AMENDMENT TO CHAUTAUQUA COUNTY SCHOOL DISTRICTS' MEDICAL HEALTH PLAN

Effective January 1, 2011

The Chautauqua County School Districts' Medical Health Plan Summary Plan description is amended as follows:

1. The **Summary of Benefits** for the Indemnity Medical Plan, Point of Service Plan and Preferred Provider Organization Plan are deleted and replaced by those in **Exhibit A** attached.

2. Section II, **Key Terms**, is modified to revise the definition of Emergency Illness and to add a new definition of Emergency Services:

- **Emergency Illness**. In accordance with New York State Law, an emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms or sufficient severity, including severe pain, that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of 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 care of a behavioral condition placing the health of such person or others in serious jeopardy, or serious impairment to such person's bodily functions, or the serious dysfunction of any bodily organ or part of such person, or the serious disfigurement of such person.

APPROVED
STATE OF NEW YORK
APR 16 2012
SUPERINTENDENT
BENJAMIN M. LAWSKY

- **Emergency Services.** A medical screening examination 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 are required to stabilize the patient.

3. Section III. A. 1., **Employee Eligibility,** third paragraph is deleted and replaced as follows:

Effective July 1, 2011, under Federal Law, coverage for adult children, regardless of marital status, is available through age twenty-six. The parent of the adult child will need to be enrolled in the appropriate tier of coverage prior to or at the date of enrollment of the adult child.

4. Section III. B. 5., **Special Enrollment Periods**, is deleted and replaced as follows:

If you, the employee, reject initial enrollment in this Plan, or elect not to enroll during a subsequent open enrollment, you may enroll for coverage if the following conditions are met:

a. You or your dependent had coverage under another plan or contract when coverage was initially offered or at a subsequent open enrollment period; and

b. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you or your dependent lost eligibility for one or more of the following reasons:

- Termination of employment;
- Termination of the other plan or contract;
- Death of your spouse;
- Legal separation, divorce or annulment;
- Reduction in the number of hours worked;
- The employer or other group ceased its contribution toward the premium for the other plan or contract;
- The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;
- Cessation of dependent child status;
- Benefits are no longer offered to similarly situated individuals (e.g., part-time employees); or
- The benefit maximum under the plan or contract has been reached

c. You acquire a dependent due to birth, adoption, guardianship, placement for adoption or marriage, in which case you, the employee, may enroll for individual coverage or for a type of coverage available to your group that will cover you and your eligible dependents; or

d. You lose eligibility for coverage under Medicaid, Family Health Plus, or Child Health Plus, or you become eligible for State premium assistance under Medicaid, Family Health Plus, or Child Health Plus.

e. You apply for coverage under this Plan within 30 days after termination for one of the reasons set forth in Subparagraph b. above or acquisition of a dependent as set forth in Subparagraph c. above; or you apply for coverage under this Plan within 60 days of the occurrence of an event set forth in Subparagraph d. above.

If you enroll for coverage pursuant to Subparagraphs a. and b., or Subparagraph d., your coverage will begin at 12:01 a.m. on the first day of the month following the request for enrollment. If you enroll for coverage pursuant to Subparagraph c. above, your coverage will begin at 12:01 a.m. on: the date of the birth, adoption, guardianship or placement for adoption; or on the first day of the month following the request for enrollment, when you are entitled to special enrollment based on marriage.

5. Section III. D. 1. **Major Medical Benefits-Key Features** is modified effective July 1, 2011 to add the following at the end of the section:

Preventive Services. Effective July 1, 2011 the Patient Protection and Affordable Care Act of 2010 requires certain preventive services to be covered on a first-dollar basis, which means that

copayments, coinsurance and deductible requirements do not apply to such preventive services. The following items and services are those for which copayments, coinsurance and deductibles do not apply:

- evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, to the extent not already required above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A list of all Preventive Services will be made available to a plan member upon request.

6. Section III. D. 3. (f) (2) **Second Cancer Opinion (Indemnity)** is deleted and replaced as follows:

The plan pays 80% of covered charges, after the deductible is met, for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer. A second cancer opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation for a course of treatment for cancer. The cost shall be the same for a plan participant seen by an out-of-network appropriate specialist as it is for a plan participant seen by an in-network appropriate specialist.

7. Section III. D. 3. (f) (13) **Well Child Care (Indemnity)** is modified to add the following:

Routine eye examinations are covered in full for children under the age of five.

8. Section III. D. 3. (f) (14) **Other Medical Services (Indemnity)** is modified to add the following:

The Plan pays 100% of covered charges for the following health care services when medically necessary:

- Chemoprevention of breast cancer (service should be performed as part of a consultation)
- Immunizations (Adults 19+)
- Cholesterol abnormality screening

- Diabetes screening (Adults 19+)
- Depression screening for all adults and adolescents
- Congenital hyperthyroidism screening (children less than 1 year old)
- Hearing loss screening (children less than 1 year old)
- Flu vaccinations
- Gonorrhea, Syphilis, and Chlamydia infection screening
- Hepatitis B screening (women only)
- Sexually Transmitted Infection (STI) counseling (adults and adolescents)
- Healthy diet counseling (Adults 19+)
- High blood pressure screening (Adults 18+ - generally performed as part of physician visit)
- HIV screening
- Obesity screening and counseling
- Phenylketonuria (PKU) screening (newborns)
- Sickle cell screening (newborns or infants less than 1 year old)
- Reduce alcohol misuse screening and counseling
- Drug use assessments screening and counseling
- Tobacco use counseling (Adults)
- Routine Physicals - includes labs, routine vision and services related to preventive visit
- Abdominal Aortic Aneurysm Screening (men ages 65-75)

9. Section III. D. 4. **Pregnancy and Maternity (Indemnity)** is deleted and the following is substituted:

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance, and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. This shall include interventions to support breast feeding. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Home care services covered under the maternity benefit are not subject to deductibles, coinsurance or co-payments. Coverage under the maternity benefit also includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care. Coverage also includes full coverage for medically necessary iron deficiency (anemia) and bacteriuria screening during the pregnancy.

10. Section III. E. 1. **Description of Point of Service Benefit.** The last sentence in the third paragraph is deleted and replaced, and the following additional language is inserted:

The out-of-network benefit level will be paid for all claims submitted by any out-of-network providers regardless of where you live or your ability to access in-network providers.

Preventive Services. Effective July 1, 2011 the Patient Protection and Affordable Care Act of 2010 requires certain preventive services to be covered on a first-dollar basis **when such services are provided by an in-network provider**, which means that copayments, coinsurance and deductible requirements do not apply to such preventive services. The following items and services are those for which copayments, coinsurance and deductibles do not apply:

- evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, to the extent not already required above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The federal Department of Health and Human Services will develop these guidelines and expects to issue them no later than Aug. 1, 2011.

Specialty Services. At the time of enrollment or thereafter, if you are diagnosed with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you must notify the Plan Administrator who will work with an in-network specialist or specialty care center who will provide and coordinate your primary and specialty care. Note: A *specialty care center* is a center accredited by a state or federal agency or by a voluntary national health organization as having special expertise in treating a specific, life-threatening disease or condition or degenerative and disabling disease or condition. If the Plan agrees that an out-of-network authorization is necessary, services will be provided at no additional cost to you beyond what would normally be paid to an in-network specialist or specialty care center.

Standing Referral. If you have a medical condition that requires ongoing care from a specialist, your primary care physician or OB/GYN will make the arrangements, and recommend a specialist for ongoing care. Please make sure you are being directed to an in-network health care provider.

Transitional Care. Transitional care begins when an in-network provider's contractual obligation to provide services to plan participants terminates. If you are a new participant and your health care provider is not in-network, you will be able to continue treatment with the same health care provider during a transitional period of up to 60 days from the effective date of enrollment. If you are a current participant and your health care provider should decide to leave the network, you may continue treatment with this same provider during a transitional period of up to 90 days.

11. Section III. E. 3. a. **Physician Office Visits** is modified to add the following:

The $10 copayment does not apply to physician office visits where only preventive services are being performed.

12. Section III. E. 3. k. **Physicals** is deleted and the following is substituted:

In-network the Plan pays 100% of covered charges, without a deductible, for routine physicals. There is no out-of-network benefit; you will be responsible for the entire cost.

13. Section III. E. 3. s. **Well Child Care (POS)** is modified to add the following:

Routine eye examinations are covered in full for children under the age of five.

14. Section III. E. 3. t. (11) **Other Services (POS)** is modified to add the following:

- Immunizations for adults 19+
- Cholesterol abnormality screening
- Chemoprevention of breast cancer (service should be performed as part of a consultation)
- Immunizations (Adults 19+)
- Cholesterol abnormality screening
- Diabetes screening (Adults 19+)
- Depression screening for all adults and adolescents
- Congenital hyperthyroidism screening (children less than 1 year old)
- Hearing loss screening (children less than 1 year old)
- Flu vaccinations
- Gonorrhea, Syphilis, and Chlamydia infection screening
- Hepatitis B screening (women only)
- Sexually Transmitted Infection (STI) counseling (adults and adolescents)
- Healthy diet counseling (Adults 19+)
- High blood pressure screening (Adults 18+ - generally performed as part of physician visit)
- HIV screening
- Obesity screening and counseling
- Phenylketonuria (PKU) screening (newborns)
- Sickle cell screening (newborns or infants less than 1 year old)
- Reduce alcohol misuse screening and counseling

- Drug use assessments screening and counseling
- Tobacco use counseling (Adults)
- Routine Physicals -includes labs, routine vision and services related to preventive visit.
- Abdominal Aortic Aneurysm Screening (men ages 65-75)

15. Section III. E. 4. **Pregnancy and Maternity (POS)** is deleted and the following is substituted:

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance, and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. This shall include interventions to support breast feeding. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Coverage under the maternity benefit also includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care. Coverage also includes full coverage for medically necessary iron deficiency (anemia) and bacteriuria screening during the pregnancy.

16. Section III. F. 1. **Description of Preferred Provider Organization Benefit** is modified to add a new third paragraph as follows:

The out-of-network benefit level will be paid for all claims submitted by any out-of-network providers regardless of where you live or your ability to access in-network providers.

Preventive Services. Effective July 1, 2011 the Patient Protection and Affordable Care Act of 2010 requires certain preventive services to be covered on a first-dollar basis **when such services are provided by an in-network provider**, which means that copayments, coinsurance and deductible requirements do not apply to such preventive services. The following items and services are those for which copayments, coinsurance and deductibles do not apply:

- evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

- with respect to women, to the extent not already required above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The federal Department of Health and Human Services will develop these guidelines and expects to issue them no later than Aug. 1, 2011.

A list of all Preventive Services will be made available to a member upon request.

Specialty Services. At the time of enrollment or thereafter, if you are diagnosed with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you must notify the Plan Administrator who will work with an in-network specialist or specialty care center who will provide and coordinate your primary and specialty care. Note: A *specialty care center* is a center accredited by a state or federal agency or by a voluntary national health organization as having special expertise in treating a specific, life-threatening disease or condition or degenerative and disabling disease or condition. If the Plan agrees that an out-of-network authorization is necessary, services will be provided at no additional cost to you beyond what would normally be paid to an in-network specialist or specialty care center.

Standing Referral. If you have a medical condition that requires ongoing care from a specialist, your primary care physician or OB/GYN will make the arrangements, and recommend a specialist for ongoing care. Please make sure you are being directed to an in-network health care provider.

Transitional Care. Transitional care begins when an in-network provider's contractual obligation to provide services to plan participants terminates. If you are a new participant and your health care provider is not in-network, you will be able to continue treatment with the same health care provider during a transitional period of up to 60 days from the effective date of enrollment. If you are a current participant and your health care provider should decide to leave the network, you may continue treatment with this same provider during a transitional period of up to 90 days.

17. Section III. F. 3. s. **Well Child Care (PPO)** is modified to add the following:

Routine eye examinations are covered in full for children under the age of five.

18. Section III. F. 3. t. (11) **Other Services (PPO)** is modified to add the following:

- Immunizations for adults 19+

- Cholesterol abnormality screening
- Chemoprevention of breast cancer (service should be performed as part of a consultation)
- Immunizations (Adults 19+)
- Cholesterol abnormality screening
- Diabetes screening (Adults 19+)
- Depression screening for all adults and adolescents
- Congenital hyperthyroidism screening (children less than 1 year old)
- Hearing loss screening (children less than 1 year old)
- Flu vaccinations
- Gonorrhea, Syphilis, and Chlamydia infection screening
- Hepatitis B screening (women only)
- Sexually Transmitted Infection (STI) counseling (adults and adolescents)
- Healthy diet counseling (Adults 19+)
- High blood pressure screening (Adults 18+ - generally performed as part of physician visit)
- HIV screening
- Obesity screening and counseling
- Phenylketonuria (PKU) screening (newborns)
- Sickle cell screening (newborns or infants less than 1 year old)
- Reduce alcohol misuse screening and counseling
- Drug use assessments screening and counseling
- Tobacco use counseling (Adults)
- Routine Physicals - includes labs, routine vision and services related to preventive visit
- Abdominal Aortic Aneurysm Screening (men ages 65-75)

19. Section III. F. 4. **Pregnancy and Maternity** is deleted and replaced as follows:

Group health plans and health insurance issuers, under New York State law, must provide maternity care coverage which, other than coverage for perinatal complications, shall include inpatient hospital coverage for the mother and newborn child for at least 48 hours after childbirth for any delivery other than a caesarian section and for at least 96 hours following a caesarian section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to New York State law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. In accordance with New York State law the Plan is not required to pay for duplicative routine services actually provided by both a licensed midwife and physician. The maternity care coverage shall include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. This shall include interventions to support breast feeding. The mother shall have the option to be discharged earlier than the time periods stated earlier in this paragraph. In such case, the inpatient hospital coverage includes one home care visit, which is in addition to, rather than in lieu of, any other home care coverage available in the Plan. The home care visit may be requested any time within 48 hours of the time of delivery (96 hours for a caesarian section) and shall be delivered within 24 hours after discharge or the mother's request, whichever is later. Coverage under the maternity benefit also

includes the care and treatment for, at a minimum, two prenatal visits and separate coverage for the delivery and postnatal care. Coverage also includes full coverage for medically necessary iron deficiency (anemia) and bacteriuria screening during the pregnancy.

20. Section III. G. **Medical Plan Exclusions** is deleted and replaced as follows:

G. Medical Plan Exclusions/Non-Covered Benefits

1. **Medical Plan Exclusions**

The following is excluded coverage under this Medical Plan:

- Travel expenses
- Cosmetic services and procedures (except for medically necessary cosmetic services and procedures and reconstructive surgery when it is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved body part or reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect)
- foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet
- Services rendered for custodial care
- Routine eye examinations, eyeglasses and contact lenses, except following cataract surgery or injuries sustained while covered by the Plan, in which case benefits will be available for the contact lenses or regular lenses exclusive of frames
- Hearing aids
- Services provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable, services rendered and separately billed by employees of hospitals, laboratories or other institutions
- Services performed by a member of the covered person's immediate family and services for which no charge is normally made

- Costs incurred while under an act-of-war
- Injuries or illness arising from the commission of a felony
- Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident, surgical and the anesthesia charges incurred for the removal of impacted teeth and except for dental care or treatment necessary due to congenital disease or anomaly

2. **Non-Covered Benefits**

- Services or care in connection with toenails (except full removal) or instability or imbalances of the foot
- Marriage or vocational counseling
- Special clothing, including orthopedic shoes
- Household equipment
- Special food, diets, and food supplements (except for enteral formulas and modified solid food products)
- Equipment repairs and adjustments, unless due to a physical change
- Research or experimental procedures including services and equipment unless directed pursuant to external review
- Acupuncture
- Hypnosis
- Any services or care for which coverage is available in whole or in part under another health benefits contract or rider, except Medicaid or another plan that by its terms does not permit coordination of benefits
- Services furnished to the covered person before the effective date of their coverage
- Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue, alveolar processes, treatment to the repair or the replacement of a denture or other dental treatment unless medical in nature

- Any deductibles or coinsurance under the Plan
- Elective abortions
- Services which are not medically necessary
- Charges in excess of the Schedule of Allowances
- Massage Therapy except when deemed to be medically necessary by a physician and performed in the office of a physician or chiropractor

21. Section VII. B. **Claim Appeal Procedures** is modified to delete the first four paragraphs and substitute a new Section 1 as follows:

VII. B. 1. **Grievance Procedure for Service or Coverage Denials (POS and PPO Plans Only)**

This section explains the procedure for filing a grievance with us regarding our service or your coverage under the POS or PPO Plans. This grievance procedure does not apply to disputes involving medical necessity or investigational treatment, and does not apply to the Traditional (Indemnity) Plan.

a. Filing the Grievance. If you do not agree with a decision we have made concerning your coverage under the POS or PPO Plan, you or a representative you designate may file a written request for a review of our decision within one hundred eighty (180) days after you receive the notice of our decision. Your request should contain the reasons why you do not agree with the decision and any additional pertinent information. Send your written request to the Chautauqua County School Districts' Medical Health Plan, P.O. Box 399, Jamestown, New York 14702-0339, Attn: Pam Frangione. If you do not agree with a decision we have made concerning referrals or covered benefits, you may file an oral (telephone) request for a review of our decision within one hundred eighty (180) days of receipt of our decision by contacting the Plan at 1-800-913-1615.

b. Notification of Grievance Determination. If a claim is wholly or partially denied, we will notify you of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan. If we determine that special circumstances require an extension of time for processing the claim, we shall furnish you with written notice of the extension of time prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

For coverage related to the circumstances below, the timing of notification is as follows:

(i) Urgent Care Claims. With respect to prospective urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

(ii) Concurrent Care Decisions. If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated. Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and we shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(iii) Prospective (Pre-service) Claims. With respect to prospective claims, we shall notify you of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that we determine that such an extension is necessary due to matters beyond the control of the plan and notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded 45 days from receipt of the notice within which to provide the specified information.

(iv) Retrospective (Post-service) Claims. With respect to retrospective claims, we shall notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the claim by the Plan. This period may be extended one time by the plan for up to 15 days, provided that we determine that such an extension is necessary due to matters beyond the control of the plan and we notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

c. Manner and Content of Notification of Grievance Determination. A notice of grievance determination will be provided in writing or electronically and will include the reasons, including clinical rationale (if applicable) for our determination, date of service, provider name, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of any clinical review criteria used

to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the Plan provision on which the denial is based.

d. Appeal of a Grievance Determination. You or your designated representative shall have one hundred eighty (180) days after receipt of notice of a grievance determination to file a written appeal to the Plan. Within fifteen (15) days of receipt of the appeal we or a party we designate will provide you written acknowledgement of the appeal, including the name, address and telephone number of the party handling the appeal and what information, if any must be provided in order for the Plan to make a decision.

The determination of an appeal on a clinical matter will be made by qualified personnel who did not make the initial determination, at least one of whom will be a clinical peer reviewer as defined New York Insurance Law Article 49. A determination of an appeal on a non-clinical matter will be made by qualified personnel at a higher level than the personnel who made the grievance determination.

A decision on the appeal of a grievance determination shall be made and notice will be provided to you or your designated representative within the following timeframes:

- For urgent care claims we will provide notice to you within 72 hours after the receipt of the appeal;
- For prospective claims we will provide notice to you within thirty (30) days from receipt of the appeal;
- For retrospective claims we will provide notice to you within sixty (60) days from receipt of the appeal;
- In all other instances, we will provide notice to you within sixty (60) days from receipt of the appeal.

e. Manner and Content of Notification of Grievance Determination on Appeal. A notice of benefit determination on appeal will be provided in writing or electronically and will include the reasons, including clinical rationale (if applicable), for our determination, date of service, provider name, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the Plan provision on which the denial is based.

22. Section VII. B. 1. **Utilization Review** Subsections a. – c. and d.(1)-(4) are deleted in their entirety and replaced with the following:

VII. B. 2. **Utilization Review Procedure**

a. Prospective (Pre-service) Reviews. If we have all the information necessary to make a determination regarding a prospective review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three

business days of receipt of the request. If we need additional information, we will request it within three business days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to prospective urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

b. 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 information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of the earlier of our receipt of the information or the end of the 45-day time period.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for prospective urgent claims.

If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

If we receive a request for coverage of home health care services following an inpatient hospital admission, we will notify you (or your designee) and your provider of our decision by telephone and in writing within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information unless it is a prospective urgent claim for which the prospective urgent claim time frames are applicable.

When we receive a request for home health care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home health care services, either on the basis of medical necessity or for failure to obtain prior authorization, while our decision on the request is pending.

c. Retrospective (Post-service) Reviews. If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) and your provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you and your provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

Notice of Adverse Determination. A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical rationale, for our determination, date of service, provider name, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your health care provider.

d. Internal Appeals. You (or your designee) have up to 180 calendar days after you receive notice of the adverse determination to file an internal appeal.

We will decide internal appeals related to prospective reviews 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 health care provider) within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

We will decide internal appeals related to retrospective reviews within 60 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 health care provider) within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, home health care services following an inpatient hospital admission, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours of receipt of the appeal request or two business days of receipt of the necessary information. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request. If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your internal appeal within 60 calendar days of receipt of the necessary information for a standard appeal (unless an extension is requested by the Plan as described below) or two business days of receipt of the necessary information for an expedited appeal shall be deemed a reversal of the initial adverse determination.

Your Right to an Immediate External Appeal. If we fail to adhere to the utilization review requirements described in this Plan document, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in this Plan document.

23. Section VII. B. 1. **Utilization Review** Subsection d.(5) is deleted in its entirety and replaced with the following:

VII. B. 3. **External Appeal**

i. Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity (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), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

ii. Your Right to Appeal a Determination that a Service is not Medically Necessary

If the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Plan; and

- You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

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

If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Plan; and

- You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- 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 in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered);or

- 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.

iv. The External Appeal Process

If, through the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary, or is an experimental or investigational treatment you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four (4) months from receipt of such waiver to file a written request for an external appeal. If the Plan fails 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 Plan's internal appeal process or its 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 satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

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

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

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan 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 Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Plan will

provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such 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 instruct you on the manner in which you must submit the fee. The Plan will also waive the fee if the Plan determines that paying the fee would pose a hardship to you. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

v. Your Responsibilities

It is YOUR RESPONSIBILITY to initiate the external appeal process. You may initiate 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 external appeal request; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage, or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.

COVERED SERVICES/EXCLUSIONS

In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with Section VII. B. 3 of this Summary Plan Description. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

EXHIBIT A

SUMMARY OF BENEFITS

INDEMNITY MEDICAL PLAN SUMMARY	
Annual Deductible Single Family	Depends on your District $50 or $100 or $200 or $250 or $400 or $500 per individual $100 or $200 or $400 or $500 or $800 or $1000 per family
Annual Out of Pocket Maximum	$400 per individual or $300 per individual for participants in Option 4 of the Prescription Drug Plan
Ambulatory Care (Diagnostic X-ray and Laboratory)	100% of Reasonable & Customary (*R&C*) – *Please see definition on page 5 of Section I*
Inpatient Hospital	100% of R&C for up to 365 days per confinement
Inpatient Mental Health; Chemical Dependence or Abuse	100% of R&C
Outpatient Mental Health;	80% of R&C coverage after deductible
Ambulance Services	100% of R&C coverage
Chiropractic Care	80% of R&C coverage after deductible
Outpatient Chemical Abuse or Dependence Treatment	100% of R&C
Inpatient Physician	100% of R&C coverage
Outpatient Physician	80% of R&C after deductible
Surgery Physician Charges Facility Charges	 100% of R&C coverage 100% of R&C coverage
Supplemental Accident	100% of R&C for the first $500 resulting from an accident
Annual OB/GYN & Maternity Care	100% of R&C coverage for laboratory and test charges for pap smear – see Section III Medical Plan for further details
Well Child Care/ Preventive Primary Care	100% of R&C coverage (includes physicals as well as labs, routine vision, and services related to preventive visit).
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	80% of R&C after deductible 100% of R&C coverage for chemoprevention of breast cancer
Preadmission Testing	100% of R&C coverage
Emergency Room	100% of R&C coverage
Home Care	100% of R&C coverage for up to 365 visits (4 hours equals 1 visit)
Second Surgical Opinion	100% of R&C coverage
Second Cancer Opinion	80% of R&C after deductible
Hospice Care	80% of R&C after deductible
Mammography Screening	100% of R&C coverage
Mastectomy	100% of R&C coverage
Breast Reconstruction after a Mastectomy	100% of R&C coverage
Infertility Treatment	100% of hospitalization, surgical care, laboratory tests, and FDA-approved drugs (subject to copay); 80% of medical care for the diagnosis of infertility
Diabetes Testing and Treatment	100% of R&C coverage (Adults 19+)

Diagnostic Screening & Treatment of Prostatic Cancer	100% of R&C coverage
Bone Mineral Density Measurements, Testing, and Treatment	100% of R&C coverage for men & women meeting eligibility requirements
Diagnosis & Treatment of Eating Disorders	100% of R&C coverage if in-patient treatment; 80% of R&C after deductible if out-patient treatment
Diagnosis & Treatment of Autism Spectrum Disorder	100% of R&C coverage if in-patient treatment; 80% of R&C after deductible if out-patient treatment
Abdominal Aortic Aneurysm Screening	100% of R&C coverage (men ages 65-75)
Immunizations	100% of R&C coverage (adults 19+)
Cholesterol Abnormality Screening	100% of R&C coverage
Depression Screening	100% of R&C coverage (adults and adolescents)
Congenital hyperthyroidism screen	100% of R&C coverage (children less than 1 year of age)
Hearing Loss Screening	100% of R&C coverage (children less than 1 year of age)
Flu Vaccinations	100% of R&C coverage
HIV Screening	100% of R&C coverage
Gonorrhea, Syphilis, and Chlamydia infection screen	100% of R&C coverage
Hepatitis B screening	100% of R&C coverage (women only)
Sexually Transmitted Infection (STI) Counseling	100% of R&C coverage (adults and adolescents)
Obesity Screening and Counseling	100% of R&C coverage
Healthy Diet Counseling	100% of R&C coverage (adults 19+)
High Blood Pressure Screening	100% of R&C coverage (adults 18+)
Phenylketonuria (PKU) Screening	100% of R&C coverage (newborns)
Sickle Cell Screening	100% of R&C coverage (newborns or infants less than 1 year of age)
Reduce Alcohol Misuse - Screening and Counseling	100% of R&C coverage
Drug Use Assessment Screening and Counseling	100% of R&C coverage
Tobacco Use Counseling	100% of R&C coverage (adults)
PRESCRIPTION DRUG PLAN	
Prescription through Medical Plan	80% of R&C after deductible
Prescription Drug card	
Option 1	$1 copay
Option 2	$5 copay
Option 3	$5 copay for generics/$10 copay for brand drugs
Option 4	20% coinsurance per prescription up to the first $100; then 100% coverage
Option 5	$7 copay
Option 6	$10 copay
Option 7	$5/$10 with $250 deductible
Option 8	$3/$10/$20 Copays
Option 9	$7/$15/$35 Copays
Option 10	$10/$20 Copays
Option 11	$10/$20/$40 Copays
Options 12	20% Coinsurance per prescription up to the first $250, then 100% coverage

DENTAL PLAN	
Deductible	None
Maximums	$1,500 per year per person/ $1,000 lifetime orthodontia
Preventive/Diagnostic	90% of R&C coverage
Restorative/Endo/Periodontics	80% of R&C coverage
Prosthodontics	50% of R&C coverage
Orthodontia	50% of R&C coverage
VISION PLAN	
In Network Option A	100% coverage for exam, frames, and lenses after $15 copay. Services limited to once per 24 months.
In Network Option B	100% coverage for exam, frames, and lenses after $25 copay. Services limited to once per 12 months.
Out-of-Network	100% coverage up to scheduled maximum for exam, frames and lenses. Option A services limited to once per 12 months. Option B services limited to once per 12 months

This is a brief summary of the benefits available. A complete description of your benefits, including any additional provision or limitations is contained in the body of this document.

A list of all Preventive Services will be made available to a member upon request.

SUMMARY OF BENEFITS POINT OF SERVICE MEDICAL PLAN SUMMARY – MANAGED CARE OPTION		
	IN-NETWORK BENEFIT*	**OUT OF NETWORK BENEFIT****
Annual Deductible		
Single	None	$250
Family	None	$500
Coinsurance	N/A	20%
Annual Out of Pocket Maximum	N/A	$2,000 Single/$4,000 Family
Ambulatory Care (Diagnostic X-ray Diagnostic Laboratory)	$10 Copay Covered in full – *must utilize Quest labs*	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Inpatient Hospital	Covered in full	80% of Fee Schedule after deductible
Inpatient Mental Health; Chemical Abuse or Dependence	Covered in full	80% of Fee Schedule after deductible
Outpatient Mental Health	$10 Copay	80% of Fee Schedule after deductible
Ambulance Services	$50 Copay	80% of Fee Schedule after deductible
Chiropractic Care	$10 Copay	80% of Fee Schedule after deductible
Outpatient Chemical Abuse or Dependence Treatment	$10 Copay	80% of Fee Schedule after deductible
Inpatient Physician	Covered in full	80% of Fee Schedule after deductible
Outpatient Physician	$10 Copay	80% of Fee Schedule after deductible
Surgery Physician Charges Facility Charges	Covered in full ($10 Copay if performed in a physician's office)	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Annual OB/GYN & Maternity Care	$10 Copay	80% of Fee Schedule after deductible
Preventive Care Adult Physical Well Child Care	$10 Copay Covered in full (includes physicals as well as labs, routine vision, and services related to preventive visit)	No Coverage 80% of Fee Schedule after deductible
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	$10 Copay; Full coverage for chemoprevention of breast cancer	80% of Fee Schedule after deductible
Skilled Nursing Facility Services	Must be pre-authorized. Covered in full; limited to 50 days per year regardless of in/out of network.	Must be pre-authorized. 80% of Fee Schedule after deductible
Preadmission Testing	Covered in full	80% of Fee Schedule after deductible
Emergency Room Services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services

	services	
Home Care Services	$10 Copay	80% of Fee Schedule after deductible
Second Surgical Opinion	Covered in full	80% of Fee Schedule after deductible
Second Cancer Opinion	Covered in full	Covers specialist actual charge.
Hospice Care Services	Covered when medically necessary.	
Mammography Screening	Covered in full	
Mastectomy	Covered in full	80% of Fee Schedule after deductible
Reconstructive Surgery Post Mastectomy	Covered in full	80% of Fee Schedule after deductible
Infertility Treatment	100% Hospitalization and surgical care, lab tests and FDA drugs. See Section III for more details.	
Diabetes Testing & Treatment	Covered in full (Adults 19+)	
Diagnostic Screening & Treatment of Prostatic Cancer	Covered in full	
Bone Mineral Density Measurements, Testing, and Treatment	Covered in full – See Part III for eligibility requirement	
Diagnosis & Treatment of Eating Disorders	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Diagnosis & Treatment of Autism Spectrum Disorder	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Abdominal Aortic Aneurysm Screening	Covered in full (men ages 65-75)	80% of Fee Schedule after deductible
Immunizations	Covered in full (adults 19+)	80% of Fee Schedule after deductible
Cholesterol Abnormality Screening	Covered in full	80% of Fee Schedule after deductible
Depression Screening	Covered in full	80% of Fee Schedule after deductible
Congenital hyperthyroidism screen	Covered in full (children less than 1 year of age)	80% of Fee Schedule after deductible
Hearing Loss Screening	Covered in full (children less than 1 year of age)	80% of Fee Schedule after deductible
Flu Vaccinations	Covered in full	80% of Fee Schedule after deductible
HIV Screening	Covered in full	80% of Fee Schedule after deductible
Gonorrhea, Syphilis, and Chlamydia infection screen	Covered in full	80% of Fee Schedule after deductible

Hepatitis B screening	Covered in full (women only)	80% of Fee Schedule after deductible
Sexually Transmitted Infection (STI) Counseling	Covered in full (adults and adolescents)	80% of Fee Schedule after deductible
Obesity Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Healthy Diet Counseling	Covered in full (adults 19+)	80% of Fee Schedule after deductible
High Blood Pressure Screening	Covered in full (adults 18+)	80% of Fee Schedule after deductible
Phenylketonuria (PKU) Screening	Covered in full (newborns)	80% of Fee Schedule after deductible
Sickle Cell Screening	Covered in full (newborns and infants less than 1 year of age)	80% of Fee Schedule after deductible
Reduce Alcohol Misuse - Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Drug Use Assessment Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Tobacco Use Counseling	Covered in full (adults)	80% of Fee Schedule after deductible

PRESCRIPTION DRUG PLAN	
Prescription Drug Card	**Up to a 30 day Retail Supply**
Option 5	$7 copay
Option 6	$10 copay
Option 7	$5/$10 with $250 deductible
Option 8	$3/$10/$20 Copays
Option 9	$7/$15/$35 Copays
Option 10	$10/$20 Copays
Option 11	$10/$20/$40 Copays
Option 12	20% Coinsurance per prescription up to the first $250, then 100% coverage
Option 13	$7/$15 copay
Option 14	$5/$10/$25 copay

** Member must select a Primary Care Physician (PCP) from the In-network Providers of the Medical Administrator** Out-of-Network benefits are paid by the Plan if a receives care from a non-participating provider.*

This is a brief summary of the benefits available. Not all districts offer all benefits. Please check with your district for your benefit eligibility. A complete description of the benefits, including any additional provision or limitations. contained in the body of this document.

A list of all Preventive Services will be made available to a member upon request.

SUMMARY OF BENEFITS PREFERRED PROVIDER ORGANIZATION MEDICAL PLAN SUMMARY – MANAGED CARE OPTION		
	IN-NETWORK BENEFIT - PPO*	**OUT OF NETWORK BENEFIT****
Annual Deductible		
Single	None	$250
Family	None	$500
Coinsurance	N/A	20%
Annual Out of Pocket Maximum	N/A	$2,000 Single/$4,000 Family
Ambulatory Care (Diagnostic X-ray Diagnostic Laboratory)	$10 Copay Covered in full – *must utilize Quest labs*	80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Inpatient Hospital	Covered in full	80% of Fee Schedule after deductible
Inpatient Mental Health; Chemical Abuse or Dependence	Covered in full	80% of Fee Schedule after deductible
Outpatient Mental Health	$10 Copay	80% of Fee Schedule after deductible
Ambulance Services	$50 Copay	80% of Fee Schedule after deductible
Chiropractic Care	$10 Copay	80% of Fee Schedule after deductible
Outpatient Chemical Abuse or Dependence Treatment	$10 Copay	80% of Fee Schedule after deductible
Inpatient Physician	Covered in full	80% of Fee Schedule after deductible
Outpatient Physician	$10 Copay	80% of Fee Schedule after deductible
Surgery Physician Charges Facility Charges	Covered in full	 80% of Fee Schedule after deductible 80% of Fee Schedule after deductible
Annual OB/GYN & Maternity Care	$10 Copay	80% of Fee Schedule after deductible
Preventive Care Adult Physical Well Child Care	$10 Copay Covered in full (includes physicals as well as labs, routine vision, and services related to preventive visit)	No Coverage 80% of Fee Schedule after deductible
Therapy (Chemo, Phys., Radiation, Resp., Occ.)	$10 Copay; Full coverage for chemoprevention of breast cancer	80% of Fee Schedule after deductible
Preadmission Testing	Covered in full	80% of Fee Schedule after deductible
Emergency Room Services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services	$50 Copay- waived if admitted. Additional $50 copay for non-emergency use of emergency room services
Home Care Services	365 Visits @ $10 Copay	80% of Fee Schedule after deductible
Second Surgical Opinion	Covered in full	80% of Fee Schedule after deductible
Skilled Nursing Facility Services	Must be pre-approved; Covered in full	Must be pre-approved; 80% of Fee Schedule after deductible

Second Cancer Opinion	Covered in full	Covers specialist actual charge.
Hospice Care Services	Covered when medically necessary.	Covers specialists' actual charges.
Mammography Screening	Covered in full	
Mastectomy	Covered in full	
Reconstructive Surgery Post Mastectomy	Covered in full	80% of Fee Schedule after deductible
Infertility Treatment	100% Hospitalization and surgical care, lab tests and FDA approved drugs. See Section III for more details.	
Diabetes Testing & Treatment	Covered in full (Adults 19+)	
Diagnostic Screening & Treatment of Prostatic Cancer	Covered in full	
Bone Mineral Density Measurements, Testing, and Treatment	Covered in full – Where eligibility requirements are met.	
Diagnosis & Treatment of Eating Disorders	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Diagnosis & Treatment of Autism Spectrum Disorder	Inpatient- Covered in full Outpatient- $10 co-pay	Inpatient- 80% of Fee Schedule after deductible Outpatient- 80% of Fee Schedule after deductible
Abdominal Aortic Aneurysm Screening	Covered in full (men ages 65-75)	80% of Fee Schedule after deductible
Immunizations	Covered in full (adults 19+)	80% of Fee Schedule after deductible
Cholesterol Abnormality Screening	Covered in full	80% of Fee Schedule after deductible
Depression Screening	Covered in full	80% of Fee Schedule after deductible
Congenital hyperthyroidism screen	Covered in full (children less than 1 year of age)	80% of Fee Schedule after deductible
Hearing Loss Screening	Covered in full (children less than 1 year of age)	80% of Fee Schedule after deductible
Flu Vaccinations	Covered in full	80% of Fee Schedule after deductible
HIV Screening	Covered in full	80% of Fee Schedule after deductible
Gonorrhea, Syphilis, and Chlamydia infection screen	Covered in full	80% of Fee Schedule after deductible
Hepatitis B screening	Covered in full (women only)	80% of Fee Schedule after deductible
Sexually Transmitted Infection (STI) Counseling	Covered in full (adults and adolescents)	80% of Fee Schedule after deductible
Obesity Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Healthy Diet Counseling	Covered in full (adults 19+)	80% of Fee Schedule after deductible
High Blood Pressure Screening	Covered in full (adults 18+)	80% of Fee Schedule after deductible
Phenylketonuria (PKU) Screening	Covered in full (newborns)	80% of Fee Schedule after deductible

Sickle Cell Screening	Covered in full (newborns and infants less than 1 year of age)	80% of Fee Schedule after deductible
Reduce Alcohol Misuse - Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Drug Use Assessment Screening and Counseling	Covered in full	80% of Fee Schedule after deductible
Tobacco Use Counseling	Covered in full (adults)	80% of Fee Schedule after deductible
PRESCRIPTION DRUG PLAN		
Prescription Drug Card	**Up to a 30 day Retail Supply**	
Option 5	$7 copay	
Option 6	$10 copay	
Option 7	$5/$10 with $250 deductible	
Option 8	$3/$10/$20 Copays	
Option 9	$7/$15/$35 Copays	
Option 10	$10/$20 Copays	
Option 11	$10/$20/$40 Copays	
Option 12	20% Coinsurance per prescription up to the first $250, then 100% coverage	
Option 13	$7/$15 copay	
Option 14	$5/$10/$25 copay	

***Out-of-Network benefits are paid by the Plan if a member receives care from a non-participating provider.*

This is a brief summary of the benefits available. Not all districts offer all benefits. Please check with your district for your benefit eligibility. A complete description of the benefits, including any additional provision or limitations. contained in the body of this document.

A list of all Preventive Services will be made available to a member upon request.

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