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

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:
Eligibility • 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. 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 • Claim Forms (Post service claims) • Plan Benefit Information • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage	To request a claim form, contact your School District Health Benefits Representative. Submit claims to: SWSCHP P.O. Box # 5035 White Plains, New York 10602-5035 To file an Appeal, contract: Coordinated Health/Care (CHC) Appeals Department 1215 Polaris Parkway, Suite 229 Columbus, OH 43240-2037 Phone: 1-888-779-7247 To request a Certificate, call 1-888-P SWSCHP (779-7247).
Preferred Provider Organization (PPO) Network • Medical Network Provider Directory • Additions/Deletions of Network Providers **Point of Service (POS) Network** POS Network effective July 1, 2012 for all Members residing in the 28 Southern Counties of New York State	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. 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.
Care Coordination Program • Precertification of Admissions and Medical Services • Case Management • Appeals of decisions	Coordinated Health/Care (CHC) 1215 Polaris Parkway, Suite 229 Columbus, OH 43240-2037 Phone: 1-888-779-7247 SWSCHP.org
Prescription Drug Plan • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs	Mail Order: Medco Health Solutions Inc. P.O. Box 650322 Dallas, TX 75265-0322 1-800-711-0917 If you need to submit a claim, send it to: Medco Health Solutions, Inc. P.O. 14711

FOR INFORMATION ON:	YOU SHOULD CONTACT:
• Direct Member Reimbursement (for Non-network retail pharmacy use) • Specialty Drug Program: Precertification and Ordering • Submit claims and appeals	Lexington, KY 40512 Website: Medco.com For prior approval, call Medco Member Services at 1.800.711.0917.
COBRA Administrator • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification	You should contact your School District Health Benefits Representative at your Participating Employer.
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice **Level Two Appeals/Grievances**	Norm Freimark Executive Director State-Wide Schools Cooperative Health Plan 12 Metro Park Road Suite 208 Colonie, NY 12205-1139 1-800-814-6265 NFSWSCHP@hotmail.com

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.

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 Participant (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 amount the Plan allows as payment for eligible Medically Necessary 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.

With respect to Emergency Services in an Out-of Network Emergency Room, Allowed Amount means either the negotiated rate or charges.

If the health care provider's/facility's actual billed charge is less than what is listed in the two items 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. Participants 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 lay person 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 licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by Registered Nurses when patients are there and does not provide for overnight stays.

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. Member 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 Plan Participant 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. Typically, In-Network providers do not balance bill except in situations of third-party liability claims. 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, usually represented as a fixed percentage. See the subsection entitled "Coinsurance" contained in the "Out-of-Network/Non-Participating Medical Expense Benefits Cost Sharing" section for further details.

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.

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 an Employee, Member, Retiree or Dependent who has completed all required formalities for enrollment for coverage under the Plan and is actually covered under this Plan.

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. 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:

1. An Employee's spouse, to whom the Employee is legally married.

2. 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.

3. 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.

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:

(1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(2) Serious impairment to such person's bodily functions;

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

(4) Serious disfigurement of such person.

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. Emergency Services are not subject to prior authorization requirements.

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

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 Care Coordination 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 Care Coordination 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 Phase II and III of qualifying 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. Routine costs of a clinical trial include all supplies and services that are otherwise generally covered under the Plan, and are not excluded, provided in either the Experimental or the control arms of a clinical trial, except:

- The investigational supply or service itself, unless otherwise covered outside of the clinical trial;

- Supplies and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); and

- Items and services customarily provided by the research sponsors free of charge for any person in the trial.

Routine costs in clinical trials generally include:

- Supplies or services that are typically provided absent a clinical trial (e.g., conventional care);

- Supplies or services required solely for the provision of the investigational supply or service (e.g., administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the supply or service, or the prevention of complications; and

- Supplies or services needed for reasonable and necessary care arising from the provision of an investigational supply or service in particular, for the diagnosis or treatment of complications.

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 Care Coordination Program section of this Plan Document.

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.

Health Care Practitioner 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. 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 Services and Supplies are those provided through a Hospice Organization and under a Hospice Care Plan, and include Inpatient care in a Hospice Unit or other licensed facility, home care and family counseling during the bereavement period.

Hospice Organization is an organization or agency which has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the Hospice Organization must have an operating certificate issued, under criteria similar to those used in New York, by a state agency in the state where the Hospice Care is provided.

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, on an Inpatient basis, diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick Persons by or under the supervision of a staff of Physicians; and

(2) is not a school, college or camp infirmary; and

(3) gives ongoing 24 hours a day nursing service by or under the supervision of Registered Nurses;

(4) is not, other than incidentally:

a) a place of rest;
b) a place for the aged or nursing home;
c) a place for drug addicts;
d) a place for alcoholics;
e) a hemodialysis center;
f) a place for the treatment of tuberculosis or mental disorders; or
g) a nursing home or similar institution.

This definition shall apply even though the term "Hospital" may have a different meaning in other legal contexts.

Hospital, Private Proprietary is an institution, other than a general or public Hospital, which:

(1) is properly licensed or permitted legally to operate as a facility for the Inpatient treatment of mental and nervous conditions and/or chemical dependence; and

(2) is approved by the Plan as a legitimate provider of services; and

(3) is not a Skilled Nursing Facility; and

(4) is not, other than incidentally, a place for the aged or nursing home.

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:

(1) the date a purchase is contracted;

(2) the date delivery is made; or

(3) the actual date a service is rendered.

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:

(1) facilities for special nursing care not available in regular rooms and wards of the Hospital;

(2) special life-saving equipment that is immediately available at all times;

(3) at least two beds for the accommodation of the critically ill; and

(4) at least one Registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

Lifetime Maximum Benefit is the maximum dollar amount payable by the Plan, under the Medical Benefits portion, for covered services. It applies to You as the Employee and each Dependent of the Member, separately.

Medically Necessary

A. A medical service or supply will be determined to be “Medically Necessary” or “Medical Necessity” by the Plan if it:

1. 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

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

3. 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.

B. A medical service or supply will be considered to be “Appropriate” if:

1. 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

2. 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.

C. A medical service or supply will be considered to be "Cost-Efficient" if it is no more costly 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:

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

Mental Health Disorder 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 Disorders that are covered by the Plan include:

Biologically based mental illness: A mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant psychological syndrome or pattern that substantially limits the functioning of the person with the illness. The following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

Children with serious emotional disturbances: Those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that places the child at substantial risk of removal from the household.

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 Provider means a hospital defined by Section 1.03(10) of the Mental Hygiene Law, a facility issued an operating certificate by the Commissioner of Mental Health, a facility operated by the Office of Mental Health, a facility operated by the Office of Mental Health, a psychiatrist or psychologist, or a professional cooperation or university facility practice corporation.

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 means the yearly out-of-pocket Coinsurance maximum that 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 Dependent who has satisfied the eligibility requirements and is covered under this Plan.

Participating Employer refers to the School Districts participating in SWSCHP.

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

Pregnancy is childbirth and conditions associated with Pregnancy including complications.

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).

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 refers to You, the Employee, upon retirement under the conditions set forth by Your Participating Employer.

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

Skilled Nursing Facility (SNF) is a facility that fully meets ALL of these tests:

(1) It is licensed to provide for persons convalescing from Injury or Sickness and provides professional nursing services on an Inpatient basis.

These services must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse.

Physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation from its patients and under the full-time supervision of a Physician or a Registered Nurse.

(3) It provides 24 hours a day nursing services by Licensed Practical Nurses, under the direction of a full-time Registered Nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for:

- Rest
- Alcoholics
- The Aged
- The Mentally Retarded
- Drug Addicts
- Custodial or Educational Care
- Care of Mental Health Disorders

(7) It is approved and licensed by Medicare or is accredited as a Skilled Nursing Facility.

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) Six 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) Six 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 six 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.

Spell of Illness or Injury begins separately on the first day the Participant is admitted to a Hospital, Birthing Center or Skilled Nursing Facility; or the Participant receives Home Health Care. A Spell of Illness ends when the Participant 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.

Total Disability (Totally Disabled) is a physical state of a Participant resulting form 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 Claim See the Claim Filing and Appeal Information section for the definition.

Urgent Care Facility is a private Hospital-based or free-standing facility 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.

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 You and Your Dependents

Initial Eligibility: Your (the Employee) 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 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 QMSCOs 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. A member 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 including 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. 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 a 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 health

care 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.

HIPAA Certification of Creditable Coverage When Coverage Ends

When your medical coverage ends, you and/or your Covered Dependents are entitled by law to and will automatically be provided, with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your Covered Dependent(s) has ended. In addition, such a certificate will be provided upon receipt of a request for such a certificate that is received by the Plan within two years after the date coverage ended.

Procedure for Requesting and Receiving a Certificate of Creditable Coverage: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Plan within two years after the date coverage ended under this Plan. The written request must be mailed to the SWSCHP at the address found in the "Contact Information" at the beginning of this Plan Document and should include the names of the individuals for whom a certificate is requested (including spouse and Dependent children) and the address where the certificate should be mailed. A copy of the certificate will be mailed by the Plan to the address indicated. See the COBRA section for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

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.

A summary of the Plan's cost-sharing provisions are described in the chart entitled "Overview of Deductibles, Coinsurance, Copayments and Annual Out-of-Pocket Maximums". Please refer to the Schedule of Preventive Services and the Schedule of Benefits for details on how and when specific cost-sharing provisions apply.

CARE COORDINATION PROCESS

Introduction

The Plan incorporates a "Care Coordination" process based on a program called Coordinated Health/Care. This program includes a staff of Care Coordinators who receive a notification regarding most healthcare services sought by Covered Persons, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Persons obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and for early identification of complex medical conditions. The Care Coordinators are available to Covered Persons and their providers for information, assistance, and guidance, and can be reached toll-free by calling Care Coordinators at 1-888-P SWSCHP (779-7247).

PROCESS OF CARE STANDARDS

Overview

Designated Coordinating Physician

Upon enrollment, all Covered Persons are asked to designate a coordinating Primary Care Physician (PCP) for each member of their family. While such designation is not mandatory, it is strongly recommended. To ensure the highest level of benefits, all Covered Persons should designate an in-network primary care Physician to be their coordinating Physician.

It is recommended that the Covered Person begin every healthcare event with a call or visit to their designated PCP, who will issue a referral for specialty care as required. However, referral notices can be submitted by any PCP, including non-network providers. Please note: an office visit to a non-network PCP would be covered at the non-network benefit level. The referral will be authorized for a certain time period, number of visits, or number of units, as requested by the PCP. During the authorized period, further referrals are not required for additional visits or treatments associated with the initial referral.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from an In-Network Provider who specializes in obstetrics or gynecology. The In-Network Provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

The Schedule of Benefits included in this Plan Document specifies the Copayment differential that occurs for specialty services that are received without an authorized specialty referral from a PCP in place.

The Care Coordination process generally begins with the "Coordinating Physician," who is a Primary Care Physician and who maintains a relationship with the Covered Person and provides general healthcare guidance, evaluation, and management. The following types of Physicians can be selected by Covered Persons as their coordinating PCP:

- Family Physician
- General Practice
- Internal Medicine
- Pediatrician (for children)
- An OB/GYN may serve as a primary care Physician ONLY during the course of a woman's pregnancy

Covered Persons should begin all healthcare events or inquiries with a call or visit to their designated PCP, who will guide patients as appropriate. In addition to providing care coordination and submitting referral and pre-certification requests, the designated PCP will also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance. If you have trouble obtaining access to a PCP, the Care Coordinators may be able to assist you by providing a list of available PCPs and even contacting the PCP offices on your behalf. Please contact the Care Coordinators at 1-888-779-7247.

In order to receive the highest benefits available in the Plan, Covered Persons must follow the "Care Coordination Process" outlined in this section. In some cases, failure to follow this process of care can result in significant benefit reductions, penalties, or even loss of benefits for specific services. The Care Coordination Process generally includes:

- Designating a coordinating Physician (Primary Care Physician, referred to as the PCP)

- Review and coordination process, including:

    - Referrals from a PCP for all visits to specialist Physicians
    - Pre-certification of certain procedures
    - Utilization Review
    - Concurrent Review of Hospitalization and courses of care
    - Case Management

As described below, referral and pre-certification authorizations are generally requested by the providers on behalf of their Covered Persons.

Use of In-Network Providers and 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 and Coinsurance as well as to Balance Billing on billed charges that exceed the Allow Amounts. Specific benefit levels are shown in the Schedule of Benefits (in the following section of this Plan Document).

Review and Coordination Process

The Care Coordination process includes the following components:

1. Referrals for Specialty Care

   To receive the highest level of benefits under the Plan, Covered Persons must receive an authorized referral from a PCP to any specialty Physician or other healthcare provider before visiting the specialist. The PCP is responsible for submitting the referral notice with all required information to the Care Coordinators, who will process the referral and notify the PCP's office upon authorization. PCP offices are provided with materials and education regarding this referral process. While the referral process is initiated by the PCP, the Covered Person is ultimately responsible for ensuring that the referral authorization is in place before the specialty visit. Whenever possible, notice of this referral is sent to the Covered Person; however, Covered Persons can verify that the referral is in place by calling the Care Coordinators at 1-888-779-7247 or visiting the SWSCHP website at SWSCHP.org. Referrals submissions will not be accepted after the specialty service has been provided. Please refer to Emergency Admissions and Procedures for additional information regarding those circumstances.

2. Pre-Certification of Certain Procedures

   To be covered at the highest level of benefit and to ensure complete Care Coordination, 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 Care Coordinators 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 Care Coordinators 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. If a pre-certification request does not meet Plan criteria, the Care Coordinators will contact the Covered Person and healthcare provider and assist in redirecting care if appropriate.

The following services require pre-certification:

- Acupuncture
- Artificial Reproduction
- Biofeedback
- Dialysis
- Durable Medical Equipment (rentals or purchases over $500)
- Home Health Care (Includes Home Infusion Therapy)
- Hospice Care
- In-Patient Admissions
- MRI/MRA/PET Scans
- Occupational Therapy
- Oncology Care/Services (Chemotherapy, Radiation, Therapy, etc.)
- Organ/Bone Marrow Transplants
- Private Duty Nursing
- Physical Therapy
- Speech Therapy
- Surgery and/or Surgical Procedures (including transplants and all biopsies, In-patient or Out-patient, but not including surgeries done in the doctor's office)
- TMJ Procedures

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.

3. Time of Notice

   The referral and pre-certification notifications must be made to Coordinated Health/Care within the following timeframe:

   - At least four (4) business days, before a scheduled (elective) Inpatient Hospital admission; or
   - Upon being identified as a potential organ or tissue transplant recipient.

4. Utilization Review

Coordinated Health/Care has a utilization review process to determine whether healthcare services provided to Covered Persons are Medically Necessary. Utilization Review is conducted by a utilization review agent, who may be:

- Administrative Personnel trained in the principles and procedures of intake screening and data collection. Administrative Personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed Health Care Provider;
- A Health Care Provider who is appropriately trained in utilization reviews principles, procedures and standards. A Health Care Provider who is not a clinical peer reviewer may not render an adverse determination;
- A clinical peer reviewer, where the review involves an adverse determination.

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.

5. 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 Claims and Appeals section for information on how to file an appeal of an adverse determination (a denial of benefits).**

6. Concurrent Review

   The Coordinated Health/Care 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. The Care Coordinators will communicate 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, and conducted in accordance with the utilization criteria adopted by the Plan and Coordinated Health/Care.

7. 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.

General Provisions for Care Coordination

A. Authorized Representative

The Covered Person is ultimately responsible for ensuring that all referrals and 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 referral and pre-certification process will be executed by the Covered Person's Physician(s) or other providers on behalf of the Covered Person. By subscribing to this Plan, the Covered Person authorizes the Plan and its designated service providers (including Coordinated Health/Care, 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 Care Coordination. 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 the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process comply with all state and federal regulations regarding utilization review for maternity admissions. Because inpatient hospitalization is involved, pre-certification for maternity purposes needs to be provide as soon as possible. However, 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.

D. Care Coordination is not a guarantee of payment of benefits

The Care Coordination 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. The Care Coordination approvals do not indicate that the service is a covered benefit, that the Covered Person is eligible for such benefits, or that other benefit conditions such as copay, Deductible, co-insurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

E. Result of not following the Care Coordinated Process

Failure to comply with the Care Coordination “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 Care Coordination 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 Care Coordination, benefits will be denied in whole or part.

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses 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 by the Plan and not excluded from coverage (as provided in the Exclusions section of this Plan Document); and
3. 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).

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 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 Care Coordination 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). **Remember,** because providers are added to and dropped from the Network periodically throughout the year, you should contact Coordinated Health/Care each time **BEFORE** you seek services.

OVERVIEW OF DEDUCTIBLES, COINSURANCE, COPAYMENTS, AND ANNUAL OUT-OF-POCKET MAXIMUMS

This chart only provides a brief overview of the items listed above. For full details, including restrictions and limitations, see the provisions following this chart and the Schedule of Benefits. No benefits are payable that are not specifically listed in the Schedule of Benefits

Care Coordination Program: ☎This program requires a phone call to pre-certify before the member is admitted to a Hospital, or within 48 hours of an emergency admission, or before certain procedures are scheduled to be performed. Where such precertification is required, you will see the ☎ in the Schedule of Benefits.

Deductibles	**Coinsurance**	**Copayments**	**Annual Out-of-Pocket Maximums**
The amount you must pay each calendar year before the Plan pays benefits.	How you and the Plan will split the cost of certain covered medical expenses, after the Deductible is met. Coinsurance generally applies to Out-of-Network Medical Benefits.	A set dollar amount you pay for certain services while the Plan may pay the rest or most of the rest of the cost of that service. Copayments generally apply to In-Network benefits and Outpatient Hospital Facilities (whether received In or Out-of-Network).	The maximum amount of Coinsurance that you are responsible for paying each calendar year, in addition to the Deductible, **before** the Plan pays 100% of your covered Eligible Medical Expenses. **Some Out-of-Pocket expenses are not subject to this maximum.**
In-Network: None **Out-of-Network:** Per Individual: $300 Per Family: $900	**In-Network** Copayments apply **Out-of-Network:** ***Outpatient Hospital Facility*** N/A ***Medical Benefits*** • The Plan pays 70% Allowed Amount • You pay 30% of the Allowed Amount, plus you may be liable for the balance up to the actual charges. See the definition of Balance Billing in the Defined Terms of this Plan Document.	**In-Network:** • Inpatient Hospital - $100 per admission • Emergency Room - $60 Copayment • Ambulance - $50 Copayment • Outpatient Hospital Facility - $25 Copayment per visit for surgery, diagnostic x-rays and laboratory tests; mammography, and administration of Deferral for Cooley's Anemia (this $25 Copayment is waived if the Covered Person is admitted as an Inpatient) • Preventive Services – No Copayment • Primary Care Physician (PCP) - $10 Copayment/visit • Specialist Physician /Medical Professional with PCP referral - $15 Copayment/office visit • Specialist Physician/Medical Professional without PCP referral - $25 Copayment/office visit • Physician/Medical Professional Service (treatment) in any setting - $25 Copayment/visit. **Out-of-Network:** Coinsurance usually applies.	**In-Network:** N/A **Out-of-Network*:** $1,000/person or family* $2,000/person or family effective January 1, 2013 ***Some Out-of-Pocket expenses are not subject to this maximum. See the following text for details and the definition of "Balance Billing" in the Defined Terms section of this Plan Document.**

PARTICIPATING PROVIDERS/IN-NETWORK SERVICES

Participating Providers or 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. The claim form is sent in by the Provider after you have completed your information and signed it. You will receive an Explanation of Benefits (EOB) form, which will tell you what benefits the Participating Provider rendered. 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.

Copayment/Copay

The Copayment is the fixed amount applicable to certain services for which you have financial responsibility. The Plan's Copayments are summarized in the Overview chart on the prior page and listed specifically for each benefit where applicable in the Schedule of Benefits. Copayments generally apply to all Hospital (both Inpatient and Outpatient Hospital facility expenses) and In-Network Medical Benefits. Copayments are not used to satisfy the Deductible or out-of-pocket maximum. Copayments will continue to be your responsibility even after you reach your annual Out-of-Pocket maximum. 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.

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. 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.

Deductible

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. It does not apply to any Hospital (whether Inpatient and Outpatient Hospital facility expense), or In-Network benefits, or retail and mail order prescription drug Copayments and Coinsurance. Expenses for these benefits do not 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 and then the Plan begins to pay benefits. 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.

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. 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.

Coinsurance

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. You are responsible for the 30% balance, known of as Coinsurance.

Maximum Out-of-Pocket Expenses

Each Calendar Year, after an individual or family has incurred a maximum Out-of-Pocket cost for Coinsurance of $1,000 for any individual or a family, no further Coinsurance will apply to Out-of-Network covered Eligible Medical Expenses. ***This amount will increase to $2,000 per year effective January 1, 2013.*** As a result, the Plan will pay 100% of Eligible Medical Expenses, except for 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 maximum 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 maximum:

1. Any Plan Deductible or Copayment (including those for prescription drugs).

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 Care Coordination 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.

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 on an **in-network** basis only, 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.

In-Network Preventive Services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the Employee or Dependent. This means that the In-Network service will be covered at 100% of the Plan's network allowance, with no Coinsurance, Copayment, or Deductible.

If you do not use an In-Network provider, Out-of-Network benefits for certain limited preventive services are payable subject to the limits applicable to the Routine Adult Care, as well as any applicable Copayment, Coinsurance and/or Deductible, as described in the following Schedule of Preventive Benefits.

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.

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).

Care Coordination requirements will still apply to Preventive Services.

Office Visit Coverage

Preventive Services are paid for based on the Plan's Schedule of Preventive 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 only covered under the Routine Adult Care Benefits as described in the Schedule of Preventive 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 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. Tobacco cessation products, drugs, or medicine are not covered.
6. 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.

SCHEDULE OF PREVENTIVE BENEFITS		
Benefit Description	**In-Network**	**Out-of-Network**
Routine Adult Care	Benefits are provided for one routine physical examination per calendar year for each Employee and his or her Dependents at 100% of Allowed Amounts. The recommendations of the U.S. Preventive Service Task Force will apply to exams and screening tests, to include colorectal cancer screening as listed under Covered Preventive Services for Adults.	Coverage is provided only for Employees and their Spouses age 50 and over; limited to once per two-year period. Benefits are payable at 100% of Allowed Amounts up to $250 maximum; Deductible and Coinsurance do not apply. Related screening tests are covered according to recommended age-appropriate guidelines up to the allowance for Routine Adult Care. Please note that these services, regardless of ages stated under the Preventive Service Benefits, are only available starting at age 50.
Covered Preventive Services for Adults		
Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.	100% of Allowed Amounts	Payable as part of and up to maximum for Routine Adult Care
Alcohol Misuse screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.	100% of Allowed Amounts	Payable as part of and up to maximum for Routine Adult Care
Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit.	100% of Allowed Amounts	Payable as part of and up to maximum for Routine Adult Care
Breast Cancer Chemoprevention counseling for individuals at higher risk. The Plan will pay for counseling by Physicians with indidivuals at higher risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Cholesterol (Lipid Disorders Screening) for men aged 35 and older; men aged 20-35 if they are at increased risk for coronary heart disease; and women aged 20 and older if they are at increased risk for coronary heart disease.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care

SCHEDULE OF PREVENTIVE BENEFITS		
Benefit Description	**In-Network**	**Out-of-Network**
Colorectal Cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient.	100% of Allowed Amount	70% of Allowed Amount, subject to Deductible
Depression screening for adults	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Diet counseling for adults at higher risk for chronic disease (limited to one time per year)	100% of Allowed Amount	Not covered
HIV screening for all adults at higher risk	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting for all adults	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Syphilis screening for all adults at higher risk of infection	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Tobacco Use screening for all adults and cessation interventions for tobacco users.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Immunization vaccines for adults: Routine adult immunizations are covered for Employees and Dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation. Doses, recommended ages, and recommended populations vary: • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus (HPV). • Influenza • Measles, Mumps, Rubella (MMR) • Meningococcal • Pneumococcal (polysaccharide)	100% of Allowed Amount	70% of Allowed Amount, subject to Deductible HPV vaccine is payable for adults age 19 to 26 only. Influenza vaccine is not subject to Deductible. Influenza shots for Medicare Primary individuals are not payable under the Plan.

SCHEDULE OF PREVENTIVE BENEFITS		
Benefit Description	**In-Network**	**Out-of-Network**
• Poliomyelitis • Tetanus, Diphtheria, Pertussis (DTP) • Varicella		
Preventive Services for Men		
Prostate Cancer Screening: Benefits for diagnostic screening of prostate cancer including 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. An annual standard diagnostic examination and prostate-specific antigen test for men age fifty (50) and over who are asymptomatic and for men age forty (40) and over with a family history or other risk factors of prostate cancer.	100% of Allowed Amount	70% of Allowed Amount, subject to Deductible
Covered Preventive Services for Women, Including Pregnant Women		
Routine OB/GYN Exam annually for women (including well-woman visits to obtain recommended preventive services for women under 65)	100% of Allowed Amount	70% of Allowed Amount, subject to Deductible
Anemia screening on a routine basis for pregnant women	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Breast Cancer Mammography Mammography screening for occult breast cancer performed in a Physician's Office or a Private Facility as follows: • Upon the recommendation of a Physician, a mammogram at any age for Covered Persons having prior history of breast cancer; or who have a first degree relative with a prior history of breast cancer; • a single baseline mammogram for Covered Persons aged thirty-five through thirty-nine, inclusive; and an annual mammogram for Covered Persons aged forty and older. Mammography screening means an x-ray examination of the breast using dedicated equipment, including: x-ray tube; filter; compression device; screens; films; and cassettes; with an average glandular radiation dose less than 0.5 per view, per breast.	100% of Allowed Amount	Outpatient Hospital: $25 Copayment Non-Hospital Setting: 70% of Allowed Amount after Deductible

SCHEDULE OF PREVENTIVE BENEFITS		
Benefit Description	**In-Network**	**Out-of-Network**
BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling.	100% of Allowed Amount	Not covered
Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by Physicians with women at higher risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Breast Feeding interventions to support and promote breast-feeding. Breast feeding intervention is not payable as a separate claim, because the service is included in the payment for a Physician or OB/GYN visit.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Cervical Cancer screening for sexually active women who have a cervix at internals to be determined by the Plan based on age and whether the women has had adequate recent screening with normal Pap results. Annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older performed in the Outpatient clinic or the Physician's office. The screening may include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. As part of a routine cervical cancer screening, the Plan will pay for HPV-DNA test for women age 30 and older. Coverage will be based on the frequency guidelines recommended by the American College of Obstetricians and Gynecologists (ACOG).	100% of Allowed Amount	70% of Allowed Amount after Deductible Cervical cytology screening (Pap smear and exam) is limited to one per year. New York State Insurance Law guidelines apply to In-Network and Out-of-Network screening.
Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.	100% of Allowed Amount	70% of Allowed Amount after Deductible
Gonorrhea screening for all women for the most cost-effective test methodology only.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Hepatitis B screening for pregnant women at their first prenatal visit.	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care

SCHEDULE OF PREVENTIVE BENEFITS		
Benefit Description	**In-Network**	**Out-of-Network**
Osteoporosis Screening/ Bone Mineral Density: Measures or tests and prescribed drugs and devices approved by the Federal Food and Drug Administration or generic equivalents as approved substitutes. In determining appropriate coverage, the Plan shall use standards which include the criteria of the federal Medicare program and the criteria of the National Institutes of Health for the detection of Osteoporosis. The coverage shall be further determined as follows: • Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual-energy x-ray absorptiometry. • Coverage shall be available for individuals meeting the criteria under the federal Medicare program or the criteria of the National Institutes of Health, provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall at a minimum include individuals: – Previously diagnosed as having Osteoporosis or having a family history of Osteoporosis; or – With symptoms or conditions indicative of the presence, or the significant risk of osteoporosis; or – On a prescribed drug regimen posing a significant risk of Osteoporosis; or – With lifestyle factors to such 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.	100% of Allowed Amount	Outpatient Hospital - $25 Copayment Non-Hospital Setting – 70% of Allowed Amount after Deductible
Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative and follow-up testing for women at higher risk	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Syphilis screening for all pregnant women or other women at increased risk	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users	100% of Allowed Amount	Payable as part of and up to maximum for Routine Adult Care
Additional Preventive Services for Women effective July 1, 2013	*100% of Allowed Amount*	*Payable as part of and up to maximum for*

SCHEDULE OF PREVENTIVE BENEFITS		
Benefit Description	**In-Network**	**Out-of-Network**
• ***Contraception:*** *Patient education and counseling (see the Prescription Drug Program section for information on Food and Drug Administration-approved contraceptive methods).* • ***Domestic and interpersonal violence*** *screening and counseling for all women* • ***Gestational diabetes*** *screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes* • ***Routine Prenatal Visits*** • ***Sexually Transmitted Infections (STI)*** *counseling for sexually active women*		*Routine Adult Care*
Covered Preventive Services for Children		
Visits include the following age-appropriate screenings and assessments: • **Alcohol and Drug Use** assessments for adolescents • **Autism** screening for children at 9, 18 and 24 months • **Behavioral** assessments for children of all ages • **Cervical Dysplasia** screening for sexually active females • **Congenital Hypothyroidism** screening for newborns • **Developmental** screening for children under age 3, and surveillance throughout childhood • **Dyslipidemia** screening for children at higher risk of lipid disorders • **Fluoride Chemoprevention** supplements for children without fluoride in their water source • **Gonorrhea** preventive medication for the eyes of all newborns • **Hearing** screening for all newborns • **Height, Weight and Body Mass Index** measurements for children • **HIV** screening for adolescents at higher risk • **Iron** supplements for children ages 6 to 12 months at risk for anemia. • **Lead** screening for children at risk of exposure • **Medical History** for all children throughout development • **Newborn** screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children • **Obesity** screening for children aged 6 years and older, and counseling	Well baby and well child visits from newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics". 100% of Allowed Amount	Clinical standards of the American Academy of Pediatrics apply to visits through age 18 (to age 19). Coverage for immunizations as determined by New York State, to include the HPV vaccine. 100% of Allowed Amount

SCHEDULE OF PREVENTIVE BENEFITS		
Benefit Description	**In-Network**	**Out-of-Network**
or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status • **Oral Health** risk assessment for young children. Screening for oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. • **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk • **Tuberculin** testing for children at higher risk of tuberculosis • **Vision** screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years		
Immunization vaccines for children from birth to age 19 – doses, recommended ages, and recommended populations must be satisfied: – Diphtheria, Tetanus, Pertussis (DTP) – Haemophilus influenza type b – Hepatitis A – Hepatitis B – Human Papillomavirus (HPV) – Inactivated Poliovirus – Influenza – Measles, Mumps, Rubella (MMR) – Meningococcal – Pneumococcal (polysaccharide) – Rotavirus – Varicella	Immunizations from birth to age 19 as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." 100% of Allowed Amount	Coverage for immunizations as determined by New York State up to age 19, to include the HPV vaccine. 100% of Allowed Amount

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 (a Spell of Illness is explained in the "Defined Terms" section of this Plan Document).☎ 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: • Nursery charges for the routine care of a healthy newborn baby during its initial Hospital confinement will be considered eligible charges under this provision. • Use of Operating, Recovery, Intensive Care and Cystoscopy Room and Equipment, Laboratory and Pathology Examinations • Basal Metabolism Tests • Use of Cardiographic Equipment • Oxygen and use of equipment for its administration • Prescribed Drugs and Medicines • Intravenous Preparations, Vaccines, Sera, and Biologicals. • Blood and/or Blood, and plasma • Use of Transfusion equipment • Dressing and Plaster Casts • X-Ray Examinations, Radiation Therapy and Radioactive Isotopes • Chemotherapy • Anesthesia Supplies, equipment and administration by a Hospital staff employee • Ambulance service when supplied by the admitting Hospital • Treatment of a Mental Health Disorder by Mental Health Provider	100% of Allowed Amount after $100 Copayment per admission Once 365-days are exhausted for one Spell of Illness, benefits continue to be payable at 100% of Allowed Amount **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 Care Coordination section of this Plan Document for details on how pre-certification works.** • Expenses must be recommended and approved by a Physician for the diagnosis of and/or treatment of an illness or injury. • 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. • A Medically Necessary private room is covered. • A separate $100 Copayment will apply if the patient is discharged to a new facility after a covered inpatient Hospitalization.	Once 365-days are exhausted for one Spell of Illness, benefits are payable at 70% of Allowed Amount after Deductible
Inpatient Mental Health Disorder - Mental Disorder Day/Night Care Center or Partial Hospitalization☎	Two days count as one day of Inpatient care in a Hospital.	
Inpatient Chemical Dependence – Detoxification and Rehabilitation☎ • General Hospital or Certified Alcohol/Substance Abuse Facility Program	The Copayment for an admission for rehabilitation is waived during a continuous period of treatment if a $100 Copayment was charges for a preceding Inpatient admission for detoxification.	
Chemical Dependence Day/Night Care Center or Partial Hospitalization ☎	Two days of partial Hospitalization is equal to one day of Inpatient care. The Copayment for an admission for rehabilitation is waived during a continuous period of treatment if a $100 Copayment was charges for a preceding Inpatient admission for detoxification.	

SCHEDULE OF BENEFITS		
Inpatient Hospital Benefits – Facility Charge	**In-Network Benefits**	**Out-of-Network Benefits**
Inpatient Skilled Nursing Facility (SNF)/Rehabilitation Facility Care ☎ Benefits are payable if the following are criteria is met: • Care in a Skilled Nursing Facility must be Medically Necessary. This means that it must be furnished by skilled personnel to assure your safety and achieve the medically desired result. Custodial care, which is care primarily to assist you with the activities of daily living, is not covered. • To determine whether care is Medically Necessary, the Plan uses the federal government's Medicare program guidelines. • Coverage will only be provided for as long as Inpatient Hospital care would have been required if care in a Skilled Nursing Facility was not provided. **The Plan will not pay for benefits in a Skilled Nursing Facility if the Covered Person is eligible to receive primary benefits from Medicare.** Benefits provided include: • *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; • *Skilled nursing service*. Nursing care must be given or supervised by a Registered Nurse; • *Physical, Occupational and Speech Therapy*; • *Medical Social Services*; and • *Drugs, biologicals, supplies, appliances and equipment* furnished for use in the facility and which the facility ordinarily provides to inpatients.	100% of Allowed Amount **☎ Precertification is required** • Two (2) SNF days equal one (1) benefit day • Applies toward the 365 benefit days per Spell of Illness maximum	

SCHEDULE OF BENEFITS		
Hospital Outpatient Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
Emergency Room - Facility charge for Emergency Medical Condition Benefits are payable for Emergency Services provided in Hospital emergency rooms when the patient is suffering from an Emergency Medical Condition as defined in the "Defined Terms" section of this Plan Document.	\$60 Copayment, then 100% of Allowed Amount The \$60 Copayment is waived if the patient is admitted from the ER to the Hospital.	
Emergency Care Visit – Physician's charge for Emergency Care in an Emergency Room	\$25 Copayment, then 100% of Allowed Amount	\$25 Copayment then 100% after Deductible of greater of: (1) Network Fee; (2) Allowed Amount for Emergency Services provided by an out-of-network provider; or (3) Medicare allowance.
Non-Emergency Care in an Emergency Room (facility and/or Physician charge) 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.	70% of Allowed Amounts after Deductible	
Hospital or Free-Standing Urgent Care Facility or Hospital Outpatient Clinic	\$25 Copayment	70% of Allowed Amount after Deductible

SCHEDULE OF BENEFITS		
Hospital Outpatient Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
Ambulance – Professional, Hospital-Owned or Volunteer (when the ambulance charges for its services) Medically Necessary ambulance services are considered Eligible Medical Expenses when provided by: • a local licensed professional ambulance service which charges a fee for its services; or • an organized voluntary ambulance service. 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. 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).	$50 Copayment, then 100% of Allowed Amount	$50 Copayment, then 100% of Allowed Amount Out-of-Network Ambulance services are not subject to Deductible or Co-insurance.
Preadmission Testing (within 14 days of admission) – (Facility charge) 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: • The tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; • The tests must be Medically Necessary; • A bed and operating room must have been reserved before the tests are done; • The patient must be physically present at the Hospital when the tests are performed; and • 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 ☎ 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 approved in writing by a Physician or other Health Care Provider. Care must be provided by: • 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 • 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. The benefits provided under Home Care are as follows: • Part-time or intermittent home nursing care given you by or under the supervision of a Registered Nurse (R.N.); • Part-time or intermittent home health aide services which consist primarily of caring for you; • Physical, occupational, speech therapy, respiratory therapy or infusion therapy provided you by the Home Health agency; • 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 • Laboratory services for which you would be covered if you were an Inpatient in a Hospital.	**☎ Pre-certification is required** • 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 • Three (3) visits equal one benefit day • Four hours of aide service equal one (1) visit 100% of Allowed Amount	

SCHEDULE OF BENEFITS		
Hospital Outpatient Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
Hospice Care☎ Hospice Care benefits provided by a Hospice organization having an operating certificate issued by the New York State Department of Health. 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. The Plan will pay for Hospice Care during the period when the Hospice has accepted the Covered Person for its program. While the Covered Person in their care, coverage will be provided for the following benefits: • Bed patient care either in a designated Hospice unit or in a regular Hospital bed; • Day care services provided by the Hospice organization; • 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: • Intermittent nursing care by a Registered Nurse, Licensed Practical Nurse, or Home Health aide; • Physical, Speech, Occupational and/or Respiratory Therapy • Social service; • Nutritional services; • Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms; • Medical supplies; • 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. • Medical care provided by the Hospice Physician; • Bereavement services provided to your family during your illness, and until one year after death.	**☎ Pre-certification is required** 100% of Allowed Amount	

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits

Physician and Other Health Care Provider Services
 	
• **Medical Visits in Home or Office:** Professional fees when provided by a Physician or other Health Care Professional in an office or at home, for general medical care; diagnostic visits; treatment of illness; and allergy treatment (including allergy testing, injections and serum, one Copayment applicable per visit).
 	
• **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.
 	
• **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.
  • **Inpatient Consultation**: One in each specialty per confinement for each condition being treated. Consultations are not covered for the fields of:
  – Pathology;
  – Roentgenology; or
  – Anesthesiology.
  • **Outpatient Consultation**: One in each specialty per calendar year, for each condition being treated.
	$10 Copayment per visit for Primary Care Physicians (PCP) applicable to:
	• Family Physician
	• Physician of Internal Medicine
	• General Practitioner
	• Pediatrician
	• OB/GYN
	
	Copayments for specialists are $25. If notification is given to SWSCHP of referral from above list of Physicians, Copayment is reduced to $15 per office visit.
	
	If an office visit includes treatment, the Copayment is $10 for a PCP and $25 for a OB/GYN and a Specialist.
	
	If the office visit is for treatment only, the Copayment is $25 regardless of the provider.
		70% of Allowed Amount after Deductible

Surgical and Maternity Care Benefits/Health Care Provider Fees ☎ 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.**	

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
• **Surgery ☎** Operative and cutting procedures; reduction of fractures and dislocations; and endoscopic procedures 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. Payment for surgical procedures is subject to the following limitations: • When multiple or bilateral surgical procedures which add significant time or complexity to your care are performed at the same operative session, (whether through one or more incisions) the Plan will pay for the major procedure and, in addition, will pay one-half (50%) of the payment otherwise payable for the secondary procedure. Any additional procedures will be reimbursed at one quarter (25%) of the payment otherwise payable for the lesser procedures. • When an incidental procedure, such as, but not limited to, incidental appendectomy; lysis of adhesions; excision of previous scar; puncture of ovarian cyst; etc., is performed through the same incision, the Plan will pay for the major procedure only. • 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.	$25 Copayment	70% of Allowed Amount after Deductible
• **Assistant Surgeon ☎** 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 providers (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.)	$25 Copayment	20% of Allowed Amount payable at 70% after Deductible

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
• **Anesthesia ☎** 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.	$25 Copayment per visit	70% of Allowed Amount after Deductible
• **Maternity (including fees of nurse midwife)** Care related to pregnancy and childbirth. This includes care given before and after childbirth, and for complications of pregnancy. Maternity care may be rendered by a Physician or other Health Care Provider or licensed nurse midwife. The licensed nurse midwife must be licensed to practice nurse midwifery, and permitted to perform the service under the laws of the state where the services are rendered. 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. The care provided may be rendered by a Physician or other Health Care Provider or licensed nurse midwife and shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. 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.	$25 Copayment per visit	70% of Allowed Amount after Deductible
• **Reconstructive Surgery: ☎** The services of a Physician or other Health Care Provider for reconstructive breast surgery following a Medically Necessary mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following a mastectomy in a manner determined by the attending Physician and the patient to be appropriate).	$25 Copayment	70% of Allowed Amount after Deductible

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
• **Voluntary or Elective Sterilization** Voluntary sterilization, including tubal ligation and vasectomy. No benefits are provided for reversal of sterilization.	$25 Copayment	70% of Allowed Amount after Deductible
• **Contraception/Family Planning** Implants such as Essure, Norplant and IUD	$10 Copayment if PCP $15 Copayment for Specialist with referral $25 Copayment for Specialist without referral for treatment	70% of Allowed Amount after Deductible
• **Voluntary or Elective Abortion**	$25 Copayment	70% of Allowed Amount after Deductible
Outpatient Surgery Facility Charge		
• ***Freestanding/Ambulatory Facility Charge***	100% of Allowed Amount, no Copayment	70% of Allowed Amount after Deductible
• ***Hospital Outpatient Facility Charge*** Facility charge 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.	$25 Copayment	
Transplants☎ Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits: • 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. • The Plan does not cover charges incurred in obtaining donor organs, including charges for: – evaluating the organ; – removing the organ from the donor; and – transportation of the organ to the place where the transplant is to occur or for patient and family transportation.	**☎ Pre-certification is required** $25 Copayment per visit	70% of Allowed Amount after Deductible

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
Treatment of Correctable Medical Conditions that Cause Infertility (limited ages 21 – 44) Services of professional providers for the diagnosis and treatment of correctable medical conditions that result in the diagnosis of infertility. Diagnosis and treatment of infertility must be prescribed as part of your Physician's overall plan of care and consistent with the guidelines for coverage in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine.	☎ **Pre-certification is required** No benefits are payable for: • The reversal of elective sterilizations • Sex change procedures • Cloning • Medical or surgical services or procedures that are deemed Experimental by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine.	
Coverage is available to covered individuals ages 21 through 44 years. Benefits are available for the following: • Services in relation to surgical and medical procedures to correct malformation, disease or dysfunction resulting in infertility; • Services for diagnostic tests and procedures provided as part of your medical care that are necessary to determine infertility, or when in connection with any surgical or medical treatments or prescription drug coverage. Such diagnostic test and procedures include: • Hysterosalpingogram • Post coital tests • Hysteroscopy • Testis biopsy • Endometrial biopsy • Semen analysis • Laparoscopy • Blood tests • Sono-hysterogram • Ultrasound	See specific Plan feature detailed in this Schedule of Benefits for specific benefit (e.g., surgery, diagnostic tests, office visits)	70% of Allowed Amount after Deductible

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
Artificial Reproduction: If a Covered Person is considered infertile (has been unable to become pregnant under more conservative or conventional means for at least 12 months unless one partner has already been diagnosed as infertile), the following procedures are allowed under the Plan for advanced reproductive technologies and artificial insemination: • Artificial Insemination, intracervical • Artificial Insemination, intrauterine • Assisted Embryo Hatching, rnicrotechnique • Culture and Fertilization of oocoryte • Follicle Puncture for oocryte retrieval • GIFT-Gamete Intrafalopian Tube Transfer • ICSI-Intracytoplasmic Sperm Injection • IVF-Invitro Fertilization • Preparation of Embryo for transfer • Sperm Identification, Sperm Isolation • Sperm Isolation: complex prep for insemination or diagnosis with semen • Sperm Isolation: simple prep for insemination or diagnosis with semen analysis • Sperm Washing for Artificial Insemination • ZIFT - Zygote Ontrafallopian Tube Transfer	☎ **Pre-certification is required** Limited to four (4) attempts per Lifetime The Plan does not cover: • Cryopreservation or storage and /or retrieval of cryopreserved material • Charges for donor eggs and related services $25 Copayment	70% of Allowed Amount after Deductible
Second Surgical Opinion Consultation 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. 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. 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 <u>not</u> apply

SCHEDULE OF BENEFITS		
Medical Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
Second Medical Opinion for Diagnosis of Cancer An office visit and related diagnostic tests in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when you are diagnosed by your Physician or other Health Care Provider as having some form of cancer. A negative diagnosis of cancer occurs when your Physician or other Health Care Provider finds cancer to have been a possible diagnosis and performs a cancer screening exam on you, and then finds that you do not have cancer. The Plan will also pay for a second medical opinion concerning any recommendation of a course of treatment for cancer. The specialist rendering the second opinion must be a specialist who, by reason of his or her specialty, is an appropriate Physician to consider the proposed treatment, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer.	100% of Allowed Amount	100% of actual charge after $25 Copayment; Deductible does not apply if you have received a referral. . If no referral, the benefit will be payable at 70% of Allowed Amount with no Deductible
Outpatient Private Duty Nursing Care☎ 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** • The first 48 hours per calendar year are not covered. • The Plan does not cover the assistance in activities of daily living or custodial care or companionship or any other service which can be given by a less skilled person, such as a Home Health Aide. • This service is covered only if it is determined that such a nurse is Medically Necessary to manage medical problems of acutely ill patients. • Coverage is limited to a maximum payment of $30/hr for participating and non-participating care. • There is no coverage available for private duty nursing on an Inpatient basis.	
	$25 Copayment per visit up to a maximum Allowed Amount of $30 per hour.	70% after Deductible up to maximum Allowed Amount of $30 per hour

SCHEDULE OF BENEFITS		
Medical Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
Visiting Nurse Services 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 Care.	$25 Copayment per visit	70% of Allowed Amount after Deductible
Diagnostic Tests and X-Rays Diagnostic x-rays, laboratory services and other electronic diagnostic medical procedures 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 MRI, MRA and Pet Scan**	
• ***Outpatient Freestanding Facility (Non-Hospital setting) and Physician/Health Care Provider (Professional Fees)*** • Diagnostic X-ray, laboratory and pathology tests (non-Hospital setting and independent laboratory) • Professional Interpretation charges Benefits are also provided for the separate interpretation of x-rays by a radiologist, if the radiologist bills separately.	100% of Allowed Amount	70% of Allowed Amount after Deductible
• ***Hospital OutPatient Facility (patient is physically present)*** Benefits are payable for diagnostic x-ray and laboratory tests if the tests are: • necessary for the treatment and diagnosis of your illness or injury, • ordered by a Physician or other Health Care Provider, and • performed in the patient's presence at the Outpatient department of a Hospital.	$25 Copayment per visit	
Outpatient Treatment for Mental Health Disorders Therapy and psychological testing for treatment of mental health disorders. Services are also provided when performed at a Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services will be made, to the extent possible, in a manner to facilitate the individualized, comprehensive and integrated plans of care which such center's network of practitioners and providers are required to provide.		
• **Therapy provided by a Mental Health Provider**	$25 Copayment per visit	70% of Allowed Amount after Deductible

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
• **Psychological Testing**	100% of Allowed Amount	70% of Allowed Amount after Deductible
• **Shock Therapy:** Benefits for shock therapy treatments performed in or out of a Hospital.	$25 Copayment per visit	70% of Allowed Amount after Deductible
Outpatient Treatment for Chemical Dependence Therapy and psychological testing for treatment of chemical dependence.	$25 Copayment per visit	70% of Allowed Amount after Deductible
Dialysis☎ Benefits are provided for hemodialysis. 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** 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.	
• ***Outpatient Freestanding Facility (Non-Hospital setting) and Physician/Health Care Provider (Professional Fees)***	$25 Copayment per visit	70% of Allowed Amount after Deductible
• ***Outpatient Hospital Facility or Medicare-Certified Dialysis Center*** Hemodialysis or peritoneal dialysis administered under the direction of a Physician in a Hospital or Outpatient Hospital facility or Medicare-Certified Dialysis Center. Treatment must be ordered by Physician or other Health Care Provider and Medically Necessary for the treatment of your illness or injury.	100% of Allowed Amount	
Radiation Therapy☎ When ordered by a Physician or other Health Care Provider for the treatment of a condition, illness or injury, by: • X-ray; • Radium; or • Radioactive isotopes.	**☎ Pre-certification is required**	

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
• ***Outpatient Freestanding Facility and Physician/Health Care Provider (Professional Fees)***	$25 Copayment per visit	70% of Allowed Amount after Deductible
• ***Hospital Outpatient Facility Charge***	100% of Allowed Amount	
Chemotherapy ☎ Benefits are provided for: • parental; • infusion; • perfusion; • oral; or • intercavity chemotherapy. In no event will benefits be provided for Experimental chemotherapy or investigative anti-neoplastic drugs under this Plan, unless directed pursuant to external appeal.	**☎ Pre-certification is required**	
• ***Outpatient Freestanding Facility (Non-Hospital setting) and Physician/Health Care Provider (Professional Fees)***	$25 Copayment per visit	70% of Allowed Amount after Deductible
• ***Hospital Outpatient Facility Charge*** • Services and medications for non-Experimental cancer chemotherapy; and • Cancer hormone therapy	100% of Allowed Amount No benefits are provided under this category for oral chemotherapy, subcutaneous injection or intramuscular injections.	
IV Therapy ☎ The Plan provides benefits for at home infusion therapy when Medically Necessary.	**☎ 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)***	$25 Copayment	70% of the network allowance after Deductible
• ***Hospital Outpatient Facility Charge***	100% of Allowed Amount	
	☎ Pre-certification is required	

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
Biofeedback ☎ Biofeedback when administered by a Physician or other medical professional.	Up to 31 visits per calendar year $25 Copayment per visit	70% of Allowed Amount after Deductible
Rehabilitation Therapy, including Physical, Occupational and Speech Therapy☎ 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. The therapy must be: • reasonable; • expected to result in significant clinical improvement of condition; • intended to improve or restore bodily functions within a reasonable and generally predictable period of time; and • not be solely to prevent further deterioration or maintain a current condition.	**☎ Pre-certification is required** • No therapy is payable for Recreational or Leisure Therapy. • Any conditions that do not show significant clinical improvement after three months of therapy are not covered. • There is no coverage for long term therapy. • 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 Care Coordination Program.	
• ***Outpatient Freestanding Facility (Non-Hospital setting) and All Physician/Health Care Provider (Professional Fees)***	$25 Copayment per visit	70% of Allowed Amount after Deductible
• ***Outpatient Hospital after Related Surgery ☎*** 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.	$25 Copayment per visit	
Cardiac Rehabilitation ☎ 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: • Heart Attack; • Cardiac Surgery; or • Stroke.	**☎ Pre-certification is required** • Limited to 36 visits per Spell of Illness (Outpatient Hospital or out-of-Hospital setting combined) • No coverage is provided for Cardiac Rehabilitation rendered as a preventive measure. $25 Copayment per visit	70% of Allowed Amount after Deductible

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
Physiotherapy ☎ Services of a licensed physiotherapist.	$25 Copayment per visit	70% of Allowed Amount after Deductible
Respiratory Therapy 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.	$25 Copayment per visit	70% of Allowed Amount after Deductible
Chelation therapy 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.	$25 Copayment per visit	70% of Allowed Amount after Deductible
Foot Care and Podiatry Services (routine foot care not covered) 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: • corns; • calluses; • flat feet; • fallen arches; • weak feet; • chronic foot strain; or • symptomatic complaints of the feet.	$10 for Primary Care Physician (PCP) $15 for specialist with PCP Referral $25 Copayment without PCP Referral	70% of Allowed Amount after Deductible
Chiropractic Care☎ The services of a licensed chiropractor, including x-rays, in connection with the detection and correction (by manual or mechanical means) of: • structural imbalance; or • distortion; or • subluxation in the human body for the purpose of removing nerve interference and the effects thereof. This includes cases when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.	**☎ Pre-certification is required** $25 Copayment per visit	**☎ Pre-certification is required** 70% of Allowed Amount after Deductible
Acupuncture☎	**☎ Pre-certification is required**	

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
The services must be rendered by a: • Physician; • New York State licensed acupuncturist working under the supervision of a Physician; or • Medical Professional licensed by the State of New York to perform acupuncture If the services are being rendered outside of New York State, the practitioner must meet all the necessary local licensing 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: • Chronic low back pain. (Maintenance treatment, where the patient's symptoms are neither regressing or improving, is considered not Medically Necessary); *or* • Migraine headache; *or* • Nausea of pregnancy; *or* • Pain from osteoarthritis of the knee or hip (adjunctive therapy); *or* • Postoperative and chemotherapy-induced nausea and vomiting; *or* • Postoperative dental pain; *or* • Temporomandibular disorders (TMD) 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 Care Coordinator 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.	The maximum benefit is $75 for office visit and treatment. $25 Copayment per visit	70% of Allowed Amount after Deductible
PUVA (Psoralen & Ultraviolet Radiation Light Therapy) ☎ PUVA (Psoralen and Ultraviolet Radiation Light Therapy) for the treatment of psoriasis and certain skin disorders.	☎***Pre-certification is required.*** Limited to treatment of psoriasis and certain skin disorders $25 Copayment per visit	70% of Allowed Amount after Deductible
Diabetic Education/Self-Management ☎	☎***Pre-certification is required***	

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
Coverage includes diabetes self-management education and diet information provided by Physician or other Health Care Providers and Authorized Providers, or their staffs, 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 or treatment of diabetes, payment for the office visit shall include payment for the education. Education is also covered when provided by the following providers upon referral from a Physician, other Health Care Provider, or Authorized Provider: • Certified Diabetes Nurse Educator; • Certified Nutritionist; • Certified or Registered Dietician; or • Other provider required by law.	• Education must be provided in a group setting when practicable. • The Plan will also pay for Home Visits when Medically Necessary.	
	$10 Copayment for PCP $15 Copayment for office visit if referred by PCP $25 Copayment if no PCP referral	70% of Allowed Amount after Deductible
Diabetic Supplies/Equipment 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): • Blood glucose monitors and blood glucose monitors and cartridges for legally blind; • Testing strips for glucose monitors and visual reading and urine testing strips; • Data management systems; • Insulin, syringes, injection aids, cartridges for the legally blind; • Insulin pumps and appurtenances, and insulin infusion devices; • Oral agents for controlling blood sugar; and • Additionally Medically Necessary equipment and supplies, as may be required by the New York State Department of Health.	$25 Copayment	70% of Allowed Amount after Deductible
Durable Medical Equipment☎ The rental of durable medical equipment required for temporary therapeutic use. Such equipment must be prescribed by a Physician or Health Care Practitioner for therapeutic use and 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,	**☎ Pre-certification is required for all rentals and purchases over $500**	
	100% of Allowed Amount	70% of Allowed Amount after Deductible

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
coverage is provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they exceed the cost of standard models of such appliances or equipment.		
Prosthetics☎ Prosthetic or Orthotic Devices needed to relieve or correct conditions caused by illness or accident. Such devices including artificial limbs must be ordered by your Physician/Health Care Provider and be Medically Necessary for the treatment of your illness or injury. Replacement of such devices is also covered if it is functionally necessary to do so.	☎***Pre-certification is required*** 100% of Allowed Amount	☎***Pre-certification is required*** 70% of Allowed Amount after Deductible
Contact Lense/Eyeglasses following cataract surgery 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
Wigs (due to hair loss following cancer treatments and due to burns) Coverage for wigs following chemotherapy. Maximum benefit - $375 per Lifetime	100% of Allowed Amount	70% of Allowed Amount after Deductible
Nondurable Medical/Surgical Supplies☎ 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. To be covered by the Plan, the supply must be: • primarily and customarily used to serve a medical purpose; • generally not useful to a person in the absence of an illness or injury; and • appropriate for use in the home. Includes such items as dressings; casts; splints; lancets; mastectomy bras; ostomy supplies; but does not include common first aid supplies.	☎***Pre-certification is required*** $25 Copayment	☎***Pre-certification is required*** 70% of Allowed Amount after Deductible

SCHEDULE OF BENEFITS		
Medical Benefits	**In-Network Benefits**	**Out-of-Network Benefits**
Support Stockings☎ 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: • Varicose veins; • Phlebitis; or • Postoperative care following leg surgery	**☎ Pre-certification is required** Limited to two (2) pairs of support stockings during any 6-month period	
	100% of Allowed Amount	70% of Allowed Amount after Deductible
Oxygen 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.	100% of Allowed Amount	70% of Allowed Amount after Deductible
Therapeutic Injections☎	☎***Pre-certification is required*** $25 Copayment	☎***Pre-certification is required*** 70% of Allowed Amount after Deductible
Nutritional Supplements for Phenylketonuria and Related Disorders	$25 Copayment– up to a 90-day supply	70% of Allowed Amount after Deductible
Enteral Formulas and Modified Solid Food Products Enteral formulas for home use for which a Physician or other licensed health care provider is legally authorized to prescribe. The order must state that the formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases for which enteral formulas are effective include, but are not limited to: • Inherited amino-acid or organic acid metabolism; • Crohn's Disease • Gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and • Multiple severe food allergies, which, if left untreated, will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products, not to exceed $2,500 for any Covered Person in any calendar year or continuous period of 12 months.	$25 Copayment – up to a 90-day supply	70% of Allowed Amount after Deductible
	Modified solid food products – maximum benefit $2,500 per calendar year	
Blood Services	100% of Allowed Amount	70% of Allowed Amount after

SCHEDULE OF BENEFITS

Medical Benefits	In-Network Benefits	Out-of-Network Benefits
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.		Deductible Autologous and directed blood donations and storage are not covered.
Hearing Aid/Exam Hearing Aids, including examinations for, and the fitting of. Hearing Aid benefits are limited to a maximum payment of $600 per covered individual per 48-month period. Hearing Aid benefits are not subject to Deductibles or Coinsurance.	$25 Copayment	100%; Deductible does not apply.
Dental Care 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: (1) Emergency repair due to Injury to natural teeth. These repairs must be made within 12 months from the date of an accident. (2) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue floor and roof of the mouth, when the injuries occurred while covered under the Plan. (3) Dental care or treatment necessary due to congenital disease or anomaly.	$25 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 ☎ 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. 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** $10 for PCP $15 for specialist with PCP Referral $25 Copayment without PCP Referral	70% of Allowed Amount after Deductible
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 shall apply to this coverage. Covered expenses paid under this portion of the Plan shall not be a benefit under any other portion or coverage of the Plan. The Plan's Prescription Drug Program is administered by Medco.

How to Obtain Your Prescription Drugs

Retail Prescriptions Drugs

Participating Pharmacies

Medco has established a network of pharmacies through which you may fill prescriptions. If you use one of Medco's participating pharmacies, your out-of-pocket costs may be lower than if you use a Non-Participating Pharmacy. You can visit www.medco.com to locate Medco 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 be asked to sign a signature log to verify that you picked up the medication. While a pharmacy can usually check eligibility online through Medco, if you purchase a prescription at a Participating Pharmacy <u>without</u> your ID card, you might need to pay for the prescription and submit the prescription drug receipt to Medco 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 Medco 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 Medco on a claim form which is available from your School District Health Benefits Representative. Claim forms are also available online at www.medco.com (you must first register with the site) or by calling Medco at (800) 903.8343.

Claims for non-network pharmacies should be submitted to:

Medco Health Solutions, Inc.
P.O. 14711
Lexington, KY 40512
Website: Medco.com

Prescription Drug Formulary Program

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 Medco) for commonly prescribed formulary medications and alternatives to non-formulary medications.

Prescription Drug Copayments

	Retail Pharmacy 30-Day Supply	Mail Order Pharmacy 90-Day Supply
Generic	$7.50 After One Refill $15:00*	$15
Brand Formulary	$30 after One Refill $60.00*	$60
Brand Non-Formulary	$50 after One Refill $100.00*	$100
Accredo Specialty Pharmacy 1-800-501-7260	Not Available at Retail Pharmacy*	30-Day Supply $16.67 60-Day Supply $33.33 90-Day Supply $50.00

*****If you fail to utilize the Mail Order Pharmacy for maintenance prescriptions after one refill at a retail pharmacy, you will be responsible a Copayment equal to 50% more than the usual Copayment.

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 are dispensed through Medco's Specialty Pharmacy, Accredo Health Group. All specialty medications require prior authorization. See the subsection "Prior Authorization Required for Certain Prescription Drugs". In addition, to find out if a medication you have been prescribed is a specialty medication and for prior approval, contact Member Services at 1-800-711-0917.

Refill Limits

No refills will be dispensed until 75% of the previous supply has been scheduled for use (i.e. 30 day supply cannot be refilled until 22 days have elapsed). No refills on prescriptions written more than one year earlier.

Refills of eye drop medication requiring a will be allowed to be refilled prior to the last day of the approved dosage period without regard to the above restriction on early refills. However, any refill dispensed prior to the expiration of the prescribed and approved coverage period will, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. In addition, such limited refilling will not limit or restrict coverage with regard to any previously or subsequently approved prescription for eye drop medication (to the extent it would otherwise be covered by the Plan). The pharmacist may contact the Physician or Provider to verify the prescription.

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. If you use a retail pharmacy to refill your maintenance prescriptions more than once, you will be responsible for a higher Copayment. The refill Copayment will be 50% higher than the standard tier Copayment. Payment of the Copayment amount per prescription is the responsibility of the Covered Person.

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 Medco for a copy of the claim form.

Send Mail Order drug claims to:

Medco Health Solutions Inc.
P.O. Box 650322
Dallas, TX 75265-0322
1-800-711-09171

Prior Authorization Required for Certain Prescription Drugs

A number of drugs require Prior Authorization by Medco'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 the member.

Under the Plan, Prior Authorization is required for the following:

- Allergy and Asthma Therapy (Xolair)
- Appetite and Weight Loss Therapy
- Botulinum Toxins
- Cancer Therapy
- Eythoroid Stimulant
- Growth Hormones
- Immune Globulins (IVIG)
- Interferon Agents
- Multiple Sclerosis Therapy
- Myeloid Stimulants
- Pulmonary Agents (Pulmozyme)
- RSV Agents

The Plan also contains a Step-Therapy program for certain drugs. Under this program, Medco will first try certain drugs to treat a medical condition before they will cover another drug for that condition. For example, if Step-1 and Step-2 drugs both treat a medical condition, Medco may not cover the Step-2 drug unless you try the Step-1 drug first. If the Step-1 drug does not work, Medco will then cover the Step-2 drug.

You will need prior authorization from Medco before filling prescriptions for:

- Cystic Fibroses (Tobi)
- Hormones / Miscellaneous (Sensipar)
- Pulmonary Arterial Hypertension (all agents)
- RA Agents Package (all agents ST)
- Ribavirin Therapy

In addition, the following are subject to Medco review for quantity or dose duration:

- Allergy and Asthma Therapy (Xolair)
- Cystic Fibrosis (Tobi)
- Hormones / Miscellaneous (Tobi)
- Migraine Therapy (Milligram Based)

- Miscellaneous Dermatological (Amevive)
- RA Agents Package – All Agents (QD)
- RSV Agents

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. Medco 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 "Care Coordination" section of this Plan Document. For prior authorization for prescription drugs, you or your Physician should first contact Medco. If you cannot resolve the issue, you should contact SWSCHP at 1 (888) P SWSCHP (799-7247).

This 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 Medco 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.

- Oral, transdermal, intravaginal, injectable, or implantable contraceptives.

- Legend contraceptive devices.

- Insulin.

- Any other drug which, under applicable State law, may only be dispensed upon written prescription of a lawful prescriber.

- Compound medication of which at least one ingredient is a prescribed Legend Drug.

- Prescriptions for Zantac, Pepcid and Axid only if filled with over-the-counter, non-prescription versions. (If you choose not to use the over-the-counter version, you are responsible for the entire cost of the prescription for these particular drugs).

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.

- **Aspirin** is payable under the Prescription Drug benefit for Covered Persons age 45 years through age 79.
- **Fluoride** supplements for children without fluoride in their water supply through age 5.
- **Folic Acid** is payable for females through the age of 50 years old.
- **Iron** supplements are covered for children who are less than one (1) year only.

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 other than Insulin.
- Drugs for cosmetic purposes, which include but are not limited to:

  (1) Non-amphetamine anorexiants, except for as Medically Necessary to treat morbid obesity.

  (2) Amphetamines that are prescribed for weight loss, except for as Medically Necessary to treat morbid obesity.
- Therapeutic devices or appliances and other non-medicinal substances, regardless of use, including syringes and support garments.
- Immunizing agents, biological sera, blood or blood plasma.
- Charges for the administration of any medication.
- 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 furnished by a Hospital, Home Health Care Agency, Rest Home, Sanitarium, Skilled Nursing Facility or Convalescent Nursing Home while patient is confined.
- Any medication (other than Zantac, Pepcid and Axid) where the exact equivalent is available in a non-prescription version.

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 appropriate Copayment, **plus** the difference in cost between the brand-name medication and the generic medication.

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

Follow the directions on the EOB to appeal directly to Medco or see the “Claims and Appeals” section for on information filing an appeal directly with SWSCHP.

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.

3. Services, supplies, drugs or medicines that are determined by the Plan to be Experimental and/or Investigational as defined in the Defined Terms section of this Plan Document, unless coverage is directed pursuant to external appeal.

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. 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.

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

9. Except as otherwise required by State or Federal law, care in any government owned and operated Hospital or other institution.

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 related to the Covered Person as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.

12. Professional services billed by a Physician or Nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service, including expenses for the services of a medical student or intern.

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

14. 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.

15. 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.

16. 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.

17. 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.

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

19. 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.

20. Expenses for parental custody services,adoption services, or court-ordered services, unless otherwise covered under the Plan.

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:

Corrective Appliances, Durable Medical Equipment, and Nondurable Supplies Exclusions

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 required for reconstructive surgery which is incidental to, or follows surgery which results from, a trauma, infection or other disease of the involved part. It will also be covered if required for reconstructive surgery due to a congenital disease or anomaly which has resulted in a functional defect to a Dependent Child. 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 Care Coordination/Utilization Review Program procedures to determine if a proposed surgery or service will be considered Cosmetic Surgery, or Medically Necessary reconstructive surgery.

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:

    - Dental care or treatment due to accidental injury to sound and natural teeth within 12 months of the accident;

    - Dental care or treatment necessary due to congenital disease or anomaly; or

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

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

28. Expenses for Cloning.

29. 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.

30. Expenses for and related to adoption.

Foot Care Exclusions

31. 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.

Genetic Testing and Counseling Exclusions

32. Genetic testing and counseling unless determined to be Medically Necessary under the Care Coordination Program.

Hearing Care Exclusions

33. 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.

Virtual Colonoscopy Exclusion

34. 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)

35. Expenses for speech therapy for functional purposes, except after hospitalization or illness or a stroke.

36. Expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery, or result of a covered treatment.

Sex Change Counseling, Therapy and Surgery Exclusions

37. Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures, unless Medically Necessary.

Transplant (Organ and Tissue) Exclusions

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

39. 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

40. 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.

   Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Care Coordination/Utilization Review Program, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or the Care Coordination/Utilization Review Program for any purpose related to the care or treatment of a Covered Person; consultation with any Health Care Provider regarding Care Coordination or care of a patient; coordinating within Care Coordination in regard to of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family member.

   Expenses related to an online internet consultation with a Physician or other Health Care Provider/Professional, also called a virtual office visit/consultation, web visit, Physician-patient web service or Physician-patient e-mail service, or telemedicine (real time or store and forward types), telehealth, e-health, remote diagnosis and treatment, real-time video-conferencing, including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.

3. Any service, supplies, charges or expenses not specifically included and listed as covered expenses under a portion of this Plan. This includes any expense or portion of an expense in excess of the Allowed Amount as defined by this Plan.

4. 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.

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

6. Educational or vocational services.

7. 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);

8. Expenses for residential care services, residential schools, wilderness program, half-way house, boarding school and group home.

9. 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.

10. 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.

11. Expenses for equine (horse) assisted therapy.

12. Treatment for educational services related to reading and learning disorders, dyslexia, educational delays, or vocational disabilities.

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

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

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

16. Expenses for occupational therapy adaptive supplies and devices used to assist a Covered Person in performing activities of daily living, including self-help devices such as feeding utensils, reaching tools, devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.

17. Non-prescription contraceptive drugs and devices, such as condoms.

18. Expenses for childbirth education, Lamaze classes, breast-feeding classes.

19. 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.

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

21. Light therapy/box for seasonal affective disorder.

22. Marriage Counseling, unless medically necessary.

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

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

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

26. Expenses for tobacco/smoking cessation products, including, without limitation: nicotine gum or patches, or other services or programs.

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

28. 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).

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

30. Exercise programs for treatment of any condition.

31. Exercise facilities; exercise equipment; weight reduction facilities; weight management programs; diet pills for appetite suppression; 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.

32. 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.

33. 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

Every person involved with adjudicating claims and appeals will act independently and impartially, and decisions related to employment status or retention of such person will not be made on the basis of whether he or she is likely to support a denial of benefits.

Definition of Claims

This section describes the procedures for filing claims for benefits under this Plan and for appealing adverse benefit determinations in connection with those claims in compliance with 29 CFR §2560.503-1 and applicable New York State law and regulations.

The Plan takes steps to assure that Plan provisions are applied consistently with respect to you and other Plan participants. The claims procedures outlined in this section are designed to afford you a full, fair and fast review of the claim to which it applies.

This section also discusses the process the Plan undertakes on certain appealed claims, to consult with a Health Care Provider with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is Experimental or Investigational, or not Medically Necessary or appropriate).

Time Limit for Initial Filing of Health Claims

All Post-Service claims must be submitted to the Plan within one year (12 months) from the date of service. No Plan benefits will be paid for any claim not submitted within this period.

Additional Information Needed

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated periods.

Some Plan benefits are payable without a financial penalty only if the Plan approves payment before you receive the services. These benefits are referred to as Pre-Service Claims (also known as prior authorization or pre-certification). See the definition of Pre-Service claims, as set forth below, in this section. You are not required to obtain approval in advance for Emergency care, including care provided in a Hospital Emergency Room, or Hospital admission for delivery of a baby.

Key Definitions

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an adverse benefit determination for health care claims is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's in eligibility to participate in this Plan or a determination that a benefit is not a covered benefit under this Plan; or

- a reduction in a benefit resulting from the application of any utilization review decision, network exclusion, or other limitation on an otherwise covered benefit, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; or

- a rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's Authorized Representative (as defined later in this section) in accordance with the Plan's claims procedures, described in this section.

There are four types of claims covered by the procedures in this section: ***Pre-Service***, ***Urgent/Expedited***, ***Concurrent,*** and ***Post-Service***. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

A claim must include the following elements to trigger the Plan's claims processing procedures:

a) be written or electronically submitted (oral communication is acceptable only for Pre-Service, or Urgent/Expedited Care claims);
b) be received by the appropriate Claims Administrator, as defined later in this section;
c) name a specific individual, including a SWSCHP ID number or Medicare HICN number;
d) name a specific medical condition or symptom;
e) name a specific treatment, service or product for which approval or payment is requested;
f) made in accordance with the Plan's benefit claims filing procedures described in this section; and
g) all information required by the Plan and the appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits.

A claim is NOT:

a) a request made by someone other than the individual or his/her Authorized Representative;
b) a request made by a person who will not identify him/herself (anonymous);
c) a casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
d) a request for prior authorization or pre-certification of Plan benefits where prior approval is not required by the Plan; or
e) an eligibility inquiry that does not request Plan benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination, and the individual will be notified of the decision and allowed to file an appeal.

Pre-Service, Urgent Care/Expedited, and Concurrent Claims

Pre-Service Claim: The services that require pre-certification (also called prior authorization for drug purposes) are listed in the *Care Coordination* and *Prescription Drug Benefits* sections of this Plan Document.

The appropriate Claims Administrator may determine to pay benefits for the services needing pre-certification if you were unable to seek approval prior to service (Pre-Service) because circumstances existed that made obtaining such prior approval impossible, or application of the Pre-Service (pre-certification) procedure could have seriously jeopardized the patient's life or health.

Pre-Service, Urgent Claim: An Urgent Care Claim is a claim (request) for medical care or treatment in which applying the time periods for pre-certification:

- could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function; or

- in the opinion of a Physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving Urgent Care.

Concurrent Claim: A Concurrent Care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A Concurrent Care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short. The services that will receive Concurrent Claim review are listed in the *Care Coordination* section in this Plan Document.

***Post-Service Claim*/Retrospective Review**

A Post-Service Claim is a claim for benefits under the Plan that involve only the payment or reimbursement of the cost of the care has after it has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of Post-Service Claims. A claim regarding rescission of coverage will be treated as a Post-Service Claim.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.

Complaints/Review of Issues that are not a Claim as Defined in this Section

A Covered Person may file a complaint or request review of an issue that does not constitute a claim as defined in this section by calling State-Wide Schools Cooperative Health Plan (SWSCHP) at 1-888.P-SWSCHP (779-7247) or on the web at SWSCHP.org.

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 Coordinated Health/Care.

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.

HOW TO SUBMIT A CLAIM AND NOTIFICATION OF CLAIMS DETERMINATION

The appropriate Claims Administrator is the organization that handles each of the types of claims payable by the Plan. The Appropriate Claims Administrator is the organization to whom claims should be submitted and the organization that will make the claims determination as outlined below:

Type of Claim	**Appropriate Claims Administrator Submit Claims to:**
• Urgent, Concurrent and Pre-Service claims for Medical and Hospital Claims	SWSCHP Care Coordination Program Coordinated Health/Care (CHC) 1215 Polaris Parkway, Suite 229 Columbus, OH 43240-2037 Phone: 1 (888) 779-7247
• Post-Service Claims Medical and Hospital	Alicare is the Claims Administrator Submit claims to: SWSCHP P.O. Box #5035 White Plains, New York 10602-5035
• Pre-Service drugs as described in the "Prior Authorization Required for Certain Prescription Drugs" subsection of the Prescription Drug Benefits Program	For prior approval, call Medco Member Services at: 1 (800) 711-0917
• Post-Service Claims for Out-of-Network retail drugs.	Submit Post-Service claims: Medco Health Solutions, Inc. P.O. 14711 Lexington, KY 40512

Pre-Service, Urgent Care/Expedited, or Concurrent Claims

For information on how to file a Pre-Service Claim (including an Urgent Care/Expedited Claim or Concurrent Claim, see the sub-section entitled "Utilization Review" under the "Review and Coordination Process" in the "Care Coordination Process" section of this Plan Document.

For information on how to file a Pre-Service Claim for Prescription Drug Benefits, see the sub-section entitled "Prior Authorization Required for Certain Drugs" in the Prescription Drug Benefits section of this Plan Document.

Pre-Service Reviews. If the utilization review agent has all the information necessary to make a determination regarding a Pre-Service review, he/she will make a determination and provide notice to you (or your Authorized Representative) and your provider, by telephone and in writing, within three business days of receipt of the request. If additional information is needed, the utilization review agent will request it within three business days. You or your Health Care 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 Authorized Representative) Health Care Provider, by telephone and in writing, within three business days of the earlier of receipt by the utilization review agent of the information or the end of the 45-day time period.

With respect to ***Pre-Service Urgent Claims***, if the utilization review agent has all information necessary to make a determination, he/she will make a determination and provide notice to you (or your Authorized Representative) and your Health Care Provider, by telephone and in writing, within 24 hours of receipt of the request. If the utilization review agent needs additional information, the utilization review agent will request it within 24 hours. You or your Health Care Provider will then have 48 hours to submit the information. The utilization review agent will make a determination and provide notice to you and your Health Care 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.

Concurrent Claim Reviews. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your Authorized Representative) and your Health Care Provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If the utilization review agent needs additional information, the utilization review agent will request it within one 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 Authorized Representative) and your Health Care Provider, by telephone and in writing, within one business day of the earlier of receipt of the information or the end of the 45-day time period.

For Concurrent Claim reviews that involve urgent matters, the utilization review agent will make a determination and provide notice to you (or your Authorized Representative) and your Health Care 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 Pre-Service Urgent Claims.

If the utilization review agent has approved a course of treatment, the utilization review agent will not reduce or terminate the approved services unless the utilization review agent has 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.

Post-Service Claims/Retrospective reviews

Claims should be filed as soon as possible. Claims must be filed with the Claims Administrator within 12 months of the date of service. If you have other primary coverage, you have up to 90 days after the other plan processes your claim to submit it to this Plan. Claims filed later than that date will be denied.

Participating Providers (In-Network Claims): You are generally not required to file a claim in order to be reimbursed for services received from an In-Network Provider. You need only present your SWSCHP ID card at the time services are rendered and pay the applicable Copayment. Participating Providers have agreed to accept payment directly from the Plan as payment in full for covered medical services. Charges for covered services are paid directly to the Provider by the Plan. The claim form is sent in by the Provider after you have completed your information and signed it.

Claims Procedures

1. Check SWSCHP.org or call 1 (888) P SWSCHP (779-7247) for the specialty of your choice.

2. When making an appointment with a Participating Provider, always:

   - identify yourself as a SWSCHP Covered Person;

   - verify that the Provider is currently participating; and

   - present your SWSCHP identification card.

3. After services have been rendered:

   - Complete and sign the claim form provided by the Participating Provider, if required.

   - The Participating Provider will then submit it to the Plan for direct reimbursement in accordance with the Schedule of Benefits.

You will receive a copy of payments made. Please review the statement as it relates to the services rendered.

Non-Participating Providers (Out-of-Network Claims): You are responsible for paying a Non-Participating Provider's charges. Assignment of benefits is usually not permitted. Usually assignments will be made to Hospitals and approved facilities only. You are responsible for the charges billed and must submit a claim for benefits due.

In order to submit a claim for benefits:

- Obtain a claim form from your School District's Health Benefits Representative.

- Complete all questions in the Employee portion of the form.

- The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or Health Care Provider can complete the Health Care Provider part of the claim form, or you can attach the bill or the claim form, sometimes referred to as a CMS-1500, for professional services, if it contains all of the following information:

  - A description of the services or supplies provided;
  - Details of the charges for those services or supplies, including CPT/CDT codes;
  - Diagnosis including ICD codes;
  - Date(s) the services or supplies were provided;
  - Patient's name, social security or ID number, address and date of birth;
  - Participant/Employee's name, social security or ID number, address and date of birth, if different from the patient; and
  - Provider's name, address, phone number, professional degree or license, and federal tax identification number.

- Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Appropriate Claims Administrator. This can reduce costs to you and the Plan.

- Complete a separate claim form for each Covered Person for whom Plan benefits are being requested.

- If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

- Mail your completed claim for and itemized bill(s) for Out-of-Network Medical Benefits to: **SWSCHP, PO Box # 5035, White Plains, New York 10601-5035**.

- In all instances, when Deductibles, Coinsurance or Copayments apply, you are responsible for paying your share of the charges.

The Appropriate Claims Administrator will review your Post-Service Claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the Post-Service Claims process.

This 30-day period may be extended one time for up to 12 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, indicating the date by which it expects to make a decision and will notify you prior to the expiration of the initial 30 day period using a written Notice of Extension.

The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received. If the Post-Service Claim is approved, you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

New or Additional Information

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Notification of Claim Decision

If a claim is denied in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable), along with the Explanation of Benefits (EOB), Notice of Adverse Benefit Determination, or by phone and in writing for Pre-Service, Urgent/Expedited and Concurrent claims. This notice of initial denial will:

- identify the claim involved (e.g. date of service, Health Care Provider, claim amount if applicable);

- state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external appeal;

- give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

- reference the specific Plan provision(s) on which the determination is based;

- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

- provide an explanation of the Plan's internal appeal procedure and external appeal process, along with time limits and information regarding how to initiate an appeal;

- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and

- if the denial was based on Medical Necessity, Experimental or Investigational treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external appeal processes.

If you do not understand English and have questions about a claim denial, contact SWSCHP 1 (888) P SWSCHP (1-(888) 779-7247) to find out if assistance is available.

- ***SPANISH (Español)***: Para obtener asistencia en Español, llame al 1 (888) P SWSCHP (1-(888) 779-7247).

If you disagree with a denial of a claim, resulting in an adverse benefit determination, you or your Authorized Representative may ask to appeal that denial. You have 180 calendar days following receipt of an initial denial to request an appeal. The Plan will not accept an initial appeal filed after this 180-calendar day period.

For all appeals, you will be provided with:

- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

- free of charge, any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;

- a review that does not give deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary, or not appropriate, the Appropriate Claims Administrator will:

  - consult, if deemed appropriate, with a Health Care Provider who has appropriate experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

CLAIMS REVIEW (APPEAL) PROCEDURES

You have the right to file an appeal if you are denied coverage because a benefit is determined not to be covered under the Plan, the Plan denies access to a referral, if services are denied as Experimental/Investigational or as not Medically Necessary, or if you have a complaint concerning any Plan determination.

All appeals should be submitted as soon as possible and must be submitted within 180 calendar days after the date of denial. Please include your Member ID number, claim number in question, and any additional medical information or documentation supporting your appeal. You should file an Appeal with SWSCHP Coordinated Health/Care: Coordinated Health/Care (CHC), 1215 Polaris Parkway, Suite 229, Columbus, OH 43240-2037, Phone: 1-888-779-7247.

- Coordinated Health/Care will provide a standard appeal process if the Covered Person disagrees with the utilization review agent's decision. The Covered Person or the Covered Person's Authorized Representative has the right to appeal the decision. The Covered Person or Covered Person's Authorized Representative may file a standard appeal in writing or by telephone.

  - Coordinated Health/Care will decide internal appeals related to prospective (Pre-Service) reviews within 15 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your Authorized Representative (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.

  - Appeals pertaining to health care services (Concurrent reviews), 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 (Post-Service) reviews.

  - For expedited appeals, your Health Care 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 or an external appeal.

  - Failure to render a determination of your internal appeal within 60 calendar days of receipt of the necessary information for a standard appeal, or two business days of receipt of the necessary information for an expedited appeal, shall be deemed a reversal of the initial adverse determination.

  - If the Plan receives a request for coverage of home health care services following an Inpatient Hospital admission, you (or your Authorized Representative) and your Health Care Provider will be notified of the 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 Pre-Service, Urgent Claim in which case the Pre-Service, Urgent Claim time frames are applicable.

When the utilization review agent receives a request for home health care services and all necessary information prior to your discharge from an Inpatient Hospital admission, the Plan will not deny coverage for home health care services, either on the basis of Medical Necessity or for failure to obtain prior authorization, while the decision on the request for appeal is pending.

Appeals that do <u>not</u> Involved Medical Necessity or Experimental/Investigational – Also called Grievances or Complaints

Grievance/Complaints Procedure

This Plan maintains a two-level appeal process for claims that do not involve Medical Necessity, also known as Grievances or Complaints. You may file your Grievances concerning benefit determinations or referrals by phone by calling SWSCHP toll-free number at 1-888 P-SWSCHP (779-7247) or by writing a letter to: SWSCHP Coordinated Health/Care, Attention: Appeals Department, 1215 Polaris Parkway, Suite 229, Columbus, OH 43240-2037.
Once you notify SWSCHP of you Grievance/Complaint, you will be provided with a notice specifying what information you must provide, if any, in order to render a decision on the Grievance.

For a Level 1 Grievance Appeal, a decision will be made within 30 calendar days after receipt of your appeal (or 15 days for a Pre-Service Claim). If a decision cannot be made within this timeframe (because all necessary information has not been received), the Plan will send you a letter advising you of the reason for the delay. A written decision will be issued within 45 business days based on the available information.

For an expedited Grievance Appeal (when a delay in a decision would pose an imminent or serious threat to the health of the patient, or is otherwise warranted), you will be notified within 48 hours of receipt of all necessary information, or within 72 hours based on the available information.

If you are not satisfied with the decision on your appeal, you may make a Level 2 Grievance Appeal. The person reviewing your Level 2 Grievance Appeal will not have been involved in making the decision on your first appeal.

Level 2 Grievance/Complaint

In a situation where the denial is upheld, a claimant has 30 days to file a Level 2 Grievance to challenge the ruling. This written appeal should include any additional information or documentation not already presented, and it should be forwarded to the Executive Director of the State-Wide Schools Cooperative Health Plan c/o Wright Risk Management, State-Wide Schools Cooperative Health Plan, 12 Metro Park Road, Suite 208, Colonie, NY 13305-11391. The SWSCHP Executive Director, in coordination with representatives of the SWSCHP Board of Governors, will review all relevant documentation associated with the Grievance and reach a final settlement of the Grievance.

The Executive Director and the Board of Governors will issue a written determination, outlining the reasons for their decision, within 30 days after filing the Level 2 Grievance Appeal. The written determination of the Executive Director and Board of Governors concerning the Level 2 Grievance is final. This Level 2 appeal is not subject to external appeal, since a grievance does not involve Medical Necessity or Experimental/Investigational issues.

Appeals that Involve Medical Necessity or Experimental/Investigational

Coordinated Health/Care will handle Level 1 appeals, using qualified clinical peer reviewers who were not involved in the initial adverse benefit determination, and adhere to the same time frames for Level 1 Grievances set forth above. Level 1 appeal decisions are final, and therefore immediately subject to external appeals and can be taken directly to external appeal as a final adverse benefit determination.

Special Consideration for Matters that Involve Medical Necessity or Experimental/Investigational

An application for Special Consideration can be made to the SWSCHP Executive Director, in coordination with representatives of the SWSCHP Board of Governors, in the same way and same time frames as for a Level 2 appeal of a Grievance, described above. It is not necessary to seek Special Consideration. An external appeal can still be pursued, and the time to do so is running during the Special Consideration process. Seeking special consideration represents another avenue of relief in the case of SWSCHP Covered Persons, and may result in receiving a favorable determination and thus eliminate the need for an external appeal.

YOUR RIGHT TO AN EXTERNAL APPEAL

Under certain circumstances, you have a right to an external appeal of an adverse benefit determination. 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.

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:

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

B. 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).

YOUR RIGHT TO APPEAL A DETERMINATION THAT SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

If the Plan has denied coverage on the basis that the service is an Experimental or Investigational treatment, in addition to satisfying the two (2) criteria above, 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).

Your attending Physician must also 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.

THE EXTERNAL APPEAL PROCESS

If, through the first level of 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, or is an out-of-network 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 first level of 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 Plan. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the 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 Plan 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. There is no cost to you to file an external appeal.

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 external 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 this Plan. 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.

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. ***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.

    2. ***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 the parents are separated or divorced, the order of benefits is:
            1) the Plan of the custodial parent; then
            2) the Plan of the spouse of the custodial parent; and then
            3) the Plan of the noncustodial parent.

        c. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

3. ***Active or inactive employee***. The Plan that covers a person as an Employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a Retiree and an Employee. 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, provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(1) above.

4. ***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).

5. **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.

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

If 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

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

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.

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.

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)

IMPORTANT:

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.

HIPAA Certification of Creditable Coverage When Coverage Ends

When your COBRA coverage ends, the Plan Administrator will automatically provide you and/or your Covered Dependents (free of charge) with a HIPAA Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your Covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your Covered Dependents, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your Covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your Covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any Covered Dependent upon receipt of a written request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended. See the Eligibility section for the procedure for requesting a HIPAA Certificate of Coverage.

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.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** 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, case management and care coordination, disease 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 amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of PHI disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the 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; and
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.

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.