim for reimbursement to the PBM. Claim form are available from your School District Health Benefits Representative or online at www.caremark.com (you must first register with the site) or by calling the PBM at the phone number found in the *Contact Chart*. You will generally not be reimbursed the difference between what you pay for the Prescription and the Plan's cost. In most cases you will pay more.

See the *Contact Information* chart at the front of this document for information on where to submit claims for non-network pharmacies.

***Refill Limits.*** No refills will be dispensed until 80% of the previous supply has been scheduled for use (i.e. 30 day supply cannot be refilled until 24 days have elapsed). No refills on prescriptions written more than one year earlier.

**Mail Order Prescription Drugs**

A Mail Order Pharmacy Program may be used to provide maintenance prescription medications to treat chronic conditions such as arthritis, diabetes, high blood pressure, and ulcers. You should get any refills filled through the mail order program. Use of the mail service allows you to obtain a higher quantity of medication (a 90-day supply) at a lower Copayment. After two prescription fills at a retail pharmacy, a higher copay will apply to additional retail refills. Specifically, if you use a retail pharmacy to for the initial fill and then refill your maintenance prescriptions more than once, you will be responsible for a higher Copayment. The refill Copayment will be twice the standard tier Copayment. Payment of the Copayment amount per prescription is the responsibility of the Covered Person. In addition, the penalty of the extra copayment amount will not count toward the Maximum Out-of-Pocket Limit.

Covered Persons are encouraged to use the Mail Order Pharmacy for maintenance drugs only. Maintenance drugs are those that are taken throughout the year on a regular basis. Prescriptions for maintenance drugs should be written by your Physician for a 90-day supply with three (3) refills. You may contact the PBM for a copy of the claim form.

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

***Specialty Medications.*** Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. All specialty medications must be dispensed through the CVS Caremark Specialty Pharmacy or the PBM's Specialty Mail Service. Some specialty medications also require prior authorization. Please note that the requirement to request prior authorization for specialty medications is in addition to the pre-certification requirement you must receive from Medical Management. If you do not use the CVS Specialty Pharmacy for specialty drugs, the claim will be denied and you will be responsible for 100% of the cost of the prescription except for Limited Distribution Drugs. Limited Distribution Drugs are specialty medications that the CVS Specialty Pharmacy may not have access to and is not authorized to dispense. If CVS Specialty does not have access to a specific Limited Distribution Drug, the drug may be obtained via an alternative Specialty Pharmacy that does have access to the medication. CVS Caremark will coordinate the transfer of

the prescription to a pharmacy that is authorized to dispense the drug. Medications considered Limited Distribution may be subject to the standard non-specialty tier copayment based on CVS Caremark's classification of the medication rather than the standard Specialty copay.

Please note that for most HIV medications, two retail grace fills are permitted at a retail pharmacy under the Plan at the regular Specialty copay. Then you must utilize a CVS Specialty Pharmacy or the PBM's Specialty Mail Service for any further refills. You may NOT use any retail pharmacy to fill a prescription for specialty medications under any circumstances.

To find out if a medication you have been prescribed is a specialty medication and/or if it requires prior approval, contact the PBM (contact information can be found in the *Contact Information* chart at the front of this Plan Document).

The Plan will permit medication synchronization for prescriptions that are dispensed by a network pharmacy for less than a 30-day supply, if the medications:

(i) Are covered by the Plan;

(ii) Are used for treatment and management of chronic conditions and are subject to refills;

(iii) Are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone;

(iv) Meet all applicable prior authorization criteria at the time of the synchronization request;

(v) Are of a formulation that can be effectively split over required short fill periods to achieve synchronization; and

(vi) Do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

For the purpose of medication synchronization, the Plan will:

- Allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon.
- Apply a daily pro-rated cost-sharing rate to partial fills.
- Pay dispensing fees for partially filled or refilled prescriptions in full for each prescription dispensed.

These requirements apply only once for each prescription drug subject to medication synchronization except when either of the following occurs:

(i) The prescriber changes the dosage or frequency of administration of the prescription drug; or

(ii) The prescriber prescribes a different drug.

**Supply Limits**

Except for contraceptive drugs or devices, the Plan will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or a 90-day supply for maintenance Prescription Drugs from a Designated Pharmacy or Mail Order Pharmacy. You are responsible for one (1) Cost-Sharing amount for a 30-day supply and two (2) Cost-Sharing amounts for up to a 90-day supply. For Maintenance Drugs, the Plan will pay for up to a 90-day supply of a drug purchased at an in-network retail pharmacy.

You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs and devices are not subject to Cost-Sharing 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 Pharmacy

**Utilization Review Programs**

The Plan includes Utilization Review Programs to determine when Prescription Drug should be covered. As part of these programs, you may have to obtain prior authorization for certain drugs and/or your prescribing provider may be asked for more details before a decision can be made as to whether the Prescription Drug is Medically Necessary. See the end of this section for addition Medical Management features of this Plan. For a list of Prescription Drugs that need Preauthorization or to check if a Prescription Drug is covered, please contact the PBM (contact information can be found at in the Contact Information chart at the front of this Plan Document). The list will be reviewed and updated from time to time and the Plan may require Preauthorization for any new Prescription Drug which comes to the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not covered under the Plan. Some of the these Utilization Review programs are reflected on the Formulary document.

The Plan has the discursion to require prior authorization for any reason.

***Prior Authorization Required for Certain Prescription Drugs***

A number of drugs require Prior Authorization by the PBM’s clinical staff. This means that more medical information is needed to determine if the drug is covered by the Plan or, in some cases, what quantity can be filled. While the Covered Person is responsible for obtaining the Pre-certification, the Provider may obtain it on behalf of him or her.

Should you choose to purchase the Prescription Drug without obtaining Preauthorization, you must pay for the cost of the entire Prescription Drug and submit a claim for potential reimbursement.

Certain Non-Formulary drugs will be covered under the Plan only if you receive prior authorization. Please contact the PBM or check the PBM’s website for the most up-to-date information on what medications require prior authorization.

***Step-Therapy Program***

Step therapy is a process in which you may need to use one (1) or more type of Prescription Drugs before the Plan will cover another as Medically Necessary. This solution requires a member to try a first-line therapy prior to receiving a second-line therapy. If the prerequisite drug therapy has been tried and is not effective, or the patient is intolerant (e.g. allergic), or has another medical reason they cannot take the first-line therapy, then the second-line therapy may be dispensed and covered under the drug benefit.

A "step therapy protocol" means the Plan’s policy, protocol or program that establishes the sequence in which Prescription Drugs for your medical condition are approved. When establishing a step therapy protocol, the Plan will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. Certain Prescription Drugs are checked to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to your request for coverage of a Prescription Drug, you, your

designee, or your Health Care Provider can request a step therapy override determination as outlined in the Utilization Review section of this Plan Document.

***Review for Quantity or Dose Duration***

Some Prescription Drugs may be subject to quantity limits based on criteria that the Plan has developed in consultation with the PBM, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by visiting the PBM's website or calling them (contact information can be found at in the *Contact Information* chart at the front of this Plan Document). If a request to cover an amount that exceeds the Plan's quantity level is denied, you are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Plan Document.

If a drug requires prior authorization or is subject to step-therapy or review for quantity or dose duration, you will be informed by the pharmacist at the time you present your prescription to be filled. The PBM will work with the pharmacists and your Physician to verify whether the drug is covered under the Plan and in what quantity. The process and timing on the decision of your Pre- Service claims as well as procedures for filing an appeal are outlined in the "Claims and Appeals" section of this Plan Document.

The list of drugs that require prior authorization changes from time to time as new drugs are approved and due to other considerations. While you will receive information on any changes as they are implemented, you should contact the PBM for the most up-to-date information on drugs needing prior authorization and for information on which drugs have a limit to the quantity payable by this Plan.

**Covered Prescription Drugs**

Coverage is provided only for the following:

- Legend Drugs (including legend prenatal vitamins for females and legend pediatric vitamins through age 14). A Legend Drug is one which, under applicable State law, requires a prescription to be dispensed.
- Insulin.
- Any other drug which, under applicable State law, may only be dispensed upon written prescription.
- Inhalers (with spacers).
- Compounded Prescription Drugs will be covered only when they contain at least one (1) ingredient that is a Covered Legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $300 require Preauthorization. Compound drugs will be subject to the cost-sharing for most expensive ingredient in the compound. No coverage is provided for costly bases, bulk compounding ingredients, hormone replacement bulk ingredients or compounding kits.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Document.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.

- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.

- FDA-approved contraceptive methods for women (see *Preventive Benefits* below).

**Preventive Benefits Payable under the Prescription Drug Benefit**

The following benefits are payable under the Prescription Drug benefit with no Copayments if a prescription is presented to the pharmacist at the time the medication is purchased. Over-the-counter supplements, aspirin or other preventive drugs are only covered with a prescription. Where the FDA has approved one or more therapeutic and pharmaceutical equivalent versions of a preventive drug, device, or product, please note only the generic version (or if there is no generic, only one version of the drug in the Plan's formulary) of the therapeutic and pharmaceutical equivalent version of a drug, device or product will be paid without cost-sharing. You may request coverage for an alternative version of a drug, device and other product if the covered drug, device and other product is not available or is deemed medically inadvisable, as determined by your attending Health Care Provider.

- **Aspirin** to prevent cardiovascular disease when prescribed by a health care Provider.
- **Low-dose aspirin** after 12 weeks of gestation for women who are at high risk for preeclampsia.
- **Oral Fluoride** supplements at currently recommended doses (based on local water supplies) to preschool children through age 5 whose primary water source is deficient in fluoride.
- **Folic Acid** (over the counter/generic only) supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid.
- **FDA-approved contraceptive methods for women**, including contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter.

  Where the FDA has approved one or more therapeutic and pharmaceutical equivalent versions of a contraceptive drug, device, or product, please note only the generic version (or if there is no generic, only one version of the drug in the Plan's formulary) of the therapeutic and pharmaceutical equivalent version of a contraceptive drug, device or product will be paid without cost-sharing. You may request coverage for an alternative version of a contraceptive drug, device and other product if the covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by your attending Health Care Provider.

- **FDA-approved tobacco cessation medications** (including both prescription and over-the-counter medications including cessation treatment for e-cigarettes use) for a 90-day treatment regimen when prescribed by a health care Provider without prior authorization including generic nicotine replacement products (nicotine patch, gum and lozenges), brand Nicotrol (inhaler system), brand Nicotrol NS (nasal spray), brand Chantix and generic Zyban. Generics and single source brands are only covered until generics become available. Over-the-counter medications are covered only with a prescription.

- **Bowel Preps** in connection with a screening colonoscopy.

- **Vitamin D supplementation** to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.

- **Risk-reducing medications (such as tamoxifen or raloxifene)** for women at increased risk for breast cancer and at a low risk for adverse medication effects.

- **Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors** (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.

- **Pre-exposure Prophylaxis ("PrEP")** for the prevention of HIV infection.

- Routine adult immunizations and immunization vaccines for children from birth to age 18, including administration of such immunizations, are covered for participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

**Limitations and Terms of Coverage**

- The PBM 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.

- If it is determined that you may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, your selection of Participating Pharmacies may be limited. If this happens, you may be required to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the selected single Participating Pharmacy. If you do not make a selection within 31 days of the date you are notified, a single Participating Pharmacy will be selected for you.

- Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Covered Persons with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and you are taking the drug(s) affected by the protocol, you will be notified in advance.

- Benefit for diabetic supplies and equipment with the exception of Insulin Pumps, Insulin Pump Supplies, and Blood Glucose Monitors (which are only covered under the Medical benefits) will be provided under this section of the Plan if the Cost-Sharing is more favorable to you than those applicable to Medical benefits.

- The PBM 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 as described in the Utilization Review and External Appeal sections of this Plan Document.

- A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

**Exclusions Applicable to Prescription Drug Expense Benefits**

In addition to the "General Limitations" of the Plan, no benefits shall be payable under the Prescription Drug Benefits portion of the Plan for the following:

- Non-Federal Legend drugs and over-the-counter medicine, other than Insulin, meaning those drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an “A” or “B” rating from USPSTF, or as otherwise provided in this Plan Document. The Plan does not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. The Plan does not cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.
- Drugs for cosmetic purposes, which include but are not limited to:
  - Non-amphetamine anorexiants, except for as Medically Necessary to treat morbid obesity.
  - Amphetamines that are prescribed for weight loss, except for as Medically Necessary to treat morbid obesity.
- Therapeutic devices or appliances including hypodermic needles, syringes, support garments, ostomy supplies, durable medical equipment, and other non-medicinal substances, regardless of use.
- Biological sera, blood or blood plasma.
- Charges for the administration of any medication except for administration of immunizations.
- Drugs for an injury or sickness related to employment for which benefits are provided by any State or Federal workers' compensation, employer's liability or occupational disease law or under Medicare or other governmental program, except Medicaid.
- Drugs labeled "Caution-Limited by Federal Law to Investigational Use" or Experimental drugs, unless directed pursuant to an External Appeal.
- Drugs dispensed while in a Hospital, other institution, Facility, Rest Home, Sanitarium, Skilled Nursing Facility, Convalescent Nursing Home while patient is confined or as a Home Health Care patient in conjunction with covered Home Health Care.
- Any medication where the exact equivalent is available in a non-prescription version.
- For the administration or injection of any Prescription Drug. Prescription Drugs that are to be administered in a Physician’s office must be filled under Prescription Drug Program in accordance with the procedures described in this section. Specialty Drugs will only be covered if filled at the CVS Specialty Pharmacy and may require Prior Authorization (see the *Specialty Drug* subsection for details).
- Prescription Drugs to replace those that may have been lost or stolen.
- Blood products, blood serum
- Experimental medicines do not have NDC numbers

- Topical Analgesics*, Convenience Multi-product Kits**, Scar Products, Otic Analgesics and Combinations

  - *Topical Analgesics (may include but not limited to: patches, lotions, creams, ointments, gels, sprays, solutions) containing ingredients (alone or in combination) in strengths typically used in OTC analgesics for temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness.

  - **Convenience kits containing two (2) or more products to be used separately- may consist of an OTC (e.g., herbal/supplement/topical product).

- Bulk Ingredients (i.e., bulk chemicals, bulk powders, bulk compounding ingredients, hormone replacement bulk ingredients). Other Ingredients (high cost bases, compound kits, etc.) except for IVs, Antibiotics and Anti-Infectives bulk ingredients

- Abortifacient (i.e Mifeprex)

- Injectable allergy immunotherapy

- Medical Foods including those that require a prescription. i.g., Metanx, Limbrel, Deplin. These products are covered under the Medical portion of the Plan

- Respiratory Therapy Supplies including Peak Flow Meters and Nebulizers

- Syringes other than those for use with insulin

- Cosmetic Drugs - including hair loss drugs, anti-wrinkle creams, hair removal creams and others (requiring a prescription) and includes but are not limited to Botox Cosmetic and Dysport

- Proton Pump Inhibitor and NSA (non-sedating antihistamine)

- Periodontal Anti-infective - Arestin

- Administration of immunization vaccines provided as part of the Preventive benefits required under the ACA

- Gene Therapy is not covered under the Prescription Drug benefit. See the Medical benefits section for details.

- 510K Products

- Drugs that have limited clinical value and which have clinically-appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs)

**Dispense As Written**

If you purchase a brand-name medication when a generic medication is available, through a dispense as written prescription, you will pay the Brand Copayment, **plus** the difference in cost between the brand-name medication and the generic medication.

**Therapeutic Substitution**

Therapeutic substitution is an optional program that tells you and your Providers about alternatives to certain prescribed drugs. You and your Provider may be contacted to make you aware of these

choices. Only you and your Provider can determine if the therapeutic substitute is right for you. The therapeutic drug substitutes list is maintained and reviewed and update from time to time. For questions or issues about therapeutic drug substitutes, please visit the PBM's website or call them (contact information can be found at in the "Contact Information" chart at the front of this Plan Document).

**Drug Utilization, Cost Management and Rebates**

The Plan, in conjunction with its PBM, conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, you benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for your coverage. The Plan may also, from time to time, enter into agreements that result in it receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across the whole Plan and not solely on any one Member's utilization of Prescription Drugs. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under the Plan.

**When a Brand-Name Drug Becomes Available as a Generic Drug**

When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, you will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if you are taking a Brand-Name Drug that is being excluded due to a Generic Drug becoming available, you will receive advance written notice of the Brand-Name Drug exclusion. You may request a Formulary exception as outlined below and in the External Appeal section of this Plan Document.

**Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment**

If you have an Emergency Condition, you may immediately access, without Preauthorization, a five (5) day emergency supply of a Covered Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal at the same Copayment that would apply to a 30-day supply of the Prescription Drug. If you receive an additional supply of the Prescription Drug within the 30-day period in which you received the emergency supply, you will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug. See the "Defined Terms" section of this Plan Document for a definition of "Emergency Condition".

**Initial Limited Supply of Prescription Opioid Drugs**

If you receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for acute pain, your Copayment will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If you receive an additional supply of the Prescription Drug within the same 30-day period in which you received the seven (7) day supply, you will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

**Cost-Sharing for Orally-Administered Anti-Cancer Drugs**

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

**New Trial Prescriptions**

When taking a new maintenance medication, SWSCHP recommends that you purchase those drugs first at the retail pharmacy to be sure that these new drugs work for you. Once you and your Physician are sure that the drug is safe and effective, we suggest that you then use the mail order pharmacy for refills. This will provide you with a 90-day supply for the same cost as a 30-day supply at the retail pharmacy.

**Appeals Rights**

The PBM handles the internal appeals. The PBM also handles Health Care Reform Brand Exception Appeals. The Plan allows for Formulary Exceptions/Non-clinical requests (includes formulary exceptions, DAW, plan exclusions, and formulary edits for specific classes). If a Prescription Drug is not on the Plan's Formulary, you, your designee or your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under the standard or expedited Formulary exception process, you are entitled to an external appeal as outlined in the External Appeal section of this Document.

***Standard Review of a Formulary Exception***. The PBM will make a decision and notify you or your designee and the prescribing Health Care Professional by telephone no later than 72 hours after receipt of the request. The PBM will notify you in writing within three (3) business days of receipt of a standard request. If the PBM approves the request, the Prescription Drug will be covered while you are taking the Prescription Drug, including any refills.

***Expedited Review of a Formulary Exception.*** If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment using a non-Formulary Prescription Drug, you may request an expedited review of a Formulary exception. The PBM will make a decision and notify you or your designee and the prescribing Health Care Professional by telephone no later than 24 hours after receipt of the request. The PBM will notify you in writing within three (3) business days of receipt of the request. If request is approved, the Prescription Drug will be covered while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the non-Formulary Prescription Drug.

See the "Claims and Appeals" section for information about filing a claim and/or appeal, including an expedited or external appeal.

## PLAN EXCLUSIONS

### *General Exclusions (applicable to all medical services and supplies)*

Charges for the following services and/ or supplies are **NOT** Eligible Medical Expenses and are **NOT covered** under the Plan:

1. Services or supplies provided before the patient was covered under this Plan or after the date the patient's coverage ends, subject to any applicable extension of benefits provision.

2. Services or supplies determined by the Plan not to be Medically Necessary as defined in the Defined Terms section of this Plan Document, unless directed by external appeal. The fact that a Physician or other Health Care Provider may recommend that a Covered Person receive a surgical or medical service, or be confined to a Hospital, does not mean that:

   - such service or confinement will be deemed to be Medically Necessary; or

   - benefits under this Plan will be paid for the expense of such service or confinement.

   If an External Appeal Agent certified by the State overturns a denial, however, the Plan will cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise covered under the terms of this Plan.

3. Services, supplies, drugs or medicines that are determined by the Plan to be Experimental and/or Investigational. The Plan will cover experimental or investigational treatments, including treatment for a rare disease or patient costs for participation in a clinical trial as described in the Definition section of this Plan Document, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, the Plan will not Cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under this Plan for non-investigational treatments. See the Utilization Review and External Appeal sections of this Plan Document for a further explanation of Your Appeal rights.

4. Services or supplies received because of an occupational illness, injury or conditions subject to workers' compensation, employers' liability or occupational disease law, unless otherwise provided in State or Federal statute.

5. Services or supplies to the extent they are recovered or recoverable under a mandatory motor vehicle liability law which requires that benefits be provided for personal injury without regard to fault. This exclusion applies even if a no proper or timely claim for the benefits is made that are available under a mandatory no-fault policy. Refer to the Subrogation section of this Plan Document.

6. This Plan will reduce its payments by the amount you are eligible to receive for the same services under Medicare Part A and/or Part B, even if you fail to enroll in Medicare, if Medicare is primary.

7. If a Covered Person under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

8. Illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, and service in the Armed Forces or units auxiliary thereto. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of a medical condition (including both physical and mental health conditions).

9. Except as otherwise required by law, care or treatment in any Hospital or other institution that is owned or operated by any Federal, State or other governmental entity.

10. Services or supplies received by a Covered Person for which no charge would have been made in the absence of coverage under the SWSCHP Plan.

11. Professional services performed by a person who is immediate family member of the Covered Person, a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.

12. A Hospital stay or a portion of a Hospital stay where you receive non-acute care.

13. Expenses for Custodial Care as defined in the Defined Terms section of this Plan Document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, convalescent care, custodial care, sanitarium-type care, rest cures, and services or supplies rendered in a place of rest, a place for the aged, nursing home or in an educational facility. Services required to be performed by Physicians or other skilled Health Care Providers are not considered to be provided for Custodial Care services, and are covered if they are determined by the Plan to be Medically Necessary.

14. Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Person, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, or emergency alert system.

15. Expenses for services/supplies that are not recommended or prescribed by a Physician or Health Care Provider as set forth in the Defined Terms section of this Plan Document.

16. The use of a private room in a Hospital or other Health Care Facility, unless the use of a private room is determined to be certified as Medically Necessary by the Plan.

17. Expenses for the storage of blood or blood products.

18. Expenses for hypnosis/hypnotherapy (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness), except for hypnosis as a method to achieve tobacco cessation.

19. Expenses for parental custody services, adoption services, or court-ordered services, unless considered Medically Necessary and otherwise covered under the Plan or provided pursuant to a court order as described on page 109 under “Court Ordered Treatment”.

**Exclusions Applicable to Specific Medical Services and Supplies**

Charges for the following services and/ or supplies are **NOT** Eligible Medical Expenses and are **NOT covered** under the Plan:

Conversion Therapy

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

Corrective Appliances and Medical Equipment

21. Expenses for any items that are not Medical/Surgical Supplies, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Defined Terms section of this Plan Document, including without limitations: air conditioners; air purification units; humidifiers; allergy-free pillows; blanket or mattress covers; electric heating units; swimming pools; orthopedic mattresses; exercising equipment; vibratory equipment; elevators or stair lifts; stethoscopes; clinical thermometers; scales; first-aid supplies and non- Hospital adjustable beds; and drugs, medicines, or insulin not approved under the United States Food and Drug Act or its successors. Devices for simulating natural female body contours are also excluded, except for breast prosthetics required by the Women's Health and Cancer Rights Act of 1998.

Cosmetic Services Exclusions

22. Surgery or medical treatment to improve or preserve physical appearance, but not physical function, unless otherwise specified, except that cosmetic surgery will not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or 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. . Cosmetic Surgery or Treatment may include, but is not limited to, removal of tattoos, breast augmentation/breast reduction, elimination of redundant skin of the abdomen, surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance, treatment of varicose veins, cosmetic skin products such as Restylane, Renova, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan. Covered Persons should use the Plan's Medical Management Program procedures to determine if a proposed surgery or service will be considered Cosmetic Surgery, or Medically Necessary reconstructive surgery.

    The Plan does cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Plan Document. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the

Utilization Review and External Appeal sections of this Plan unless medical information is submitted.

23. Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement, including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis, except that the Plan will provide benefits for Wigs due to hair loss following cancer treatments or due to burns.

Dental Services Exclusions

24. Dental care or treatment, including dental implants, is not covered except for:

    a. Dental care or treatment due to accidental injury to sound and natural teeth;

    b. Dental care or treatment necessary due to congenital disease or anomaly; or

    c. Oral surgery necessary for the correction of damage caused by an illness for which you are eligible for benefits under this Plan.

Drugs, Medicines, and Nutrition Exclusions

25. Nutritional supplements are not covered, except for Enteral Formulas, as outlined in the Schedule of Benefits in this Plan Document.

Fertility and Infertility Services Exclusions

26. Costs for an ovum donor or donor sperm;

27. Sperm and ova storage costs except when performed as fertility preservation services;

28. Cryopreservation and storage of embryos;

29. Ovulation predictor kits

30. Charges for relating to surrogate gestation and/or surrogate mother, including maternity care and delivery, unless the surrogate is a Covered Person under this Plan.

31. Expenses resulting from, or in connection with, the reversal of elective sterilizations.

32. Expenses for Cloning.

33. Medical or surgical services or procedures that are deemed Experimental Investigational by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine unless denial is overturned by an External Appeal Agent.

34. Expenses for and related to adoption.

Foot Care Exclusions

35. Expenses for foot care including orthopedic shoes and other supportive devices and services in connection with corns and callouses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, the Plan covers foot care when you have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in your legs or feet.

Genetic Testing and Counseling Exclusions

36. Genetic testing and counseling unless determined to be Medically Necessary under the Medical Management Program.

Hearing Care Exclusions

37. Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices except as specifically covered under the Hearing Aid Benefit.

Limitations and Exclusions that Apply to Inpatient Care in a Facility

38. When an inpatient at a Facility, the Plan does 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.

39. The Plan does not cover radio, telephone or television expenses, or beauty or barber services.

40. The Plan does not cover any charges incurred after the day you are advised that it is no longer Medically Necessary for you to receive inpatient care, unless the denial is overturned by an External Appeal Agent.

Virtual Colonoscopy Exclusion

41. Expenses for Virtual Colonoscopy, except this procedure is payable if Medically Necessary for evaluation of the colon in a Covered Person with a known colon obstruction, colon lesion or technical difficulty that prevents use of a traditional endoscopic colonoscopy.

Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

42. This Plan covers speech and physical therapy only when:
    a. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
    b. The therapy is ordered by a Physician; and
    c. You have been hospitalized or have undergone surgery for such illness or injury.

Transplant (Organ and Tissue) Exclusions

43. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants considered to be Experimental/Investigational.

44. Expenses for insertion and maintenance of an artificial heart or other artificial organ or related device including complications thereof, except when Medical Necessary and not Experimental or Investigational.

Vision Care Exclusions

45. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except one pair of eyeglasses or contact lenses is payable as a prosthetic device following ocular surgery to remove the lens of the eye such as with a cataract extraction.

## NON-COVERED SERVICES

1. Services or supplies for the administration of anesthesia, if the charges for surgery are not covered under this Plan.

2. Expenses for preparing forms, medical reports/records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; charges for broken/missed appointments, telephone calls and consultations; e-mailing charges; prescription refill charges; disabled person's license plates/automotive forms; interest charges; late fees; mileage costs; provider administrative fees; concierge/retainer agreement/membership fees; and/or photocopying fees.

3. Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Provider was available to do so on a stand-by basis.

4. Charges for any services not considered legal in the United States.

5. Educational or vocational services.

6. Non-health related expenses for patient convenience, including, without limitation: care of family members while the Covered Person is confined to a Hospital or other facility or to bed at home; guest meals, television, DVD/Compact disc (CD) and other similar devices; telephone, barber or beautician services; house cleaning or maintenance; shopping; birth announcements; photographs of new babies; or private room (only as Medically Necessary);

7. Expenses for residential care services which are considered custodial, residential schools, wilderness program, half-way house, boarding school and group home.

8. Expenses for and related to travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Person or family member of a Covered Person, unless Medically Necessary and otherwise covered under the terms of the Plan.

9. Expenses for physical examinations, functional capacity/job analysis examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, vocation, workers' compensation, retirement/disability status or pension, or by any third party, unless Medically Necessary and otherwise covered under the terms of the Plan.

10. Expenses for equine (horse) assisted therapy.

11. Treatment for educational services even if they are required because of an injury, illness or disability of a Covered Individual. The Plan does not cover educational services, supplies or equipment, that are not specifically listed as a covered benefit or for the treatment of autism including, but not limited to: computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids, communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills (except that programs based on learning theories and motivation such as applied behavior analysis therapy is payable), programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members, and implantable medical identification/tracking devices.

12. Expenses for prayer/faith, religious healing, or spiritual healing.

13. Expenses for naturopathic, naprapathic and/or homeopathic services or treatments/supplies.

14. Expenses for replacement of lost, missing, or stolen, duplicate or personalized Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.

15. Expenses for health care services, occupational therapy and adaptive supplies and devices (such as feeding utensils, reaching tools, devices to assist in dressing and undressing, shower bench, raised toilet seat) used to assist a Covered Person to keep, learn, assist with or improve skills and functioning for daily living except for any services provided for under the Autism benefit as described in the Schedule of Benefits.

16. Non-prescription contraceptive drugs and devices for men, such as condoms.

17. Expenses for childbirth education, Lamaze classes, breast-feeding classes unless otherwise required by the Affordable Care Act (ACA) under the Preventive benefits described in this Plan Document.

18. Expenses associated with a pre-planned home birth for any non-medical and non-midwifery support, including expense of a doula (an assistant who provides various forms of non-medical and non-midwifery support (physical and emotional) in the childbirth process.

19. Expenses related to cryostorage of umbilical cord blood or other tissue or organs.

20. Light therapy/box for seasonal affective disorder.

21. Marriage Counseling, unless medically necessary and otherwise covered by the plan.

22. Expenses for educational, job training, vocational rehabilitation, respite care, or recreational therapy.

23. Expenses for massage therapy, rolfing (deep muscle manipulation and massage), craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas), and related services.

24. Expenses for prolotherapy (injection of sclerosing solutions into joints, muscles, or ligaments).

25. Donor charges incurred for an organ/tissue transplant.

26. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), Laser In-Situ Keratomileusis (LASIK) or implantable contact lenses (ICL).

27. Vision therapy (orthoptics) and supplies, including orthokeratology lenses.

28. Exercise programs for treatment of any condition.

29. Exercise facilities; exercise equipment; weight reduction facilities; weight management programs;; supplements to replace vitamins and nutrients lost while dieting; suction lipectomy; paniculectomy; surgery to remove excess fat cells; and other weight reduction treatment not Medically Necessary or otherwise required by the ACA under the Preventive benefits described in this Plan Document covered. Diet pills for appetite suppression may be covered under the Prescription Drug Program with prior authorization if Medically Necessary.

30. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, work hardening and/or

weight training services, whether or not directly or indirectly related to a Physician's recommendation of activity or participating in a recreational or leisure therapy/activity.

31. Expenses for pre-parental genetic testing (also called carrier testing) intended to determine if a Covered Person is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected children.

## CLAIMS AND APPEALS PROCEDURES

### AUTHORIZED REPRESENTATIVE

This Plan recognizes an Authorized Representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An Authorized Representative under this Plan also includes a Health Care Provider. Under the Plan you do not need to designate in writing that the Health Care Provider is your Authorized Representative if that Health Care Provider is part of the claim or appeal. The Plan requires a written statement from an individual that he/she has designated an Authorized Representative (except for a Health Care Provider who does not require a written statement in order to file or appeal a claim for a Covered Person) along with the representative's name, address and phone number. To designate an Authorized Representative other than a Health Care Provider, you must submit a completed Authorized Representative form to SWSCHP HIPAA Program Compliance Department, 333 Westchester Avenue, 2 West, White Plains, NY 10604

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed Authorized Representative has the power of attorney for health care purposes (e.g. notarized power of attorney for health care purposes, court order of guardianship/conservatorship, or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an Authorized Representative form, all future claims and appeals- related correspondence will be routed to the Authorized Representative, rather than the individual. The Plan will honor the designated Authorized Representative for two years before requiring a new authorization (or until the designation is revoked, if earlier), or as mandated by a court order. A Covered Person may revoke a designated Authorized Representative status by submitting a completed change of Authorized Representative form available from and to be returned to the SWSCHP HIPAA Program Compliance Department, 333 Westchester Avenue, White Plains, NY 10604

In the case of an Urgent Care Claim, if a Health Care Provider with knowledge of your medical condition determines that a claim involves Urgent Care (within the meaning of the definition of Urgent Care), such Health Care Provider will be considered by this Plan to be your Authorized Representative, bypassing the need for completion of the Plan's written Authorized Representative form.

The Plan reserves the right to withhold information from a person who claims to be your Authorized Representative if there is suspicion about the qualifications of that individual.

## CLAIM DETERMINATIONS

### Claims

The Plan has contract with Claims Administrators to process claims on behalf of the Plan. Each of the applicable Claims Administrator is listed below.

Contact information can be found in *Contact Information* chart in the front of this Plan Document.

A claim is a request that benefits or services be provided or paid according to the terms of this Plan. When you receive services from an In-Network/Participating Provider, you will not need to submit a claim form. However, if you receive services from an Out-of-Network/Non-Participating Provider either you or the Provider must file a claim form with the applicable Claims Administrator. If the Out-of-Network/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.

### Notice of Claim

Claims for services must include all information designated by the applicable Claims Administrator as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available by contacting the applicable Claims Administrator (please refer to the *Contact Information* chart at the front of this Plan Document for the contact information for the applicable Claims Administrator). Completed claim forms should be sent to applicable Claims Administrator and can be mailed, or submitted electronically.

### Timeframe for Filing Claims

Claims for services must be submitted to the Plan for payment within 12 months after you receive the services for which payment is being requested. 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.

### Claims for Prohibited Referrals

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

### Claim Determinations in General

The Plan's claim determination procedure described in the next section applies to all claims that do not relate to a Medical Necessity or Experimental or Investigational determination. For example, claim determination procedures apply to contractual benefit denials.

For a description of the Utilization Review procedures process for Medical Necessity or Experimental or Investigational determinations, see the Utilization Review sections of this Plan Document.

If you disagree with a claim determination or a Utilization Review, you may submit an Appeal as described in the Appeal Procedures as described in that section.

## CLAIMS DETERMINATIONS FOR CLAIMS THAT DO NOT RELATE TO MEDICAL NECESSITY OR EXPERIMENTAL OR INVESTIGATIONAL DETERMINATIONS

### Pre-Service Claim Determinations

A pre-service claim is a request that a service or treatment be approved before it has been received. If all the information necessary in available to make a determination regarding a pre-service claim the applicable Claims Administrator/Utilization Review Agent will make a determination and provide notice to you (or your designee) within 15 days from receipt of the claim.

If the applicable Claims Administrator/Utilization Review Agent needs additional information, they will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If the information is received within 45 days, a determination will be made and you (or your designee) will be provided with notice in writing, within 15 days of receipt of the information. If all necessary information is not received within 45 days, a determination will be made within 15 calendar days of the end of the 45-day period.

**Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if all information necessary is available to make a determination, a determination will be made and you (or your designee) will be provided with notice by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If additional information is needed, it will be requested within 24 hours. You will then have 48 hours to submit the information. The applicable Claims Administrator/Utilization Review Agent 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.

### Post-Service Claim Determinations

A post-service claim is a request for a service or treatment that you have already received. If the applicable Claims Administrator/Utilization Review Agent has all information necessary to make a determination regarding a post-service claim, they will make a determination and notify you (or your designee) within 30 calendar days of the receipt of the claim if the claims is denied in whole or in part. If the applicable Claims Administrator/Utilization Review Agent needs additional information, it will be requested within 30 calendar days. You will then have 45 calendar days to provide the information. A determination will be made and you (or your designee) will be provided in writing within 15 calendar days of the earlier of receipt of the information or the end of the 45-day period if the claim is denied in whole or in part.

### Payment of Claims

Where the Plan's obligation to pay a claim is reasonably clear, the applicable Claims Administrator will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If additional information is requested, pay the claim will be paid within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

## GRIEVANCE PROCEDURES

The Plan's Grievance procedures applies to any issue not related to a Medical Necessity or experimental or investigational determination by the Plan or its designees (Claims Administrators) or is not related these. For example, it applies to contractual benefit denials or issues or concerns you have regarding administrative policies or access to Providers.

### Filing a Grievance

You can contact the appropriate Claims Administrator by phone or in writing to file a Grievance. Please see the Contract Chart at the beginning of this Plan Document for contact information. You or your designee has up to 180 calendar days from when you received the decision you are asking be reviewed to file the Grievance.

When your Grievance is received, an acknowledgment letter will be mailed within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your Grievance, and indicate what additional information, if any, must be provided.

All requests and discussions will be kept strictly confidential and no discriminatory action will be taken because of your issue. The Plan maintains a process for both standard and expedited Grievances, depending on the nature of the inquiry.

Qualified personnel will review your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional/Utilization Review Agent review it. A decision will be made about the Appeal and you will be notified within the following timeframes:

| Type of Appeal | Timeframe for Notification |
|---|---|
| **Urgent Care/Expedited 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 Grievance** (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 Grievance (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] [45 calendar days of receipt of all necessary information] [45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of your Grievance]. |

### Grievance Appeals

If you are not satisfied with the resolution of your Grievance, you or your designee may file an Appeal by phone or in writing (see the Contact Chart at the beginning of this Plan Document). 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.

Upon receipt of your Appeal, an acknowledgment letter will be mailed 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 Appeal will be reviewed and you will be notified in writing within the following timeframes:

| Type of Appeal | Timeframe for Notification |
|---|---|
| **Expedited/Urgent Grievance** (A request for a services or treatment that has not yet been provided that for an Urgent Care claim) | The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal. |
| **Pre-Service Grievance** (A request for a service or treatment that has not yet been provided) | 15 calendar days of receipt of Your Appeal. |
| **Post Service Grievance** (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 business days of receipt of all necessary information to make a determination] [30 calendar days of receipt of Your Appeal]. |

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

Call the New York State Department of Health at 1-800-206-8125 or write them at:

New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

If you need assistance filing a Grievance or Appeal, you may also contact the state independent Consumer Assistance Program at:

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

## UTILIZATION REVIEW (CLAIMS DETERMINATIONS FOR CLAIMS THAT INVOLVE MEDICAL NECESSITY OR EXPERIMENTAL OR INVESTIGATIONAL DETERMINATIONS)

### Utilization Review

The Plan 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). The Plan maintains Utilization Review Programs under both Medical and Prescription Drug programs and are described under each section of this Plan Document. If you have questions about the Utilization Review Programs or need to contact the applicable Claims Administrator/Utilization Review Agent, please refer to the *Contact Information* chart.

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's Utilization Review Programs do not compensate or provide financial incentives to their employees or reviewers for determining that services are not Medically Necessary. The Plan's Claims Administrators/Utilization Review Agent have developed guidelines and protocols to assist in this process. For substance use disorder treatment, the Plan will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for your review upon request.

### Pre-Certification (Preauthorization) Reviews

**Non-Urgent Pre-Certification/Preauthorization Reviews.** If the applicable Utilization Review Agent has all the information necessary to make a determination regarding a Preauthorization review, they will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

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

**Urgent Pre-Certification/Preauthorization Reviews.** With respect to urgent Preauthorization requests, if the applicable Utilization Review Agent has all information necessary to make a determination, they will make a determination and provide notice to you (or your designee) and your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If additional information is needed, it will be requested within 24 hours. You or your Provider will then have 48 hours to submit the information. The applicable Utilization Review Agent will make a determination and provide notice to you (or your designee) and your Provider by telephone within 48 hours of the earlier of receipt of the information

or the end of the 48-hour period. Written notification will be provided within the earlier of three (3) business days of receipt of the information or three (3) calendar days after the verbal notification.

**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, a determination will be made and you (or your designee) and your Provider will be provided with notice 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.

**Concurrent Reviews.**

**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 additional information is needed, it will be requested within one (1) business day. You or your Provider will then have 45 calendar days to submit the information. The Utilization Review Agent 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 information is not received, within the earlier of 15 calendar days of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

**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, a determination will be made and notice provided 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 applicable Utilization Review Agent has all the information necessary to make a determination, they 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 additional information is needed, it will be requested within 24 hours. You or your Provider will then have 48 hours to submit the information. A determination will be made and you (or your designee) and your Provider will be provided written notice to within the earlier of one (1) business day or 48 hours of receipt of the information or, if the information is not received within 48 hours, the end of the 48-hour period.

**Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, the applicable Utilization Review Agent 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, a determination will be made and notice will be provided to you (or your designee) and your Provider within 72 hours of receipt of the necessary information. When a request for home care services is received and all necessary information prior to your discharge from an inpatient hospital admission, coverage for home care services will not be denied while the decision on the request is pending.

**Substance Use Disorder Treatment Reviews for In-Network Facilities**

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

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

**Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies the Claims Administrator of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, the entire stay may be reviewed to determine whether it is Medically Necessary using clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, you are only responsible for the In-Network Cost-Sharing that would otherwise apply to your inpatient admission.

**Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified Facility provides notification of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, the entire outpatient treatment may be reviewed to determine whether it is Medically Necessary using clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, you are only responsible for the in-network Cost-Sharing that would otherwise apply to your outpatient treatment.
None of the above provisions apply to Out-of-Network Facilities.

**Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH) for In-Network Facilities**

Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital provides notification of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, the entire stay may be reviewed to determine whether it is Medically Necessary, utilizing clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, you are only responsible for the in-network Cost-Sharing that would otherwise apply to your inpatient admission.

This provision does not apply to Out-of-Network Facilities.

**Retrospective Reviews**

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

Once all the information to make a decision is received, 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.

**Retrospective Review of Preauthorized Services.**

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

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

**Step Therapy Override Determinations**

You, your designee, or your Health Care Professional may request a step therapy protocol override determination for coverage of a Prescription Drug selected by your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, the applicable Claims Administrator (the Pharmacy Benefits Manager) will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for you and your medical condition.

- **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
  - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to you;
  - The required Prescription Drug(s) is expected to be ineffective based on your known clinical history, condition, and Prescription Drug regimen;
  - You have tried the required Prescription Drug(s) while covered by the Plan or under your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

- You are stable on a Prescription Drug(s) selected by your Health Care Professional for your medical condition, provided this does not prevent the Plan from requiring you to try an AB-rated generic equivalent; or
- The required Prescription Drug(s) is not in your best interest because it will likely cause a significant barrier to your adherence to or compliance with your plan of care, will likely worsen a comorbid condition, or will likely decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

- **Standard Review.** The applicable Claims Administrator/Pharmacy Benefits Manager will make a step therapy protocol override determination and provide notification to you (or your designee) and where appropriate, your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

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

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

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

  If the applicable Claims Administrator/Pharmacy Benefits Manager determine that the step therapy protocol should be overridden, we will authorize immediate coverage for the Prescription Drug prescribed by your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

**Reconsideration**

If an attempt to consult with your Provider who recommended the Covered Service is not made 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.

## UTILIZATION REVIEW INTERNAL APPEALS

You, your designee, and, in retrospective review cases, our 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. We 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. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

**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 it is determined that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, you or your designee must submit:

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

- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to you than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service. Publication documents must be from peer reviewed, scientifically sound journals where the publication date is less than 5 years from the date of the appeal.

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

- That the recommended Participating Provider 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.

**First Level Appeal.**

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

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

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

   There is only one level of Expedited Appeal. If you are not satisfied with the resolution of your expedited Appeal, you may file a standard internal Appeal or an external appeal.

Failure to render a determination of your Appeal within 30 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.

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

**Full and Fair Review of an Appeal.** You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by us or any new or additional rationale in connection with your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

**Second Level Appeal.**

If you disagree with the first level Appeal determination, you or your designee can file a second level Appeal. You or your designee can also file an external appeal. The four (4) month timeframe for

filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for you to file an external appeal.

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. Your request for an internal Appeal will be acknowledged within 15 calendar days of receipt. This acknowledgment will inform you, if necessary, of any additional information needed before a decision can be made.

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

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

***Appeal Assistance.***

If you need Assistance filing an Appeal, you may contact the state independent Consumer Assistance Program at:

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

## SPECIAL CONSIDERATION REVIEW

The Plan offers a Special Consideration review for Medical and Prescription Drug benefits and all other claims that are not in relation to a claim or request for a service or treatment after the internal Appeals process is completed. Therefore, if you are dissatisfied with the outcome of your internal Appeal, you may file a Special Consideration with the Plan/Executive Director within 30 calendar days from the date on the notice of the letter denying your internal Appeal.

You may submit written comments, documents, medical records and other information relating to the claim for benefits. In administering the Special Consideration review, the Plan will obtain a written report summarizing the facts underlying the claim and prior denials from the appropriate Claims Administrator. The Plan will not impose fees or costs on you (or your representative), should you or your authorized representative choose to exercise this right. Note that this voluntary level of review has no effect on the claimant's right to any other benefits under the Plan or to External Appeals rights. However, you should keep in mind that there are deadlines for filing an External Appeal request as noted in the next section.

A decision will be made not more than 60 days of following receipt of your request and you will be notified in writing.

## EXTERNAL APPEAL

### Your Right to an External Appeal

In some cases, you have a right to an external appeal of a denial of coverage. If coverage has been denied 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 Plan's 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 Plan agrees in writing to waive the internal Appeal. It 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 applicable Claims Administrator failed 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 it is demonstrated 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 Administrator).

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

If coverage has been denied 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 described in "Your Right to an External Appeal" above.

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

If coverage has been denied on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two (2) requirements for an external appeal described in "Your Right to an External Appeal" 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.

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

If coverage of an out-of-network treatment is denied 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.

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

You can submit additional documentation with your external appeal request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which the denial is based, the External Appeal Agent will share this information with the applicable Claims Administrator/Utilization Review Agent in order for the Plan to exercise its right to reconsider the decision. If the applicable Claims Administrator chooses to exercise this right, they will have three (3) business days to amend or confirm the decision. Please note that in the case of an expedited external appeal (described below), there is no right to reconsider the decision.

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

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending Physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care or continued stay, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must notify you and the Plan/ applicable Claims Administrator/Utilization Review Agent 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, coverage will be provided 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, only the cost of services required to provide treatment to you according to the design of the trial will be covered. The Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this Plan for non-investigational treatments provided in the clinical trial.

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

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

**Your Responsibilities**

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

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

## COORDINATION OF BENEFITS (COB)

### HOW DUPLICATE COVERAGE OCCURS

- This section provides you with information about:
- What you need to know when you have coverage under more than one Plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

#### Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other Plan that provides benefits to you.

#### When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one benefit Plan.

The order of benefit determination rules described in this section determine which Plan will pay as the Primary Plan. The Primary Plan pays first pays, without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays. This is to prevent payments from all Plans from exceeding 100 percent of the total Allowable Expense.

#### Definitions

For the specific purposes of this COB section, terms are defined as follows:

1. "Plan" is a form of coverage written on an expense incurred basis with which coordination is allowed. "Plan" includes: group insurance and group subscriber contracts; uninsured arrangements of group coverage; group coverage through HMO's and other prepayment, group practice and individual practice plans; and blanket contracts, except as stated below.

    - "Plan" includes the medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.
    - "Plan" includes Medicare or other governmental benefits. However, "Plan" shall not include a State plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.

    Each contract for coverage described above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

    "Plan" does not include individual or family:

    (i) insurance contracts;

    (ii) direct-payment subscriber contracts;

(iii) coverage through health maintenance organizations (HMO's); or

(iv) coverage under other prepayment, group practice and individual practice plans.

"Plan" does not include blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium.

2. A "Primary Plan" is one whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if:

(i) the Plan either has no order of benefit determination rules, or it has rules which differ from those included in this COB section; or

(ii) all Plans which cover the person use the order of benefit determination rules included in this COB section and under those rules the Plan determines its benefits first.

There may be more than one Primary Plan (for example, two Plans that have no order of benefit determination rules).

3. A "Secondary Plan" is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this COB section decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this COB section, has its benefits determined before those of that Secondary Plan.

4. "Allowable Expense" means the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the Plans involved, except where a statute requires a different definition. Dental care and routine vision care are examples of expenses or services that are not Eligible Medical Expenses under this SWSCHP Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice.

5. "Claim" means a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:

(i) services (including supplies);

(ii) payment for all or a portion of the expenses incurred; or

(iii) a combination of (i) and (ii) above.

6. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this SWSCHP Plan, or before the date this COB provision or a similar provision takes effect. During each Claim Determination

Period, Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:

(i) whether over-insurance exists; and

(ii) how much each Plan will pay or provide.

As each Claim is submitted, each Plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

**Order of Benefit Determination Rules**

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a COB provision that is consistent with this provision is always primary. There are two exceptions:

(i) coverage obtained by virtue of membership in a group designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan; or

(ii) any noncontributory group or blanket insurance coverage in force on January 1, 1987, that remains in force, provides excess major medical benefits intended to supplement any basic benefits on a Covered Person, and may continue to be excess to such basic benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that is used.

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

2. ***Non-Dependent or Dependent***. The Plan that covers the person other than as a Dependent, for example as an employee, Covered Person, subscriber or Retiree is primary and the Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an Employee, Covered Person, subscriber or retiree is secondary and the other Plan is primary.

3. ***Child Covered Under More Than One Plan***. The order of benefits when a child is covered by more than one Plan is:

a. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if the parents are not separated or divorced. If both parents have the same birthday, the Plan that covered either of the parents longer is primary. If the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits;

b. If a child is covered by both parents' plans, the parents are separated or divorced or were never married, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

1) The plan of the parent who has custody (custodial parent) will be primary;

2) If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third

3) If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

4. ***Active or inactive employee***. If the person receiving services is covered under one plan as an active employee or Participant (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. . If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. ***Longer or shorter length of coverage***. The Plan that covered the person as an employee, Covered Person, subscriber or retiree longer is primary. To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new Plan does not include:

a. a change in the amount or scope of a Plan's benefits;

b. a change in the entity which pays, provides or administers the Plan's benefits; or

c. a change from one type of Plan to another (such as, from a single employer Plan to that of a multiple employer Plan).

If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

6. **Marriage**. If a married couple is covered under this SWSCHP Plan as a Covered Person and as a Covered Dependent, the Dependent benefits will be coordinated as

if they were provided under another Plan, meaning the Covered Person's benefit will pay first.

**Effect on the Benefits of this Plan**

When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the Plan (or Plans) that paid first. In no case will this Plan pay more in benefits for each claim as it is submitted than it would have paid had it been the Plan that paid first. This has the effect of maintaining this Plan's Deductibles, Coinsurance and Exclusions. As a result, when this Plan pays second, you do not receive the equivalent of 100% of the total cost of the health care services.

If benefits are reduced by a primary plan because a Covered Person did not comply with the primary plan's provisions, such as the provisions related to the Medical Management utilized by this Plan, the amount of those reductions will not be reimbursable by this Plan when it pays second. In addition, if this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, this Plan will coordinate benefits as if there were out-of-network benefits on a secondary basis.

**Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The Plan may get the facts it needs from, or give them to, other organizations for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits.

The Plan need not tell, or get the consent of, any Covered Person to do this. Each Covered Person claiming benefits under this Plan must give the Plan any facts it needs to apply those rules and determine benefits payable. If you do not provide the Plan the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

## COORDINATION OF BENEFITS WITH MEDICARE

### Entitlement to Medicare Coverage

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period).

### Medicare Individuals May Retain or Cancel Coverage under This Plan

If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible employee remains actively employed, that employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If an eligible individual under this Plan is covered by Medicare and an employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of the eligible employee's Dependents are covered by Medicare and the employee cancels that Dependent's coverage under this Plan, that Dependent will **not** be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

### Coverage under Medicare and This Plan When Totally Disabled

**I**f an eligible employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible employee will no longer be considered to remain actively employed. As a result, once the employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible Dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that Dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more employees.

### Coverage under Medicare and This Plan for End-Stage Renal Disease

If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of: the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

### Summary Chart on COB with Medicare

If you are covered by Medicare and also have Plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

| Summary of the Coordination of Benefits between Medicare and the Group Health Plan | | | |
|---|---|---|---|
| **If you:** | **Condition** | **Pays First** | **Pays Second** |
| Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age | The employer has less than 20 employees | Medicare | Group health plan |
| | The employer has 20 or more employees | Group health plan | Medicare |
| Have an employer group health plan after you retire and are age 65. | Entitled to Medicare | Medicare | Group health plan (*e.g.* a retiree plan coverage) |
| Are disabled and covered by a large group health plan from your work because of active employment, or from a family member who is working | The employer has less than 100 employees | Medicare | Group health plan |
| | Employer has 100 or more employees | Group health plan | Medicare |
| Have End-Stage Renal Disease (ESRD is permanent kidney failure) and group health plan coverage (including a retirement plan) | First 30 months of eligibility or entitlement to Medicare | Group health plan | Medicare |
| | After 30 months | Medicare | Group health plan |
| Are covered under worker's compensation because of a job-related injury or illness | Entitled to Medicare | Workers' Compensation for Worker's Compensation-related services | Medicare |
| Have black lung disease and are covered under the Federal Black Lung Program | Entitled to Medicare and the Federal Black Lung Program | Federal Black Lung Program for black lung-related services | Medicare |
| Have been in an accident where no-fault or liability insurance is involved | Entitled to Medicare | No-fault or Liability insurance, for the accident-related services | Medicare |
| Are a Veteran and have Veterans' benefits | Entitled to Medicare and Veterans' benefits | Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA authorized services. Generally, Medicare and VA cannot pay for the same service. | Usually does not apply |
| Are covered under TRICARE | Entitled to Medicare and TRICARE | Medicare pays for Medicare-covered services. TRICARE pays for services from a military Hospital or any other federal provider. | TRICARE may pay second |
| Are age 65 or over OR are disabled and covered by both Medicare and COBRA | Entitled to Medicare | Medicare | COBRA |
| Have End-Stage Renal Disease (ESRD) and COBRA | First 30 months of eligibility or entitlement to Medicare | COBRA | Medicare |
| | After 30 months | Medicare | COBRA |

## HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY TO MEDICARE

### When Covered by this Plan and also by Medicare Parts A and B

When an eligible individual under this Plan is also covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the same benefits provided for active employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider. No supplemental benefits are payable by the Plan for Skilled Nursing Facilities when Medicare is primary for an individual covered under this Plan.

**IMPORTANT NOTE FOR MEDICARE-ELIGIBLE RETIREES AND THEIR MEDICARE-ELIGIBLE DEPENDENTS**

**When Covered by this Plan and Eligible for but Not Covered by Medicare**

Benefits that are paid for by this Plan for Medicare-eligible Retirees and their Medicare- eligible Dependents are reduced by the amounts payable under Medicare Parts A (Hospital), and B (Professional services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and Part B; therefore, if you are Medicare- eligible, you should consider enrolling in Medicare Part A and Part B in order to receive the maximum amount of benefits under this Plan.

### When Covered by this Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits

If an individual is covered by both this Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable Copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program.

Also, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/preauthorization, case management or utilization of In-Network provider requirements, this Plan will only pay benefits as if the Medicare Advantage plan did pay benefits.

### When Covered by this Plan and the Individual receives care from a Provider Who Does Not Accept Medicare Assignment

The Plan will treat these providers as Out-of-Network Providers. Benefits payable by this Plan in such circumstances are payable as an Out-of-Network benefit at 20% of the Allowable Amount subject to the Deductible and the 70% Coinsurance. The Allowed Amount will be based on Medicare's Allowed Amount and all Out-of-Network cost-sharing provisions will apply.

### When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract

Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract, this Plan will

NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

**Benefits that are Not Covered by Medicare**

This Plan will cover expenses for services or supplies that are not covered under Medicare, provided that such services or supplies are covered by this Plan as Eligible Medical Expenses and are not excluded. Any and all of the Plan's cost-sharing provisions, limitations and exclusions will apply.

**When a Retired Participant is covered by this Plan and also by a Medicare Part D Prescription Drug Plan**

If you have dual coverage under both this Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage:

- For Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage is primary and this Plan pays secondary.
- For Medicare eligible Active Employees, this Plan pays primary and Medicare Part D coverage is secondary.

For more information on Medicare Part D refer to www.medicare.gov or contact SWSCHP at 1- 888-P SWSCHP (779-7247) or on the web at SWSCHP.org.

**COORDINATION WITH GOVERNMENT AND OTHER PROGRAMS**

**Medicare**

When this Plan is secondary to Medicare, benefits will be reduced by the amount Medicare would have paid for Covered Services. Except as otherwise required by law, this reduction is made even if you fail to enroll in Medicare when first eligible or you do not pay your Medicare part B premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first (is primary to Medicare) or if you are not eligible for premium-free Medicare Part A.

**Medicaid**

If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

**TRICARE**

If a Dependent is covered by both this Plan and the TRICARE Program (formerly known as the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), that provides health care services to Uniformed Service Persons, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service- related illness or injury, benefits are not payable by this Plan.

**Veterans Affairs/Military Medical Facility Services**

If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.

**Motor Vehicle Coverage Required by Law**

If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

**Indian Health Services (IHS)**

If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

**Other Coverage Provided by State or Federal Law**

If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

**Subrogation and Reimbursement**

We have the right of reimbursement (or subrogation), if you or anyone on your behalf receives payment from any responsible party (including any insurer) from any settlement, verdict or insurance proceeds, in connection with an injury, illness or condition for which we provided benefits. 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 have the right, independently of you, to proceed directly against the other party to recover the benefits that it has provided.

Under New York General Obligations Law Section 5-335, a right of recovery does not apply when you reach a settlement with the party responsible for your injury, illness or condition, unless there is a statutory right of recovery. The law provides that, by entering into a settlement, you did not take an action against our rights or violate any contract between you and us. Absent a statutory right of recovery, the law presumes that a settlement in New York between you and the other party does not include compensation for the cost of health care for which we provided benefits.

You should 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 designees/claims administrators including, but not limited to, completing and submitting any applications or other forms or statements as may be reasonably requested.

## CONTINUATION OPTIONS

### SURVIVOR BENEFITS:

If an Employee with Family coverage dies, surviving Dependents will have extended benefits at no cost for three months after the death.

If the deceased Employee has completed 10 years of Active Service, survivors, at their own expense, will be eligible to continue benefits in the SWSCHP Plan. Also, if the death was the result of a work related accident, the survivor, at his or her own expense, will be eligible to continue benefits in the Plan if the Employee had not completed 10 years of service.

A surviving spouse may continue benefits at his/her own expense until he or she remarries. Surviving children may be covered as long as they continue to meet the definition of Dependent child.

If you are eligible to continue benefits at your own expense in this Plan as a Dependent survivor, but do not do so; or if you fail to remit the required payment, your benefits will end, and the survivor may continue benefits in the SWSCHP plan under COBRA only.

For information on Dependent survivor benefits and its costs, contact your School District Health Benefits Representative.

### CONTINUATION OF COVERAGE (COBRA)

*This section serves as a notice to summarize your rights and obligations under the COBRA Continuation Coverage law. It is provided to all Covered Employees, and their covered spouses and is intended to inform them (and their Covered Dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your spouse take the time to read this notice carefully and be familiar with its contents.*

**NOTE:** Domestic Partners and children of Domestic Partners are offered the ability to elect temporary continuation of benefits (COBRA) when coverage ends (described in this section); however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary. This section describes in general how the Domestic Partner COBRA benefit will work. Contact your School District Health Benefits Representative with any questions.

**This Plan provides no greater COBRA rights than what is required by law and nothing in this section is intended to expand a Covered Person's COBRA rights.**

**COBRA Administrator**: The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is the School District Health Benefits Representative.

Pursuant to federal COBRA and state continuation coverage laws, you, your spouse and your children may be able to continue coverage under this Plan in certain situations where you would otherwise lose coverage, known as qualifying events:

1. If your coverage ends due to voluntary or involuntary termination of employment or covered membership in the group/class or reduction the number of hours of employment, you may continue coverage. Coverage may be continued for you, your spouse and any of your Covered Dependents.

2. If you are an eligible spouse, you may continue coverage if it ends due to:

    a. Voluntary or involuntary termination of the covered Employee's employment or covered membership in the group/class;

    b. Reduction in the hours worked by the covered Employee;

    c. Divorce or legal separation of the covered Employee;

    d. Death of the covered Employee; or

    e. The covered Employee becoming entitled to Medicare.

3. If you are an eligible child, you may continue coverage if it ends due to:

    a. Voluntary or involuntary termination of the covered Employee's employment or membership in the group/class;

    b. Reduction in the hours worked by the covered Employee;

    c. Loss of Dependent child status under the Plan rules;

    d. Death of the covered Employee; or

    e. The covered Employee becoming entitled to Medicare.

An Employee or Covered Person who wishes to continue coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of:

1. The date of the qualifying event; or

2. The date the Employee or Covered Person is sent notice by first class mail of the right of continuation by the applicable Participating Employer.

The Plan can charge an additional 2% administrative fee for continued coverage. Coverage will terminate at the earliest of the following:

1. The date 36 months after your coverage would have terminated because of termination of employment or membership;

2. If you are an eligible Dependent, the date 36 months after coverage would have terminated due to the death of the Employee or Member, divorce or legal separation, the Employee or Member's eligibility for Medicare or the failure to qualify under the definition of "children";

3. The date you become covered by an insured or uninsured arrangement that provides group Hospital, surgical or medical coverage that does not contain a pre-existing condition exclusion or limitation with respect you, your spouse or your children;

4. The date to which premiums are paid if you fail to make a timely payment; or

5. The date the group no longer provides coverage to any of its employees.

**COBRA Questions or To Give Notice of Changes in Your Circumstances**

If you have any questions about your COBRA rights, please contact your Participating Employer.

**Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify your Participating Employer:**

1. within 31 days of a **change in marital status (e.g. marry, divorce)**; or have **a new Dependent child**; or

2. within 60 days of the date you or a Covered Dependent spouse or child has been determined to be **totally and permanently Disabled** by the Social Security Administration; or

3. within 60 days if a covered child **ceases to be a "Dependent Child"** as that term is defined by the Plan; or

4. promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

**Rights under New York State Continuation of Coverage:** A qualified beneficiary who has exhausted continuation coverage pursuant to the provisions described in this section has the opportunity to continue coverage for up to thirty-six months from the date the Employee's or Dependent's continuation coverage began, if the Employee or Dependent is entitled to less than thirty-six months of continuation benefits under federal law. Contact your Participating Employer for information on extending your COBRA period.

## MISCELLANEOUS PROVISIONS

**No Assignment:** You cannot assign any right for benefits or monies due under this Plan to any person, corporation or other organization. Any such assignment by you will be void. Assignment means the transfer to another person, corporation or organization of your right to the benefits or payment under this Plan, or your right to collect money from this Plan for those services.

**Your Medical Records:** In order to process your claims, it may be necessary for the Plan Administrator to obtain your medical records and information from Hospitals, Skilled Nursing Facilities, Doctors, Pharmacists or other Health Care Providers who treated you. When you become covered under this Plan, you automatically give the Administrators permission to obtain and use those records. The information will be kept confidential.

**When you must repay Plan Benefits**

If it is found that the Plan benefits paid by the Plan are too much because:

(1) some or all of the health care expenses were not payable to or on behalf of you or your Covered Dependent; or

(2) you or your Covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or

(3) you or your Covered Dependent achieve any recovery whatsoever, through a legal action or settlement (in which event the Plan will not seek subrogation in New York in the absence of a statutory right of subrogation in favor of the Plan) in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid (see also the Subrogation subsection of the COB section); or

(4) the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or

(5) the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;

(6) In such case, the Plan will be entitled to:

   (a) a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;

   (b) offset future benefits (that would otherwise be payable on behalf of you or your Dependents) if necessary in order to recover such expenses; and/or

   (c) its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

**Recovery of Overpayment:** On occasion, a payment will be made when you are not covered under this Plan, or for a service which is not covered, or in an amount which is more than proper. When this happens, the problem will be explained to you, and you must return the amount of the overpayment within 60 days.

**Right to Develop Guidelines:** The Plan reserves the right to develop or adopt criteria, which set forth in more detail the instances and procedures when they will make payment. An example of the use of the criteria is to determine whether Hospital Inpatient Care was Medically Necessary, or whether Emergency Care in the Outpatient department of a Hospital was necessary. If you have a question about the criteria which apply to a particular benefit, you may contact the Plan Administrator(s).

**Time to Sue:** You may start any lawsuit against the Plan 60 days after proof is given and within two years from the day you received the service for which you want to Plan to pay.

**Benefits After Termination Due to Total Disability:** If you are totally disabled on the date your coverage ends with this Plan, SWSCHP will pay benefits for covered benefits for that total disability, on the same basis as if coverage had continued without change. These benefits will continue until the day you are no longer totally disabled or the date 12 months after your coverage ended, whichever is earlier.

**Confined on Date of Change of Options:** "Option" means either the SWSCHP Plan, or any other benefit plan option offered by your Participating Employer.

If, on the effective date of transfer without break from one Option to the other, you are confined in a Hospital or similar facility, or confined at home under the care of a Doctor:

1) if the transfer is out of this Plan, and you are confined on the day Plan coverage ends, benefits are payable as described in the Benefits After Termination Due to Total Disability Continuation Option of this Plan Document.

2) if the transfer is into the SWSCHP Plan, benefits are payable to the extent they are not paid through the former Option.

**Payment in Accordance With This Plan:** Payment in accordance with this Plan will be made to either the Employee or to the Health Care Providers that rendered the service to the Covered Person. This payment satisfies the Plan's obligation for payment.

**Conformity with Law**

Any term of this Plan which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

**Furnishing Information and Audit**

All persons covered under this Plan will promptly furnish all information and records that may be require by the Plan’s Claims Administrators from time to time to perform its obligations under this Plan. You must provide the information over the telephone for reasons such as the following: to determine the level of care you need; so that care can be certified that was authorized by your Physician; or to make decisions regarding the Medical Necessity of your care.

**Fraud and Abusive Billing**

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

**Incontestability**

No statement made by you will be the basis for avoiding or reducing coverage unless it is in writing and signed by you. All statements contained in any such written instrument shall be deemed representations and not warranties.

**Independent Contractors**

Participating Providers are independent contractors. They are not agents or employees of the Plan. The Plan or its employees are not the agent or employee of any Participating Provider. The Plan is not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by you or any covered Dependents while receiving care from any Participating Provider or in any Participating Provider's Facility.

**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 problem will be explained to you and you must return the amount of the overpayment to the Plan within 60 days after receiving notification. However, overpayment recovery efforts will not be initiated more than 24 months after the original payment was made unless there is a reasonable belief of fraud or other intentional misconduct

**Third Party Beneficiaries**

No third party beneficiaries are intended to be created by this Plan and nothing in this Document shall confer upon any person or entity other than you or the Plan any right, benefit, or remedy of any nature whatsoever under or by reason of this Document. No other party can enforce this Plan's provisions or seek any remedy arising out of either the Plan's or your performance or failure to perform any portion of this Plan, or to bring an action or pursuit for the breach of any terms of this Plan.

**Time to Sue**

No action at law or in equity may be maintained against the Plan prior to the expiration of 60 days after written submission of a claim has been furnished as required in this Document. You must start any lawsuit against the Plan within [two (2)] years from the date the claim was required to be filed.

## HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH),** requires that health plans maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

- **PHI does not include** health information contained in employment records held by your Participating Employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), etc.

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

The Plan, the Board of Governors, and member school districts will not use or further disclose information that is protected by HIPAA ("Protected Health Information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of a member school district. The Plan may disclose PHI to a member school district for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under HIPAA. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

   - **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to Coordination of Benefits with a third party and consultations and referrals between one or more of your Health Care Providers.

   - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

     a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and Copayments as determined for an individual's claim), and establishing Employee contributions for coverage;

     b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes),

coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; or

c. Medical Necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies and quality assessment;

b. Population-based activities relating to improving health or reducing health care costs, protocol development, Medical Management, contacting of Health Care Providers and patients with information about treatment alternatives and related functions;

c. Underwriting, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs; or

e. Business management and general administrative activities of the Plan, including, but not limited to, management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, member school districts, or other customers.

B. **When an Authorization Form is Needed:** Generally, the Plan will require that you sign a valid authorization form (available by calling SWSCHP or on the website at SWSCHP.org) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations (TPO). The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. **The Plan will disclose PHI to Member school districts only** upon receipt of a certification from the member school districts that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the member school districts agree to:

1. Not use or disclose PHI other than as permitted or required by the Plan Document or as required by law;

2. Ensure that any agents, including subcontractors, to whom the member school districts provide PHI received from the Plan agree to the same restrictions and

conditions that apply to the member school district with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

3. Not use or disclose the information for employment-related actions and decisions;

4. Not use or disclose PHI in connection with any other benefit or employee benefit Plan of the Plan member school district (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Plan member school district becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amending and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of PHI disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;

10. If feasible, return or destroy all PHI received from the Plan that the member school district maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to permissible purposes; and

11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. In order to ensure that adequate separation between the Plan and the member school district is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Executive Director;

2. Staff designated by the Executive Director; and

3. Business Associates under contract to the Plan.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions. If these persons do not comply with this obligation, the Plan has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed in the Contact Chart in the front of this Plan Document.

F. In compliance with HIPAA security regulations, the Plan:

1. Has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

2. Ensured that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

3. Ensured that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

4. Will report to the Plan any security incident of which it becomes aware concerning electronic PHI.