PLAN DOCUMENT

This Municipal Cooperative Health Benefit Plan is not a licensed insurer. It operates under a more limited Certificate of Authority granted by the Superintendent of Insurance. Municipal Corporations participating in the Municipal Cooperative Health Benefit Plan are subject to Contingent Assessment Liability.

January 2024

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PREAMBLE

INTRODUCTION

The Putnam|Northern Westchester Health Benefits Consortium Health Plan, a Municipal Cooperative Health Benefit Plan, referred to as the Plan, assures covered individuals during the continuance of the Plan that all benefits hereinafter described shall be paid to them, or on their behalf, in the event they incur covered expenses as defined herein. The Plan is subject to all the terms, provisions and limitations stated on the following pages.

This Municipal Cooperative Health Benefit Plan is not a licensed insurer. It operates under a more limited Certificate of Authority granted by the Superintendent of Insurance. Municipal Corporations participating in the Municipal Cooperative Health Benefit Plan are subject to Contingent Assessment Liability.

It is intended that the terms of the Plan be legally enforceable and that the Plan be maintained for the exclusive benefit of eligible employees, retirees, and dependents.

The terms of the Plan of benefits are described herein. The eligibility, coverage and benefit provisions, terms and conditions are subject to change with at least 30-days notice.

The Plan Administrator has retained Aetna and Navitus as third party administrators to process claims and administer the Plan. Please refer to your Aetna or Navitus identification card for Plan/group numbers.

Your Employer is providing health benefits to you through the self-funded Putnam|Northern Westchester Health Benefits Consortium Health Plan (also referred to as the “PNW HBC Plan” or “the Plan”). This booklet is your Plan document and summary Plan description, and it provides information on your Plan benefits and your responsibilities to provide information to the Plan for proper administration of your medical claims. Any apparent conflict between this document and any other publication or presentation involving this Plan will be resolved by reference to this Plan document.

Participating Districts

The Putnam|Northern Westchester Health Benefits Consortium is comprised of the following employers (referred to as the Group in the “Definitions” section of the Booklet):

- Brewster Central School District
- Briarcliff Manor Union Free School District
- Chappaqua Central School District
- Croton- Harmon Union Free School District
- Garrison Union Free School District
- Haldane Central School District
- Hendrick Hudson Central School District
- Lakeland Central School District
- Mahopac Central School District
- Peekskill City School District
- Putnam Valley Central School District
- Somers Central School District
- Yorktown Central School District
- Putnam/Northern Westchester BOCES

Plan Administrator
Joint Governance Board
Putnam/Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

Note: The Joint Governance Board will hire organizations to administer the Plan on their behalf.

BENEFITS AND ELIGIBILITY

The following, along with the Medical Plan Booklet and Prescription Drug Benefit sections describe the health care benefits funded by the PNW HBC.

The purpose of this document is to explain your rights and responsibilities in working with PNW HBC, 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 Putnam|Northern Westchester Health Benefits Consortium website. https://www.pnwboces.org/Health-Benefits-Consortium/Health-Benefits-Consortium-Home.aspx.

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.

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.

When Coverage Begins

As an employee you can enroll yourself and your dependents

- At the end of any waiting period your Employer requires

- During your Employer's annual enrollment period
- At other special times during the year (see the Special times you and your dependents can join the Plan section below)

If you do not enroll yourself and your dependents when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

Waiting Period
You and your Dependents (see Definitions) are eligible for coverage as specified under 'Waiting Period" in the "Definitions" section.

Open Enrollment Period
Certain provisions of your Open Enrollment Period may be modified by your Employer. If you have Open Enrollment Period questions, contact your School District's business or personnel office.

Each component employer may allow eligible employees to enter the Plan during an annual open enrollment period. This period shall be May/June and become effective July 1.

An individual entering the Plan during the open enrollment period shall not be considered a late enrollee.

WHO IS ELIGIBLE

Employee Eligibility
Minimum requirements for determination of eligibility shall be established by each individual Employer subject to the following:

An individual who is employed by more than one participating employer shall only be allowed to enroll under one employer.

Employee Coverage
If an employee submits a completed enrollment application to the Employer's HR Department within 31-days of the date of FIRST eligibility, the employee's coverage may become effective on the first day of the month following the month in which the employee applies for coverage.

A. If an employee requests that coverage begin on the first date of employment, the employer may, at its discretion, comply with the employee's request provided the employee submits a completed enrollment application to the Employer's HR Department on or before the date of employment.

B. The participating employer may, at its discretion, also require the employee to satisfy a period of employment before coverage for the employee and any eligible dependents becomes effective; however, this employment period must be applied on a uniform basis for all new employees and may not exceed ninety (90) days. The effective date of coverage will be the first day of the month following the month during which the employee satisfies the required period of employment. An employee who is hired on, or otherwise acquires

eligibility on, the first day of a month may count that month in establishing his effective date of coverage.

An employee who fails to submit a completed enrollment application to the Employer's HR Department for enrollment during the 31-day period following the date of his first eligibility must then wait for the annual enrollment period to apply for coverage.

Who can be on Your Plan (who can be your dependent)?
You can enroll the following family members on your Plan. They are referred to in this booklet as your "Dependents". The following section provides additional guidance:

A. Spouse means an individual to whom the employee is legally married, as recognized in New York State.

B. Children covered under this Plan include your natural Child(ren), legally adopted Child(ren), stepchild(ren), and Child(ren) for whom You are the proposed adoptive parent without regard to financial dependence, residency with you, student status or employment. A proposed adopted Child(ren) is eligible for coverage on the same basis as a natural Child(ren) during any waiting period prior to the finalization of the Child(ren)'s adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. A natural, legally adopted or step-child(ren) under age 26 is eligible for coverage. A child(ren) under age 26 who is not the natural, adopted or step-child(ren) of the employee may be covered if s/he is claimed as a dependent in accordance with section 152(f) of the Internal Revenue Code.

   The Plan Administrator has the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Plan at any time.

C. Any unmarried dependent Child(ren), over age 26, incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap, chiefly dependent upon the employee for support and maintenance and claimed as a dependent in accordance with section 152(f) of the Internal Revenue Code, and who became so incapable prior to age 26. Proof of such incapacity and dependency must be furnished to the Plan at least 31 days prior to the child's 26th birthday.

   If a dependent child is 26 or older at the time of initial enrollment, and that child was incapable of self-sustaining enrollment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap before age 26, such proof as required by the Plan must be submitted within 31 days of the initial effective date of coverage.

   The Claims Administrator may require, at reasonable intervals, subsequent proof of the child's disability, handicap status, and dependency. The request form and all clinical documentation will be reviewed by the Claims Administrator's medical director to determine status.

D. Any person who does not specifically meet one of the criteria outlined in this section shall not be an eligible dependent.

E. Any person who is on active duty in the armed forces of any country shall not be an eligible dependent

F. Time spent in service with a branch of the United States military, not to exceed 4 years, may be deducted from the age of a child(ren) in determining his eligibility for enrollment.

Adding New Dependents
You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your Plan.
    - Your Employer must receive your completed enrollment information not more than 31 days after the date of your marriage.
    - Ask your Employer when benefits for your spouse will begin. If the employee requests that dependent coverage begin on the date of marriage, the employer shall comply with the employee's request provided he/she submits a completed enrollment application to the Employer's HR Department on or before the date of marriage.
- No later than the first day of the first calendar month after the date your Employer receives your completed enrollment information and
- Within 31 days of the date of your marriage.
- A newborn child(ren) - Your newborn child(ren) is covered on your health Plan for the first 48 hours for a vaginal delivery or 96 hours for C-section even if the baby is not added to the Plan within the required 60 days.
    - To keep your newborn covered, your Employer's HR Department must receive your completed enrollment information within 60 days of birth.
    - You must still enroll the child(ren) within 60 days of birth even when coverage does not require payment of an additional contribution for the covered dependent.
- An adopted child(ren) -
    - Your Employer's HR Department must receive your completed enrollment information within 60 days after the adoption.
- A stepchild(ren) - You may put a child(ren) of your spouse on your Plan.
    - You must complete your enrollment information and send it to your Employer's HR Department within 31 days after the date of your marriage with your stepchild(ren)'s parent.
    - Ask your Employer when benefits for your stepchild(ren) will begin. It is either on the date of your marriage or the first day of the month following the date your Employer's HR Department receives your completed enrollment information.

Dependent Coverage
This section shall not apply to adult children who are enrolling pursuant to the NY State "Age 29" Law.

A. If an employee applies for Family coverage at the same time as Individual coverage, the effective date of Family coverage will be the same as the employee's.

B. If an employee submits a completed enrollment application to the Employer's HR Department to add a dependent within 31-days of the date an eligible dependent is first acquired, the effective date of coverage for that dependent will be the first day of the month following the month in which the completed enrollment application is received by the employer's HR Department. If the completed enrollment application is submitted on the first day of the month and is within 31-days of acquiring the dependent, then coverage may become effective that day.

    1. If this change is due to marriage and the employee requests that dependent coverage begin on the date of marriage, the employer shall comply with the employee's request provided he submits a completed enrollment application to the Employer's HR Department on or before the date of marriage.

    2. If this change is due to the birth or adoption of a child(ren) and the employee requests that coverage begin on the date of birth or adoption, the employer shall comply with the employee's request provided he submits a completed enrollment application to the Employer's HR Department within 60-days of the date of birth or adoption

C. If an employee who has only Individual coverage submits a completed enrollment application to the Employer's HR Department to add a dependent more than 31-days after the acquisition of the eligible dependent (60-days following the birth or adoption of a child(ren)), then the employee must wait until the annual enrollment period to add the dependent however, if the new dependent is a newborn infant and the employee did not submit a completed enrollment application to the Employer's HR Department within 60-days, then coverage shall become effective from the date the employee submits a completed enrollment application to the Employer's HR Department.

D. If an employee who has Family coverage submits a completed enrollment application to the Employer's HR Department to add an additional dependent more than 31-days after acquisition of the new dependent (60-days following the birth or adoption of a child(ren)), coverage shall become effective no earlier than the first day of the calendar month following the month in which the employee submits a completed enrollment application to the Employer's HR Department; however, if the new dependent is a newborn infant and the employee did not submit a completed enrollment application to the Employer's HR Department within 60-days, then coverage shall become effective from the date the employee submits a completed enrollment application to the Employer's HR Department

Changes from Family Coverage

A. A Subscriber may change from Family coverage to Individual coverage at any time. Adjustment of the employer's and employee's contribution toward the cost of coverage shall not take effect until the first day of the month following the month of the request to change to Individual coverage.

B. If, and only if, the sole dependent of a Subscriber is also an eligible employee or retiree of a participating employer, but not already covered as an employee or retiree, Family coverage

may be changed to two Individual coverages. This coverage change shall take effect on the first day of the month following the month of the change request.

C. If the spouse of an employee enrolled for Family coverage is also an employee or retiree of a participating employer, but not already covered as an employee or retiree, enrollment may be transferred from the currently enrolled spouse to the dependent spouse only during the annual, open enrollment period.

Eligibility for Retiree Benefits

A. An employee or retiree of a participating employer is eligible to continue coverage in retirement if he:
    1. has had at least ten (10) years of full-time service, not necessarily continuous, with the employer from which he is retiring; (In the event that an employer's collective bargaining agreement, internal policy or past practice differs from 10-years, it shall take precedence over this provision of the Plan Document). and
    2. has vested for benefits from a retirement system administered by the State of New York; and
    3. is at least 55 years of age.

B. An employee or retiree is also eligible to continue coverage during retirement, regardless of age or length of service with the participating employer, if granted a service connected disability retirement by a retirement or pension plan or system administered and operated by the State of New York due to an injury, illness or disease that resulted from his service with the participating employer.

C. Employees who have qualified for Social Security Disability payments are considered to be retired for health benefits purposes, regardless of age, provided that they have had at least 10 years of service with the participating employer. Proof of Social Security status will be required.

Vesting for Benefits

A. Employees who terminate their employment before age (55) may continue their health benefits if they have;
    1. satisfied the minimum requirements established by their retirement system for vesting receipt of their retirement allowance (this need not be done officially); and
    2. met the minimum requirements of the employer, other than age, for continuation of health benefits into retirement; and
    3. terminated employment within five (5) years of the date on which they
        i. are entitled to receive a retirement allowance or
        ii. become age fifty five (55).

B. Eligible employees who wish to continue coverage as Subscribers in the program during vested status, must pay both the employer and employee share of the cost of coverage (i.e., the full cost of coverage) from the date their employment terminates until the date they become eligible to receive a retirement allowance from an approved retirement system. After that date, they are only responsible for the retiree's share of payments, if any. All required payments by vestees must be made to the employer where they were formerly employed.

C. Vestees who wish to continue coverage into their retirement, must continue health insurance coverage as a Subscriber or as a dependent of a Subscriber while in vested status. This may include coverage as the spouse of a Subscriber of a participating employer different than that of the vestee. Further, if the vestee maintains continuity of coverage as a dependent of a Subscriber, they may continue vestee status beyond that date that he initially becomes eligible to receive a retirement allowance from an approved retirement system. **A vestee whose coverage lapses will not be permitted to reinstate coverage, either during vested status or after retirement.**

D. Once an employee has established eligibility to continue health benefits coverage as a vestee through one participating employer, that eligibility shall not be impaired by subsequent employment and/or enrollment through another participating employer, except when the employee establishes eligibility for coverage as a vestee or retiree through the second, or subsequent employer.

Notification of Change in Status
It is important that you notify your Employer's HR Department of any changes in your benefit status. This will help your Employer effectively maintain your benefit status. Please notify your Employer as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other group health plan of any covered dependent

Special Times You and Your Dependents can Join the Plan
You can enroll in these situations:

- When you did not enroll in this Plan before because:
  - You were covered by another group health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
  - You or your dependents lose eligibility for State premium assistance under Medicaid or an S-CHIP plan for the payment of your contribution for coverage under this Plan. Your Employer's HR Department must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Declination of Health Benefits
Except as noted below, an individual who declines coverage at the time he initially becomes eligible or declines coverage during the annual enrollment period, shall be required to wait until the next Open Enrollment Period Effective Date to become covered under the Plan. This shall include, but not be limited to, an employee who declines coverage in favor of an employee's "buy out" option or to avoid paying the employee's share of the health benefits premium.

Certain changes in your status may enable you to enroll in the Plan at times other than the annual open enrollment period. Where an employee, retiree, or dependent rejected initial enrollment in the Plan, he may later enroll if each of the following conditions are met:

- The employee, retiree or dependent was covered under another plan at the time coverage was initially offered, and;

- Eligibility for coverage under the other plan was lost and coverage was terminated for one of the following reasons:
  - continuation coverage required by federal or state law was exhausted; or
  - termination of employment; or
  - death of the spouse; or
  - legal separation, divorce, or annulment; or
  - reduction in the number of hours of employment; or
  - contract holder contributions toward the payment of premium for the other plan were terminated; or
  - reaching the maximum eligibility age.

A completed enrollment application must be submitted to the Employer's HR Department within 31-days of termination to be considered timely.

Death of Subscriber - Survivor Coverage

A. In the event of the death of an employee or retiree enrolled for Individual coverage, coverage will terminate on the date of death.

B. In the event of the death of an employee or retiree enrolled for Family coverage, the coverage of any surviving dependents may be continued in accordance with the Federal COBRA continuation coverage rules. The employer shall make a contribution toward the cost of this coverage, for a period of at least 3 months, at the same percentage the employer had been making immediately preceding the death of the employee. After 3 months, the full cost of coverage shall be paid by the surviving spouse or dependents, unless the participating employer establishes administratively or through contract negotiations, a contribution less than 100% for surviving spouses and/or dependents.

1. If the deceased employee or retiree was enrolled for Family coverage and had completed ten (10) years of active service or as an employee having had completed the years of service required to become eligible for vesting in the Teachers' Retirement System or Employees' Retirement System prior to death, then the spouse of the deceased employee may continue coverage as long as the spouse remains unmarried and dependent children may continue coverage for as long as the children would have been eligible had the Subscriber lived. The surviving spouse and/or dependents shall pay the full cost of coverage (i.e., the employer's and employee's share). A participating employer may choose to reduce the above ten (10) year requirement. In addition, a participating employer may share in the cost of the surviving spouse's and/or dependent's coverage.

2. Regardless of the length of service, if the death of an active employee enrolled for Family coverage results from a work incurred injury, the surviving dependents may be eligible to continue coverage as dependent survivors. To be eligible, the survivors must be entitled to accidental death benefits payable by a retirement system or pension plan administered by the state or civil division thereof, or to death benefits provided under the Worker's Compensation law. The surviving spouse and/or dependents shall pay the full cost of coverage (i.e., the employer's and employee's share).

C. To enroll as a surviving dependent or spouse, the spouse or dependent must inform the business or personnel office of the applicable employer within 90 days of the employee's death.

No application made after the 90 day period will be accepted. Since application must be made while coverage is still in effect, the dependent survivor(s) will retain the Subscriber's original effective date of coverage.

D. The survivor(s) will be issued new identification cards containing the name of the surviving spouse. If there is no spouse and only dependent children are being enrolled, the name of the oldest child will be entered on the card.

E. When the dependent survivors are required to pay the full cost of coverage and only one or two survivors are eligible to continue health benefits, one or two Individual enrollments can be established rather than a Family enrollment. If there are three or more survivors and a Family enrollment is established, a change to two Individual enrollments can be subsequently established at any time if only two of these survivors continue to be eligible.

COBRA ADMINISTRATOR

- Information about coverage
- Adding or dropping dependents
- Cost of COBRA continuation Coverage
- COBRA premium payments
- Second qualifying event and disability notification

Contact your School District Health Benefits Representative at your Participating Employer.

HIPAA PRIVACY OFFICER AND HIPAA SECURITY OFFICER

- Request a HIPAA Notice of Privacy Practice

Privacy Officer
Putnam/Northern Westchester Health Benefit Consortium
200 BOCES Drive
Yorktown Heights, NY 10598
(914) 248-3694

MEDICAL AND PRESCRIPTION DRUG CLAIMS ADMINISTRATORS CONTACT INFORMATION

Aetna - Medical and Hospital Claims Administrator
Customer Service: 1-877-223-1685 POSII Plan
1-888-267-2637 Medicare Advantage Plan

To locate an Aetna participating provider on the web go to: http://www.aetna.com/docfind/index.html or call Aetna’s Customer Service phone number listed above.

Medical and hospital claims should be mailed to:
Aetna, Inc.
P.O. Box 981106
El Paso, TX 79998-1106

Navitus Health Solutions – Prescription Drug Claims Administrator
Customer Service: 1-866-333-2757 Commercial Plan
1-866-270-3877 MedicareRx Plan

Paper claims should be mailed to:
Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999

Birdi Mail Service Pharmacy – Customer Service 1-888-240-2211 www.birdirx.com

Putnam|Northern Westchester Health Benefits Consortium
Office of Risk Management
200 BOCES Drive
Yorktown Heights, NY 10598
914-248-2456
914-962-6819 (fax)
To view a copy of the Summary of Benefits, Plan Document, Notices, and Newsletters and to download forms go to:
http://pnwboces.org/Health-Benefits-Consortium/Health-Benefits-Consortium-Home.aspx

District Benefits Representatives
Enrollment and eligibility questions and updates should be directed to the District Benefits Representative of your school district

New York State Department of Financial Services
http://www.dfs.ny.gov/
1 State Street
New York, NY 10004-1511
212-480-6400
800-342-3736

The Summary of Benefits and Plan Document outline your rights to register a complaint or grievance with Aetna or Navitus.

Joint Governance Board
If your complaint or grievance has not been resolved, you may submit it to the Joint Governance Board for review. **Please note that the Joint Governance Board will NOT address Adverse Benefit Determinations by the Claims Administrators** (Aetna/Navitus)

Submit all documentation that you wish to be reviewed by the Joint Governance Board, **within 60 days after receipt of the notice of determination**. The Board will review your complaint or grievance at a regularly scheduled meeting and render a decision. The decision will be communicated to you, in writing within 15 days. Documentation should be submitted to:

Joint Governance Board
Attn: Office of Risk Management
Putnam/ Northern Westchester Health Benefits Consortium
200 BOCES Drive
Yorktown Heights, NY 10598

If you are not satisfied with the Joint Governance Board's decision you may request a hearing before the Board.

A. Your request for a hearing must be made in writing to the Joint Governance Board **within 60 days from the date of notice of the Joint Governance Board's decision**.
B. The Board will determine if your request for a hearing will be granted. If granted, the Board will set a hearing date.
    1. Your complaint or grievance should be presented to the Board at the hearing by you and/or your personal representative.
    2. The Board will review all materials submitted through the hearing process and will provide you with a written response as to its determination within 15 days. That determination is final.

DESCRIPTION OF RELEVANT PROVISIONS OF ANY APPLICABLE COLLECTIVE BARGAINING AGREEMENT

The current applicable collective bargaining agreements are between the various participating School Districts and their collective bargaining units and/or unions representing Employees eligible to participate in the Plan. An Employee may obtain a copy of any such bargaining agreement applicable to him from his Employer.

DATES OF THE PLAN YEAR

January 1 through the December 31

INTERNAL REVENUE SERVICE TAX IDENTIFICATION NUMBER

Tax Identification Number 13-3962250

CMS HEALTH INSURANCE OVERSIGHT SYSTEM HEALTH PLAN IDENTIFICATION NUMBER

HPID 7679576422

PLAN AMENDMENT PROCEDURE

The Joint Governance Board, by a majority decision and as authorized by the Trustees under separate agreement, may alter, change, or amend any Plan coverage or benefit if such change, modification, or amendment is determined to be required for the prudent administration of the Plan. Any decisions of the Joint Governance Board shall be binding upon all members of the Plan. This includes, but is not limited to, active employees, retirees, dependents of employees and retirees, and beneficiaries of Continued Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

MEDICAL PLAN BOOKLET

Medical Plan Booklet

Third Party Administrative Services provided by Aetna Life Insurance Company

This Medical Plan Booklet ("Booklet") explains the benefits available to You through the Putnam|Northern Westchester Health Benefits Consortium Health Plan, a Municipal Cooperative Health Benefit Plan (the Plan) a self-funded health benefit Plan providing in-network and out-of-network coverage. This Booklet is not a contract between a covered participant and the Consortium. Amendments, riders, or endorsements may be delivered with the Booklet or added thereafter.

The Plan allows You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in the Claims Administrator's Network. You should always consider receiving health care services first through the in-network benefits portion of this Booklet

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Plan provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

READ THIS ENTIRE BOOKLET CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE PLAN. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND OF THE PLAN.

This Plan is governed by the laws of New York State.

SECTION I

Definitions

Defined terms will appear capitalized throughout this Booklet.

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

Allowed Amount: The maximum amount on which he Plan's payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Booklet for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

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

Appeal: A request for the Plan to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Booklet: Refers to the Medical Plan Booklet section of the Plan Document.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Booklet.

Claims Administrator: Entities retained by the Plan Administrator to provide, but not limited to, operational services such as claims processing, benefits management, billing, plan design, record keeping, regulatory compliance activities, and other services deemed necessary to deliver the benefits outlined in this Booklet.

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

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

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by the Claims Administrator under the terms and conditions of the Plan.

Deductible: The amount You owe before the Plan begins to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before the Plan begins to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children. Refer to the Preamble document.

Durable Medical Equipment ("DME"): Equipment which is: Designed and intended for repeated use;

- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and

Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that the Plan does not pay for or Cover.

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

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Sections 1.03, certified by the New York State Office of Addiction Services and Support, or certified under New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder

outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to the Plan that does not involve a Utilization Review determination.

Group: The employer participating in the Putnam|Northern Westchester Health Benefits Consortium.

Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy, and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under the Plan.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

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

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
  1. Has organized departments of medicine and major surgery;
  2. Has a requirement that every patient must be under the care of a Physician or dentist;
  3. Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
  4. If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
  5. Is duly licensed by the agency responsible for licensing such Hospitals; and
  6. Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

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

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

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

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

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before the Plan begins to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium or services the Plan does not Cover.

Medically Necessary: See the How Your Coverage Works section of this Booklet for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Network: Providers the Claims Administrator has contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with the Claims Administrator to provide health care services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Copayment: A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before the Plan begins to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before the Plan begins to pay for a particular Covered Service.

Out-of-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before the Plan begins to pay 100% of the Allowed Amount for Covered Services received from

Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services the Plan does not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before the Plan begins to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services the Plan does not Cover.

Participating Provider: A Provider who has a contract with the Claims Administrator to provide health care services to You. A list of Participating Providers and their locations is available on the Claims Administrator’s website or upon Your request, to the Claims Administrator. The list will be revised from time to time by the Claims Administrator.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: The health benefits provided to you through the self-funded Putnam|Northern Westchester Health Benefit Consortium as described in the Preamble section of this document.

Plan Administrator: The Joint Governance Board of the Putnam/Northern Westchester Health Benefits Consortium

Plan Year: The 12-month period beginning on the effective date of the Plan or any anniversary date thereafter, during which the Plan is in effect.

Preauthorization: A decision by the Claims Administrator prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. The Plan indicates which Covered Services require Preauthorization in the Schedule of Benefits.

Preferred Provider: A Provider who has a contract with the Claims Administrator to provide health care services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider. You will see these providers as Maximum Savings in the directory.

Premium: The amount that must be paid for Your health insurance coverage.

Primary Care Physician (“PCP”): A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

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

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick,

hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The document that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

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

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions, including mental health or substance use disorders.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Plan Document is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (e.g., treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Plan.
The Plan will provide the benefits described in this Booklet to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Booklet is not a contract between You and the Plan. You should keep this Booklet with Your other important papers so that it is available for Your future reference.

B. Covered Services.
You will receive Covered Services under the terms and conditions of the Plan only when the Covered Service is:
- Medically Necessary;
- Furnished by a Provider acting within the scope of their license;
- Provided by a Participating Provider or a Provider from the Claims Administrator's network for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits; and
- Received while the Plan is in force.

Services received from a Non-Participating Provider are covered but paid at a lesser benefit than a Participating Provider.

C. Participating Providers.
To find out if a Provider is a Participating Provider:
- Check the Claims Administrator's Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit the Claims Administrator's website.

The Provider directory will give You the following information about Participating Providers:
- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

D. The Role of Primary Care Physicians.
This Plan does not have a gatekeeper, usually known as a Primary Care Physician ("PCP"). Although You are encouraged to receive care from Your PCP, You do not need a Referral from a PCP before receiving certain Specialist care from a Participating Provider.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits when the services provided are related to specialty care.

E. Access to Providers and Changing Providers.
Sometimes Providers in the Claims Administrator's Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a member of the Network provided by the Claims Administrator, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

If the Claims Administrator does not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, the Claims Administrator may approve an authorization to a specific Non-Participating Provider until You no longer need the care or the Claims Administrator has a Participating Provider in their network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

F. Out-of-Network Services.
The Plan Covers the services of Non-Participating Providers. Services received from a Non-Participating Provider are covered but paid at a lesser benefit than a Participating Provider. See the Schedule of Benefits section for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply to in-network and out-of-network services.

G. Services Subject to Preauthorization.
Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network and out-of-network services listed in the Schedule of Benefits. Your Participating Provider is responsible for requesting Preauthorization for in-network services and You are responsible for requesting Preauthorization for the out-of-network services listed in the Schedule of Benefits.

H. Preauthorization Procedure.
If You seek coverage for out-of-network services that require Preauthorization, Your Provider must call the Claims Administrator at the number on Your ID card.

You must contact the Claims Administrator to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.

- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.

- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.

- Before air ambulance services are rendered for a non-Emergency Condition.

- If You are hospitalized in cases of an Emergency Condition, You must call the Claims Administrator within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, the Claims Administrator will review the reasons for Your planned treatment and determine if benefits are available under the Plan. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

I. Failure to Seek Preauthorization.
If You fail to seek Preauthorization for benefits subject to this section, the Plan will pay an amount of $250 less than the Plan would otherwise have paid for the care, or the Plan will pay only 50% of the amount the Plan would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. The Plan will pay the amount specified above only if the Claims Administrator determines the care was Medically Necessary even though You did not seek Preauthorization. If the Claims Administrator determines that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

J. Medical Management.
The benefits available to You under the Plan are subject to pre-service, concurrent, and retrospective reviews to determine when services should be Covered by the Plan. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

K. Medical Necessity.
The Plan Covers benefits described in this Booklet as long as the health care service, procedure, treatment, test, device, Prescription Drug, or supply (collectively, “service”) is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that the Plan has to Cover it.

The Claims Administrator may base it’s decision on a review of:

- Your medical records;
- The Claims Administrator’s medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;

- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Appeal sections of this Booklet for Your right to an internal Appeal and external appeal of the Claims Administrator's determination that a service is not Medically Necessary.

L. Protection from Surprise Bills.

1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:
   - For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
     - A participating Physician is unavailable at the time the health care services are performed;
     - A non-participating Physician performs services without Your knowledge; or
     - Unforeseen medical issues or services arise at the time the health care services are performed.

   A surprise bill does not include a bill for health care services when a participating Physician is available, and You elected to receive services from a non-participating Physician.
   - You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by the Plan. For a surprise bill, a referral to a Non-Participating Provider means:
     - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
     - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
     - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under the Plan.

   You will be held harmless for any Non-Participating Provider charges for the surprise bill

that exceed Your In-Network Copayment, Deductible or Coinsurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your In-Network Copayment, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit the Claims Administrator's website for a copy of the form. You need to mail a copy of the assignment of benefits form to the Claims Administrator at the address on their website and to Your Provider.

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

M. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, the Plan will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Plan that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies, including telephone or video using smart phones or other devices, by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

N. Case Management.

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Plan's programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

The Plan's case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, the Claims Administrator will help You meet Your identified health care needs. This is reached through contact and teamwork with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care through the Plan's case management program that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the benefit maximums of the Plan. The Plan will make its decision on a case-by-case basis if the Claims Administrator determines the alternate or extended benefit is in the best interest of You and the Plan.

Nothing in this provision shall prevent You from appealing the Claims Administrator's decision. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Plan will notify You or Your representative in writing.

O. Important Telephone Numbers and Addresses of the Medical Plan Administrator.

- CLAIMS
  Refer to the address on Your ID card
  (Submit claim forms to this address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Call the number on Your ID card

- ASSIGNMENT OF BENEFITS FORM
  Refer to the address on Your ID card
  (Submit assignment of benefits forms for surprise bills to this address.)

- MEDICAL EMERGENCIES AND URGENT CARE
  Call the number on Your ID card
  Monday – Friday, 8:00 a.m. – 6:00 p.m.

- MEMBER SERVICES
  Call the number on Your ID card
  (Member Services Representatives are available Monday - Friday, 8:00 a.m. – 6:00 p.m.)

- PREAUTHORIZATION
  Call the number on Your ID card

- BEHAVIORAL HEALTH SERVICES
  Call the number on Your ID card

SECTION III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

If there is no Participating Provider that has the appropriate training and experience to treat Your condition, the Claims Administrator will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If the Claims Administrator approves the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by the Claims Administrator in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit if available.

B. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves the Network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the Claims Administrator's relationship with the Provider. The Provider must also agree to provide the Claims Administrator necessary medical information related to Your care and adhere to the Plan's policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by the Claims Administrator. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by the Claims Administrator due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

C. New Members In a Course of Treatment.

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Plan becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under the Plan. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under the Plan becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment the Plan's fees for such services. The Provider must also agree to provide the Claims Administrator necessary medical information related to Your care and to adhere to the Plan's policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by the Claims Administrator. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.
There is no Deductible for Covered in-network Services under this Plan during each Plan Year.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits for Covered out-of-network Services during each Plan Year before the Plan provides coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under the Plan. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under the Plan collectively total the family Deductible amount in the Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under the Plan for that Plan Year.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments.
Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits for Covered out-of-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.
Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. The Plan will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. In-Network Out-of-Pocket Limit.
When You have met Your Out-of-Pocket Limit in payment of In-Network and Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits, the Plan will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits, the Plan will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person.

Cost-Sharing for out-of-network services, except for Emergency Services and out-of-network services approved by the Claims Administrator as an in-network exception and out-of-network dialysis does not apply toward Your In-Network Out-of-Pocket Limit. The Preauthorization penalty described in the How Your Coverage Works section of this Booklet does not apply toward Your In-Network Out-of-Pocket Limit. The In-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

E. Out-of-Network Out-of-Pocket Limit.
The Plan has a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits for out-

of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits, the Plan will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual; per person Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits, the Plan will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under the Plan have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits, the Plan will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for the entire family. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward Your Out-of-Network Out-of-Pocket Limit.**

Cost-Sharing for in-network services does not apply toward Your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in the How Your Coverage Works section of this Booklet does not apply toward Your Out-of-Network Out-of-Pocket Limit. The Out-of-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

F. Your Additional Payments for Out-of-Network Benefits.

When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds the Plan's Allowed Amount. This means that the total of the Plan's coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, the Claims Administrator will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that the Plan pays for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. The Plan will make one (1) inclusive payment in that case rather than a separate payment for each billed code. Another example of when the Claims Administrator will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If the Claims Administrator receives a claim that does not have the correct modifier, the Claims Administrator will change it and make the appropriate payment. Additionally, another example of when the Plan will apply a payment rule to a claim is when You receive services from a Health Care Professional who is not a Physician, such as a physician's assistant. Under the payment rule, the Allowed Amount for a physician's assistant or other Health Care Professional who is not a Physician will be less than the Allowed Amount for a Physician.

G. Allowed Amount.

"Allowed Amount" means the maximum amount the Plan will pay for the services or supplies Covered under the Plan before any applicable Copayment, Deductible and Coinsurance

amounts are subtracted. The Plan determines the Allowed Amount as follows:

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. **Facilities**
   For Facilities, the Allowed Amount will be 200% of Medicare amount.

   If there is no amount as described above, the Allowed Amount will be an amount based on cost information from the Centers for Medicare and Medicaid Services.

2. **For All Other Providers**
   For all other Providers, the Allowed Amount will be 200% of the Medicare amount.

   If there is no amount as described above, the Allowed Amount will be an amount based on cost information from the Centers for Medicare and Medicaid Services.

The Plan's Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed the Plan's Allowed Amount. You must pay the difference between the Plan's Allowed Amount and the Non-Participating Provider's charge. Contact the Claims Administrator at the number on Your ID card or visit the Claims Administrator's website for information on Your financial responsibility when You receive services from a Non-Participating Provider.
The Claims Administrator reserves the right to negotiate a lower rate with Non-Participating Providers. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

See the Emergency Services and Urgent Care section of this Booklet for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Booklet for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V

Who is Covered

A. Who is Covered Under this Plan.

You, the Subscriber to whom this Booklet is issued, are covered under the Plan. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

The Plan offers the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse or Child.** If You selected individual and Spouse or Child coverage, then You and Your Spouse or Child are covered.

3. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Plan.

Refer to the Preamble Document

D. When Coverage Begins.

Refer to the Preamble Document

E. Special Enrollment Periods.

You, Your Spouse or Child can also enroll for coverage within 31 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce, or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

SECTION VI

Preventive Care

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

Preventive Care.
The Plan Covers the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact the Claims Administrator at the number on Your ID card or visit their website for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. **Well-Baby and Well-Child Care.** The Plan Covers well-baby and well-childcare which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan also Covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per calendar year, The Plan will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 22 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

B. **Adult Annual Physical Examinations.** The Plan Covers adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

   Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on the Claims Administrator's website or will be mailed to You upon request.

   You are eligible for a physical examination once every calendar year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

C. **Adult Immunizations.** The Plan Covers adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. **Well-Woman Examinations.** The Plan Covers well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. The Plan also Covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive Services is available on the Claims Administrator’s website or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

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

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

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, the Plan Covers mammograms as recommended by the Member’s Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.
Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

The Plan also Covers additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

F. **Family Planning and Reproductive Health Services.** The Plan Covers family planning services which consist of: FDA-approved contraceptive methods prescribed by a Provider; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

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

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

G. **Bone Mineral Density Measurements or Testing.** The Plan Covers bone mineral density measurements or tests. Bone mineral density measurements or tests shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:
   - Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
   - With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
   - On a prescribed drug regimen posing a significant risk of osteoporosis;
   - With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
   - With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

   The Plan also Covers osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

   This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider and in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services.

H. **Screening for Prostate Cancer.** The Plan Covers an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test. The Plan also Covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

   This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. **Pre-Hospital Emergency Medical Services.** The Plan Covers Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

   "Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. The Plan will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:
   - Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
   - Serious impairment to such person's bodily functions;
   - Serious dysfunction of any bodily organ or part of such person; or
   - Serious disfigurement of such person.

   An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible, or Coinsurance.

   In the absence of negotiated rates, The Plan will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services will be paid under the requirements of the New York State No Surprises Act.

2. **Emergency Ambulance Transportation.** In addition to Pre-Hospital Emergency Medical Services, the Plan also Covers emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water, or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation.
The Plan Covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Air Ambulance Allowed Amount for Non-Participating Providers.
The Plan will pay an air ambulance Non-Participating Provider 100% of the Centers for Medicare and Medicaid Services Provider fee schedule unadjusted for geographic locality. The Claims Administrator reserves the right to negotiate a lower rate with the Non-Participating Provider.

If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to Your Copayment, Deductible, or Coinsurance.

D. Limitations/Terms of Coverage.

- The Plan does not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by the Claims Administrator, even though prescribed by a Physician.
- The Plan does not Cover non-ambulance transportation such as ambulette, van or taxicab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

E. Payments for Air Ambulance Services. The Plan will pay a Non-Participating Provider the amount the Claims Administrator has negotiated with the Non-Participating Provider for the air ambulance service or an amount the Claims Administrator has determined is reasonable for the air ambulance service or the Non-Participating Provider's charge. However, the negotiated amount or the amount the Claims Administrator determines is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity, the Plan will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any In-Network Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your In-Network Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your

In-Network Copayment, Deductible or Coinsurance, You should contact the Claims Administrator. Visit their website or www.dfs.ny.gov for more information on the independent dispute resolution process for air ambulance bills.

SECTION VIII

Emergency Services and Urgent Care

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

A. Emergency Services.
The Plan Covers Emergency Services for the treatment of an Emergency Condition in a Hospital.

The Plan defines an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. The Plan will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, the Plan will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**. **The Plan does not Cover follow-up care or routine care provided in a Hospital emergency department.**

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify the Claims Administrator at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

   The Plan Covers inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital. Any inpatient Hospital services received from a non-participating Hospital after Your medical condition no longer prevents Your transfer to a participating Hospital will be Covered at the out-of-network Cost-Sharing, unless Claims Administrator authorizes continued treatment at the non-participating Hospital.

   The Plan Covers inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital, unless the Claims Administrator authorizes continued treatment at the non-participating Hospital. If Your medical condition permits Your transfer to a participating Hospital, the Claims Administrator will notify You and work with You to arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital after the Claims Administrator has notified You and offered assistance in arranging for a transfer to a participating Hospital will be Covered at the out-of-network Cost-Sharing.

3. **Payments Relating to Emergency Services Rendered.** The Plan will pay a Non-Participating Provider the amount Claims Administrator has negotiated with the Non-Participating Provider for the Emergency Service or an amount the Claims Administrator has determined is reasonable for the Emergency Service or the Non-Participating Provider's charge. However, the negotiated amount or the amount the Claims Administrator determines is reasonable will not exceed the Non-Participating Provider's charge.

   If a dispute involving a payment for Emergency Services is submitted to an independent dispute resolution entity ("IDRE"), the Plan will pay the amount, if any, determined by the IDRE for the services.

   You are responsible for any In-Network Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your In-Network Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Copayment, Deductible or Coinsurance, You should contact the Claims Administrator.

B. Urgent Care.

Urgent Care is medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends, or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

1. **In-Network.** The Plan Covers Urgent Care from a participating Physician or a participating Urgent Care Center.

2. **Out-of-Network.** The Plan Covers Urgent Care from a non-participating Urgent Care Center.

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

SECTION IX

Outpatient and Professional Services

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

A. Acupuncture.
Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your physician, if the service is performed:
- As a form of anesthesia in connection with a covered surgical procedure.

B. Advanced Imaging Services.
The Plan Covers PET scans, MRI, nuclear medicine, and CAT scans.

C. Allergy Testing and Treatment.
The Plan Covers testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. The Plan also Covers allergy treatment, including desensitization treatments, routine allergy injections and serums.

D. Ambulatory Surgical Center Services.
The Plan Covers surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

E. Chemotherapy and Immunotherapy.
The Plan Covers chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Self-administered and Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Booklet.

F. Chiropractic Services.
The Plan Covers chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of the vertebral column. This includes assessment, manipulation, and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of the Plan.

G. Clinical Trials.
The Plan Covers the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:
- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

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

The Plan does not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under the Plan for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:
- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

H. Dialysis.
The Plan Covers dialysis treatments of an Acute or chronic kidney ailment.

The Plan also Covers dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:
- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify the Claims Administrator in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that the Claims Administrator Plan has a reasonable opportunity to review Your travel and treatment plans.
- The Plan has the right to Preauthorize the dialysis treatment and schedule.
- The Plan will provide benefits for no more than 10 dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount the Plan would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

I. Habilitation Services.
The Plan Covers Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office. Habilitation Services visit limits are outlined in the Schedule of Benefits.

J. Home Health Care.
The Plan Covers care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:
- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items

would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care visit limits are outlined in the Schedule of Benefits. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

K. Infertility Treatment.
The Plan Covers services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, the Claims Administrator will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

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

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

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, the Plan Covers comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultrasound;
   - Artificial insemination;
   - Hysteroscopy;

- Laparoscopy; and
- Laparotomy.

3. **Advanced Infertility Services.** The Plan Covers the following advanced infertility services:
   - Three (3) cycles per lifetime of in vitro fertilization;
   - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers only if the in vitro fertilization benefit has not been exhausted. Coverage for gamete intrafallopian tube transfers or zygote intrafallopian tube transfers does not count towards the in vitro fertilization benefit limit; and

   A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. **Fertility Preservation Services.** The Plan Covers standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

5. **Exclusions and Limitations.** The Plan does not Cover:
   - Costs associated with an ovum or sperm donor, including the donor's medical expenses;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for services relating to surrogate motherhood that are not otherwise Covered Services under the Plan;
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless the Claims Administrator's denial is overturned by an External Appeal Agent.
   - Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm, or reproductive tissue unless as outlined above in section 4.

   All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. The Plan will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status, or gender identity, when determining coverage under this benefit.

L. Infusion Therapy.

The Plan Covers infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be

ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

M. Interruption of Pregnancy.
The Plan Covers abortions, including abortions in cases of rape, incest, or fetal malformation.

N. Laboratory Procedures, Diagnostic Testing and Radiology Services.
The Plan Covers x-ray, laboratory procedures and diagnostic testing, services, and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

O. Maternity and Newborn Care.
The Plan Covers services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital, or birthing center. The Plan Covers prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. The Plan will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Booklet for Coverage of inpatient maternity care.

The Plan Covers breastfeeding support, counseling, and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy or, if greater, one (1) per calendar year for the duration of breast feeding from a Participating Provider.

P. Office Visits.
The Plan Covers office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls.

Q. Outpatient Hospital Services.
The Plan Covers Hospital services and supplies as described in the Inpatient Services section of this Booklet that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

R. Preadmission Testing.
The Plan Covers preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

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

S. Prescription Drugs for Use in the Office and Outpatient Facilities.
The Plan Covers Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider’s office and Outpatient Facility for preventive and therapeutic purposes.

T. Retail Health Clinics.
The Plan Covers basic health care services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses.

U. Rehabilitation Services.
The Plan Covers Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office. Rehabilitation Services visit limits are outlined in the Schedule of Benefits.

V. Second Opinions.

1. **Second Cancer Opinion.** The Plan Covers a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis.

1. **Second Surgical Opinion.** The Plan Covers a second surgical opinion by a qualified Physician on the need for surgery.

3. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that the Claims Administrator designate another Provider to render a second opinion. If the first and second opinions do not agree, the Claims Administrator will designate another Provider to render a third opinion. After completion of the second opinion process, the Claims Administrator will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

W. Surgical Services.
The Plan Covers Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.
Sometimes two (2) or more surgical procedures can be performed during the same operation.

1. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, the Plan will pay for the procedure with the highest Allowed Amount and 50% of the amount the Plan would otherwise pay under the Plan for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. The Plan will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, the Plan will pay:
    - For the procedure with the highest Allowed Amount; and
    - 50% of the amount the Plan would otherwise pay for the other procedures.

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, the Plan will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount the Plan would otherwise pay for the other procedures.

X. Oral Surgery.
The Plan Covers the following limited dental and oral surgical procedures:

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

Y. Reconstructive Breast Surgery.
The Plan Covers breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. The Plan also Covers implanted breast prostheses following a mastectomy or partial mastectomy.

Z. Other Reconstructive and Corrective Surgery.
The Plan Covers reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

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

AA. Telemedicine Program.
In addition to providing Covered Services via Teladoc, the Plan Covers online internet consultations between You and Providers for medical conditions that are not an Emergency Condition. You can receive Covered Services through electronic means in two different ways: Teladoc or Telemedicine.

“Telemedicine” means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than the Participating Provider’s location.

Telemedicine is a consultation between you and a telemedicine Participating Provider who is performing a clinical medical or behavioral health service by means of electronic communication.

Covered Services for telemedicine consultations are available from a number of different kinds of Providers under your Plan. This includes:

- Primary care consultations
- Specialist consultations
- Outpatient Mental Health Care Services consultations
- Outpatient cognitive therapy consultations
- Substance Use Services consultations
- Health care services provided through a Retail Health Clinic
- Preventive care

Log in to the Claims Administrator’s website to review the telemedicine Provider listing and contact the Claims Administrator to get more information about Your options, including specific cost sharing amounts. In any case where benefits are limited to a certain number of days, visits, or dollar amounts such limits apply to in-network and out-of-network services.

The following are not **covered services**:
- Telephone calls
- **Telemedicine** kiosks
- Electronic vital signs monitoring or exchanges (e.g., Tele-ICU, Tele-stroke)

Teladoc Program – The Plan covers online internet or phone consultations between You and Providers who participate in the Teladoc program for medical conditions that are not an Emergency Condition.

General Medicine: Members can receive treatment within minutes for non-emergency, acute general needs such as:	**Dermatology**: Members can request a dermatology consult for complex or ongoing conditions such as:	**Behavioral Health**: Members can receive support for such issues as:
• Flu • Cough • Sinus Problems • Sore throat • Allergies • Sunburn • Bronchitis • Ear Infection • Arthritis • Pink eye	• Rash • Psoriasis • Rosacea • Acne • Skin Infections	• Stress • Anxiety • Depression

To get started:

1. You can set up an account by the following:
    - Online: Go to Teladoc.com/Aetna and click “set up account”
    - Mobile App: Download the app at teladoc.com/mobile and click “activate account”
    - Call Teladoc: Teladoc can help you register your account at 1-855-Teladoc (835-2362)
2. Provide Medical History
    - Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.
3. Request a Consult
    - Once your account is set up, request a consult anytime you need care. Talk to a doctor by phone, web, or mobile app.

BB. Transplants.

The Plan Covers only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas, and lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that have been specifically approved and designated as Centers of Excellence to perform these procedures.

The Plan Covers the Hospital and medical expenses, including donor search fees, of the Member-recipient. The Plan Covers transplant services required by You when You serve as an organ donor only if the recipient is a Member. The Plan does not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

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

SECTION X

Additional Benefits, Equipment and Devices

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

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

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

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

   The Plan Covers repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. The Plan does not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. Coverage will be provided for the device most appropriate to Your current functional level. The Plan does not Cover delivery or service charges or routine maintenance.

3. **Behavioral Health Treatment.** The Plan Covers counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The Plan will provide such Coverage when provided by a licensed Provider. The Plan Covers applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and

functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

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

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

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

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

   You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Plan for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

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

B. Diabetic Equipment, Supplies and Self-Management Education.
The Plan Covers diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally

authorized to prescribe under Title 8 of the New York Education Law as described below. These items are either covered under your medical or pharmacy benefits, but not under both benefits. Refer to the Schedule of Benefits and Pharmacy Formulary to determine coverage:

Equipment and Supplies.
The Plan Covers the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:

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

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

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;

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

Limitations.
The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. The Plan Covers only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

C. Durable Medical Equipment and Braces.
The Plan Covers the rental or purchase of durable medical equipment and braces.

1. **Durable Medical Equipment.**
   Durable Medical Equipment is equipment which is:
   - Designed and intended for repeated use;
   - Primarily and customarily used to serve a medical purpose;
   - Generally not useful to a person in the absence of disease or injury; and
   - Appropriate for use in the home.

   Coverage is for standard equipment only. The Plan Covers the cost of repair or replacement when made necessary by normal wear and tear. The Plan does not Cover the cost of repair or replacement that is the result of misuse or abuse by You. The Claims Administrator will determine whether to rent or purchase such equipment. The Plan does not Cover over-the-counter durable medical equipment.

   The Plan does not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. **Braces.**
   The Plan Covers braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease, or defect. overage is for standard equipment only. The Plan Covers replacements when growth or a change in Your medical condition make replacement necessary. The Plan does not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. Hearing Aids.

1. **External Hearing Aids.**
   The Plan Covers hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

   Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for

associated fitting and testing. The Plan Covers a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every one to three (3) years. Refer to the Schedule of Benefits for additional coverage information.

2. **Cochlear Implants.**
   The Plan Covers bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:
   - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Plan. The Plan Covers repair and/or replacement of a bone anchored hearing aid only for malfunctions. Refer to the Schedule of Benefits for additional coverage information.

E. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. The Plan Covers inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for unlimited days of Hospice Care. The Plan also Covers five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

The Plan Covers Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. The Plan does not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

F. Medical Supplies.

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

G. Prosthetics.

1. **External Prosthetic Devices.**
   The Plan Covers prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. The Plan Covers wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). The Plan does not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

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

The Plan does not Cover Eyeglasses and contact lenses.

The Plan does not Cover shoe inserts.

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

Coverage is for standard equipment only.

The Plan Covers the cost of prosthetic device, per limb. The Plan also Covers the cost of repair and replacement of the prosthetic device and its parts. The Plan does not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. **Internal Prosthetic Devices.**
   The Plan Covers surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

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

   Coverage is for standard equipment only.

SECTION XI

Inpatient Services

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

A. Hospital Services.
The Plan Covers inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis, including:

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

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 10-180days for the same or related causes.

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

C. Inpatient Medical Services.
The Plan Covers medical visits by a Health Care Professional on any day of inpatient care Covered under this Plan.

D. Inpatient Stay for Maternity Care.
The Plan Covers inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically

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

The Plan also Covers the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

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

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

G. Habilitation Services.
The Plan Covers inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy. Refer to the Schedule of Benefits.

H. Rehabilitation Services.
The Plan Covers inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. Refer to the Schedule of Benefits.

The Plan Covers speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

I. Skilled Nursing Facility.
The Plan Covers services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent, or domiciliary care is not Covered (see the Exclusions and Limitations section of this Booklet). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your

Provider and approved by the Claims Administrator. Refer to the Schedule of Benefits for additional coverage information.

J. End of Life Care.
If You are diagnosed with advanced cancer and You have fewer than 60 days to live, the Plan will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If the Claims Administrator disagrees with Your admission to the Facility, You have the right to initiate an expedited external appeal to an External Appeal Agent. The Plan will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Plan until the External Appeal Agent renders a decision in the Plan's favor.

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

1. The Plan will reimburse a rate that has been negotiated between the Claims Administrator and the Provider.
2. If there is no negotiated rate, the Plan will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, the Plan will reimburse at 75% of the appropriate Medicare Acute care rate.

K. Centers of Excellence.
Centers of Excellence are Hospitals that the Claims Administrator has approved and designated for certain services. The Plan Covers the following Service only when performed at Centers of Excellence: Transplants

L. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, The Plan will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, the Plan's Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. The Plan does not Cover radio, telephone or television expenses, or beauty or barber services.
3. The Plan does not Cover any charges incurred after the day the Claims Administrator advises You it is no longer Medically Necessary for You to receive inpatient care, unless the denial is overturned by an External Appeal Agent.

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. The Plan Covers the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** The Plan Covers inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Plan. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
    - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
    - A state or local government run psychiatric inpatient Facility;
    - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
    - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

    and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

    The Plan also Covers inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to the New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

2. **Outpatient Services.** The Plan Covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have

been issued an operating certificate pursuant to the New York Mental Hygiene Law Article 31or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator.

B. Substance Use Services. The Plan Covers the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** The Plan Covers inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by the Claims Administrator as alcoholism, substance abuse or chemical dependence treatment programs.

   The Plan also Covers inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified, or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified, or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by the Claims Administrator as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** The Plan Covers outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified, or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified, or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by the Claims Administrator as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction

Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

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

SECTION XIII
Exclusions and Limitations

No coverage is available under this Plan for the following:

A. Aviation.
The Plan does not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
The Plan does not Cover services related to rest cures, custodial care, or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting, and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

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

D. Cosmetic Services.
The Plan does not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. The Plan also Covers services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Booklet. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Booklet unless medical information is submitted.

E. Coverage Outside of the United States, Canada, or Mexico.
The Plan does not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services, and ambulance services to treat Your Emergency Condition.

F. Dental Services.
The Plan does not Cover dental services except for care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Booklet.

G. Experimental or Investigational Treatment.
The Plan does not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, the Plan will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Booklet, when the Claims Administrator's denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, the Plan will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Plan for non-investigational treatments. See the Utilization Review and External Appeal sections of this Booklet for a further explanation of Your Appeal rights.

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

I. Foot Care.
The Plan does not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, the Plan will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility.
The Plan does not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state, or other governmental entity, except as otherwise required by law.

K. Medically Necessary.
In general, the Plan will not Cover any health care service, procedure, treatment, test, device, or Prescription Drug that the Claims Administrator determines is not Medically Necessary. If an External Appeal Agent certified by the State overturns the Claims Administrator's denial, however, the Plan will Cover the service, procedure, treatment, test, device, or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device, or Prescription Drug is otherwise Covered under the terms of this Plan.

L. Medicare or Other Governmental Program.
The Plan does not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, the Plan will reduce benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

M. Military Service.
The Plan does not Cover an illness, treatment, or medical condition due to service in the Armed Forces or auxiliary units.

N. No-Fault Automobile Insurance.
The Plan does not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.
The Plan does not Cover services that are not listed in this Booklet as being Covered.

P. Services Provided by a Family Member.
The Plan does not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Q. Services Separately Billed by Hospital Employees.
The Plan does not Cover services rendered and separately billed by employees of Hospitals, laboratories, or other institutions.

R. Services with No Charge.
The Plan does not Cover services for which no charge is normally made.

S. Vision Services.
The Plan does not Cover the examination or fitting of eyeglasses or contact lenses.

T. War.
The Plan does not Cover an illness, treatment, or medical condition due to war, declared or undeclared.

U. Workers' Compensation.
The Plan does not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability, or occupational disease law.

SECTION XIV

Claim Determinations

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

B. Notice of Claim.
Claims for services must include all information designated by the Claims Administrator as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from the Claims Administrator by calling the number on Your ID card or visiting their website. Completed claim forms should be sent to the address on Your ID card. You may also submit a claim to the Claims Administrator electronically by sending it to the e-mail address on Your ID card or visiting their website.

C. Timeframe for Filing Claims.
Claims for services must be submitted to the Claims Administrator for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 day period, You must submit it as soon as reasonably possible. Initial claims submitted more than 15-months after the date of service will be denied.

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

E. Claim Determinations.
The Claim Administrator's claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, the claim determination procedure applies to contractual benefit denials. If You disagree with the Claim Administrator's claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Booklet.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Booklet.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If the Claims Administrator has all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination, the Claims Administrator will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim. If the Claims Administrator needs additional information, they will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If the Claims Administrator receives the information within 45 days, they will make a determination and provide notice to You (or Your designee) in writing, within 15 days of the Claims Administrator's receipt of the information. If all necessary information is not received within 45 days, the Claims Administrator will make a determination within 15 calendar days of the end of the 45-day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if the Claims Administrator has all information necessary to make a determination, they will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If the Claims Administrator needs additional information, they will request it within 24 hours. You will then have 48 hours to submit the information. The Claims Administrator will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of the Claims Administrator's receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If the Claims Administrator has all information necessary to make a determination regarding a post-service claim, they will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if the Claim Administrator denies the claim in whole or in part. If the Claims Administrator needs additional information, they will request it within 30 calendar days. You will then have 45 calendar days to provide the information. The Claims Administrator will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of the Claim Administrator's receipt of the information or the end of the 45-day period if the Claims Administrator denies the claim in whole or in part.

H. Payment of Claims.

Where the Plan's obligation to pay a claim is reasonably clear, the Claims Administrator will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If the Claims Administrator requests additional information, they will pay the claim within 15 days of the Claims Administrator's determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XV

Grievance Procedures

A. Grievances.

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

B. Filing a Grievance.

You can contact the Claims Administrator by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. The Claims Administrator may require that You sign a written acknowledgement of Your oral Grievance, prepared by the Claims Administrator. You or Your designee has up to 180 calendar days from when You received the decision You are asking the Claims Administrator to review to file the Grievance.

When the Claims Administrator receives Your Grievance, they will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

The Claims Administrator keep all requests and discussions confidential and will take no discriminatory action because of Your issue. The Plan has a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that the Claims Administrator send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell the Claim Administrator in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit the Claims Administrator's website. You can opt out of electronic notifications at any time.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified, or registered Health Care Professional will look into it. The Claims Administrator will decide the Grievance and notify You within the following timeframes:

<u>Expedited/Urgent Grievances</u>:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
<u>Pre-Service Grievances</u>: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

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

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

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

E. Assistance.
If You remain dissatisfied with the Claims Administrator's Appeal determination, or at any other time You are dissatisfied, You may:

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

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

SECTION XVI

Utilization Review

A. Utilization Review.

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

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

The Claims Administrator has developed guidelines and protocols to assist in this process. The Claims Administrator will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit the Claims Administrator’s website.

You may ask that the Claims Administrator send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell the Claims Administrator in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit the Claims Administrator’s website. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

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

If the Claims Administrator needs additional information, they will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If the Claims Administrator receives the requested information within 45 days, they will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of the Claims Administrator's receipt of the information. If all necessary information is not received within 45 days, they will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if the Claims Administrator has all information necessary to make a determination, they will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If the Claims Administrator needs additional information, they will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. The Claims Administrator will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of the Claims Administrator's receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of the Claims Administrator's receipt of the information or three (3) calendar days after the verbal notification.

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

4. **Inpatient Rehabilitation Services Reviews.** After receiving a Preauthorization request for coverage of inpatient rehabilitation services following an inpatient Hospital admission provided by a Hospital or skilled nursing facility, the Claims Administrator will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.

C. Concurrent Reviews.

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

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, the Claims Administrator will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and the Claims Administrator has all the information necessary to make a determination, they will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If the Claims Administrator needs additional information, they will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. The Claims Administrator will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of the Claims Administrator's receipt of the information or, if the Claims Administrator does not receive the information, within 48 hours of the end of the 48-hour period.

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

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

5. **Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital notifies the Claims Administrator of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, the Claims Administrator may review the entire stay to determine whether it is Medically Necessary and will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

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

7. **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified Facility notifies the Claims Administrator of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, Claims Administrator may review the entire outpatient treatment to determine whether it is Medically Necessary, and they will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.
If Claims Administrator has all information necessary to make a determination regarding a retrospective claim, Claims Administrator will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If the Claims Administrator needs additional information, they will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. The Claims Administrator will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of the Claims Administrator's receipt of all or part of the requested information or the end of the 45-day period.

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

E. Retrospective Review of Preauthorized Services.
The Claims Administrator may only reverse a preauthorized treatment, service, or procedure on retrospective review when:

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

- Had the Claims Administrator been aware of such information, the treatment, service, or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. The Claims Administrator will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when the Claims Administrator determines that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
    - A written statement from Your attending Physician, who must be a licensed, board-certified, or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that the Claims Administrator approved to treat Your condition; and
    - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when the Claims Administrator determines that there is a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified, or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
    - That the Participating Provider recommended by the Claims Administrator does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and

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

G. First Level Appeal.

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

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

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

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

   The Claims Administrator’s failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If the Claims Administrator denies a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of the adverse determination, the Claims Administrator will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of the Claims Administrator’s adverse determination, they will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

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

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

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. The Claims Administrator will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and inform You, if necessary, of any additional information needed before a decision can be made.

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

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

3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, the Claims Administrator will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

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

SECTION XVII

External Appeal

A. Your Right to an External Appeal.

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

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

- The service, procedure, or treatment must otherwise be a Covered Service under this Plan; and
- In general, You must have received a final adverse determination through the first level of the Claims Administrator's internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of the Claims Administrator's internal Appeal process if:
  - The Claims Administrator agrees in writing to waive the internal Appeal. The Claims Administrator is not required to agree to Your request to waive the internal Appeal; or
  - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  - The Claims Administrator fails to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and they demonstrate that the violation was for good cause or due to matters beyond their control and the violation occurred during an ongoing, good faith exchange of information between You and the Claims Administrator).

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

If the Claims Administrator has denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

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

If the Claims Administrator has denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

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

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

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

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

D. Your Right to Appeal a Determination that a Service is Out-of-Network.
If the Claims Administrator has denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

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

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

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.
If the Claims Administrator has denied coverage of a request for a Referral to a Non-Participating Provider because they determine there is a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

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

For purposes of this section, Your attending Physician must be a licensed, board

certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. The External Appeal Process.

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

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

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

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

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

managing the research, or costs that would not be Covered under this Booklet for non-investigational treatments provided in the clinical trial.

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

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

G. Your Responsibilities.

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

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal. The Claims Administrator has no authority to extend this deadline.

SECTION XVIII

Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, the Plan will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. 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.

2. **"Plan"** is other group health coverage with which the Plan will coordinate benefits. The term "plan" includes:
   - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"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 decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

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

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Plan will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
   - The plan of the parent who has custody will be primary;
   - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
   - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.
When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this Plan during a claim determination period will not exceed the Plan's maximum available benefit for each Covered Service. Also, the amount the Plan pays will not be more than the amount the Plan would pay if the Plan was primary. As each claim is submitted, the Claims Administrator will determine the Plan's obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
The Claims Administrator may release or receive information that they need to coordinate benefits. The Claims Administrator does not need to tell anyone or receive consent to do this. The Claims Administrator or Plan are not responsible to anyone for releasing or obtaining this information. You must give the Plan any needed information for coordination purposes, in the time frame requested.

E. The Plan's Right to Recover Overpayment.
If the Plan made a payment as a primary plan, You agree to pay the Plan any amount by which the Plan should have reduced its payment. Also, the Plan may recover any overpayment from

the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help the Plan recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans. Except as described below, the Plan will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Plan is primary, as defined in this section, the Plan will pay benefits first.

2. If this Plan is secondary, as defined in this section, the Plan will pay only the amount the Plan would pay as the secondary insurer.

3. If the Claims Administrator requests information from a non-complying plan and do not receive it within 30 days, the Claims Administrator will calculate the amount the Plan should pay on the assumption that the non-complying plan and this Plan provide identical benefits. When the information is received, the Claims Administrator will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Plan is primary.

Determining who pays
Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or Dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this, you can contact the Claims Administrator.	
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only) * *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together	The plan of the parent whom the court said is responsible for health coverage.	The plan of the other parent. But if that parent has no

• With court-order	But if that parent has no coverage then the other spouse's plan.	coverage, then his/her spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	When this plan is secondary to another plan that is primary, benefits will first be calculated <u>AS IF THIS PLAN WAS PRIMARY.</u> <u>The benefit will then be reduced by the amount paid by the other plan.</u> This method of coordination is referred to as Maintenance of Benefits.

	The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.

How COB works with Medicare
This section explains how the benefits under this Plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

- Refused it
- Dropped it, or
- Did not make a proper request for it

When you are eligible for Medicare, the Plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible but not covered, the Plan may pay as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare.

Sometimes, this Plan is the primary Plan, which means that the Plan pays benefits before Medicare pays benefits. Sometimes, this Plan is the secondary Plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan

If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and you are still actively employed with the School District	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary **plan** and this Plan will be secondary.		

This Plan is secondary to Medicare in all other circumstances.

How are benefits paid?

The Plan is primary	The Plan pays your claims as if there is no Medicare coverage.
Medicare is primary	The Plan calculates the amount the Plan would pay if there were no Medicare coverage. If the Medicare payment is equal to or more than what the Plan would pay, the Plan makes no payment. If Medicare paid less than what the Plan would pay, the Plan pays the difference between the Plan's payment and the Medicare payment.

EFFECTS OF MEDICARE

Most Medicare eligible members covered by the Plan will be enrolled in the Medicare Advantage plan (Medicare Part C) provided by Aetna and the Medicare Prescription Drug Plan (Medicare Part D) provided by Navitus. Members enrolled in the Medicare Advantage medical plan/Medicare drug plan should refer to separate plan documents provided by Aetna and Navitus that addresses the benefits of those plans.

For members who are enrolled in original Medicare Parts A & B:

- Part A generally covers hospital care,
- Part B generally covers physician services

Important Note:

The Plan will not provide any benefits an Employee, Retiree or Dependent is, or could have been, eligible to receive from Medicare Parts A, B, or C whether or not that person has enrolled in Part A, Part B, or Part C of Medicare, regardless of age, **if Medicare would be primary to this Plan**. This means individuals who are eligible for Medicare due to age or disability or End Stage Renal Disease*. Consequently, to avoid a drastic reduction in health benefits, it is essential that each eligible Retiree or Retiree's Dependent be enrolled in both Part A and Part B of Medicare or Medicare Part C (Medicare Advantage) if Medicare would be primary to this Plan.

* The coordination methodology for members eligible for Medicare due to End Stage Renal Disease is different than for members eligible due to age or disability.

In the case of Retired Medicare-eligible Employees (includes those not actively at work), and their covered Medicare-eligible dependents, the Plan's normal Coordination of Benefits provisions shall not apply; Medicare Parts A & B, or Part C shall be the primary provider of coverage. The Plan will reduce its benefits payable by any amount(s) paid or payable by Medicare/Medicare Advantage. In the event such a Medicare-eligible individual chooses not to enroll for Medicare coverage (Parts A & B, or C), this Plan's payment will still be based on the amount(s) Medicare would have paid had the individual elected coverage under both Parts A & B, or C of Medicare.

In the event that a member receives services from a provider who opted out of Medicare Parts A and/or B and/or C, the Plan shall pay no more than it would have paid had the provider accepted Assignment under parts A and B.

Other health coverage updates – contact information
You should contact your HR Department if you have any changes to your other coverage.

Right to receive and release needed information
The Claims Administrator has the right to release or obtain any information they need for COB purposes. That includes information needed to recover any payments from your other health plans.

Right to pay another carrier
Sometimes another plan pays something the Claims Administrator would have paid under your Plan. When that happens, the Claims Administrator will pay your Plan benefit to the other plan.

Right of recovery
If the Claims Administrator pays more than they should have under the COB rules, the Plan may recover the excess from:
- Any person they paid or for whom they paid, or
- Any other plan that is responsible under these COB rules.

SECTION XIX

Termination of Coverage

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

1. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

2. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. Refer to the "Death of Subscriber-Survivor Coverage" section of the Preamble.

3. For Spouses in cases of divorce, the date of the divorce.

4. For Children, until the end of the month in which the Child turns 26 years of age.

5. For all other Dependents, the day in which the Dependent ceases to be eligible.

6. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the Plan to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, the Plan will rescind coverage if the facts misrepresented would have led the Plan to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Plan. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

7. The Plan is discontinued.

8. Your employer withdraws from the Putnam/Northern Westchester Health Benefits Consortium as a participating District.

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

SECTION XX

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

A. Qualifying Events.
Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Plan in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:
1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:
1. The date 36 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the

Subscriber'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;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Policy terminates. However, if the Group Policy is replaced with similar coverage, You have the right to become covered under the new Group Policy for the balance of the period remaining for Your continued coverage.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Plan will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Plan may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group Plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You notify your employer within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option.

The Subscriber's Child may be eligible to purchase continuation coverage under the Group's Policy through the age of 29 if he or she:

1. Is under the age of 30;
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works, or resides in New York State; and

5. Is not covered by Medicare.

The Child may purchase continuation 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).

The Subscriber’s 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 Group or the Group’s designee receives notice, and the Group receives 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 Group or the Group’s designee receives notice of election and the Group receives Premium payment.

The Subscriber or Subscriber’s Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Plan. The Child's children are not eligible for coverage under this option.

SECTION XXI

General Provisions

1. Agreements Between the Claims Administrator and Participating Providers.
Any agreement between the Claims Administrator and Participating Providers may only be terminated by the Claims Administrator or the Providers. This Plan does not require any Provider to accept a Member as a patient. The Claims Administrator does not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this Plan or legal claims based on a denial of benefits to any person, corporation, or other organization. You cannot assign any monies due under this Plan to any person, corporation, or other organization unless it is an assignment to Your Provider for a surprise bill or to a Hospital for Emergency Services, including inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Booklet for more information about surprise bills. Any assignment of benefits by You other than for monies due for a surprise bill or an assignment of monies due to a Hospital for Emergency Services, including inpatient services following Emergency Department Care, will be void and unenforceable.

You may request the Claims Administrator to make payment for services directly to Your Provider instead of You, including a payment for a surprise bill or to a Hospital for Emergency Services and inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Booklet for more information about surprise bills.

Assignment means the transfer to another person, corporation, or other organization of Your right to the services provided under this Plan or Your right to collect money from the Plan for those services Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes to the Plan
The Joint Governance Board may unilaterally change this Plan at any time.

4. Choice of Law.
This Plan shall be governed by the laws of the State of New York.

5. Clerical Error.
Clerical error, whether by the Claims Administrator or other agent of the Plan, with respect to this Plan, or any other documentation issued in connection with this Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.
Any term of this Plan which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Plan may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should

change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Entire Agreement.
This Booklet, including any endorsements, riders, and the attached applications, if any, constitutes the entire Plan.

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

10. Furnishing Information and Audit.
The Group and all persons covered under this Plan will promptly furnish the Claims Administrator with all information and records that they may require from time to time to perform their obligations under this Plan. You must provide the Claims Administrator with information over the telephone for reasons such as the following: to allow them to determine the level of care You need; so that they may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

11. Identification Cards.
Identification ("ID") cards are issued by the Claims Administrator for identification purposes only. Possession of any ID card confers no right to services or benefits under this Plan.

12. Admissions.
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

13. Independent Contractors.
Participating Providers are independent contractors. They are not the Claims Administrator's agents or employees. The Claims Administrator and their employees are not the agent or employee of any Participating Provider. The Plan is not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

14. Material Accessibility.
You have the right to request ID cards, Plan Document, Schedule of Benefits, and other necessary materials.

15. More Information about Your Health Plan.
You can request additional information about Your coverage under this Plan. Upon Your request, the Claims Administrator will provide the following information:

- A list of the names, business addresses and official positions of the Claims Administrators' board of directors, officers, and members; and their most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.

- The information that the Claims Administrators provide the State regarding their consumer complaints.
- A copy of the Claims Administrators' procedures for maintaining confidentiality of Member information.
- A written description of the Claims Administrators' quality assurance program.
- A copy of Claims Administrators' medical policy regarding an experimental or investigational drug, medical device, or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Claims Administrators' clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information the Claims Administrators may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Plan.

16. Notice.
Any notice that the Claims Administrator gives You under this Plan will be mailed to Your address as it appears in the Claims Administrators' records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from the Claims Administrator. If You have to give the Claims Administrator any notice, it should be sent by U.S. mail, first class, postage prepaid to the address on Your ID card.

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

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

The Claims Administrator reviews and evaluates new technology according to technology evaluation criteria developed by their medical directors and reviewed by a designated committee, which consists of Health Care Professionals from various medical specialties.

Conclusions of the committee are incorporated into the Claims Administrator's medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental, or investigational, or included as a Covered benefit.

19. Right to Offset.
If the Claims Administrator makes a claim payment to You or on Your behalf in error or You owe the Plan any money, You must repay the amount You owe. Except as otherwise required by law, if the Plan owes You a payment for other claims received, they the Claims Administrator has the right to subtract any amount You owe them from any payment owed You.

20. Severability.
The unenforceability or invalidity of any provision of this Booklet shall not affect the validity and enforceability of the remainder of this Booklet.

21. Significant Change in Circumstances.
If the Claims Administrator is unable to arrange for Covered Services as provided under this Plan as the result of events outside of their control, the Claims Administrator will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. The Claims Administrator will make reasonable attempts to arrange for Covered Services. The Claims Administrator and their Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

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

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

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

23. Third Party Beneficiaries.
No third party beneficiaries are intended to be created under this Plan and nothing in this Plan shall confer upon any person or entity other than You or the Plan any right, benefit, or remedy of any nature whatsoever under or by reason of the Plan or this Booklet. No other party can enforce the Plan's provisions or seek any remedy arising out of either the Plan's or Your performance or failure to perform any portion of the Plan's obligations, or to bring an action or pursuit for the breach of any terms of the Plan.

24. Time to Sue.
No action at law or in equity may be maintained against the Plan prior to the expiration of 60 days after written submission of a claim has been furnished to the Plan, as required under the Plan. You must start any lawsuit against the Plan or Plan Administrator within two (2) years from the date the claim was required to be filed.

25. Waiver.
The waiver by any party of any breach of any provision of the Plan will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

26. Who May Change this Plan.
This Plan may not be modified, amended, or changed, except in writing and signed by the. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Plan in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the Joint Governance Board.

27. Who Receives Payment under this Plan.
Payments under this Plan for services provided by a Participating Provider will be made directly by the Claims Administrator to the Provider. If You receive services from a Non-Participating Provider, the Claims Administrator reserves the right to pay either You or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, the claims Administrator will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Booklet for more information about surprise bills.

28. Workers' Compensation Not Affected.
The coverage provided under this Plan is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

29. Your Medical Records and Reports.
In order to provide Your coverage under this Plan, it may be necessary for the Claims Administrator to obtain Your medical records and information from Providers who treated You. The Claims Administrator's actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance

reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Plan, except as prohibited by state or federal law, You automatically give the Plan or the Plan's designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to the Claims Administrator or to a medical, dental, or mental health professional that the Claims Administrator may engage to assist them in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to the Claims Administrator, or to a medical, dental, or mental health professional that the Claims Administrator may engage to assist them in reviewing a treatment or claim; and
- Permit copying of Your medical records by the Claims Administrator.

The Claims Administrator agrees to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give the Claims Administrator permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which the Claims Administrator contracts to assist them in administering this Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

30. Your Rights and Responsibilities.
As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, the Plan wants to make sure Your rights are respected while providing Your health benefits. You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

You have the right to access the Claims Administrator's Participating Providers.

As a Member, You should also take an active role in Your care. The Plan encourages You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give the Claims Administrator, Your doctors, and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan; and
- Inform your HR department if You have any changes to Your name, address or Dependents covered under Your Plan.

For additional information regarding Your rights and responsibilities, visit the FAQs on the Claim Administrator's website. If You do not have internet access, You can call the Claims Administrator at the number on Your ID card to request a copy. If You need more information or would like to contact the Claims Administrator, please go to their website, or call them at the number on Your ID card.

No Surprises Act Rider

This section outlines the consumer protections required under the Federal No Surprises Act and how it affects other sections of this document.

Participating Providers.
To find out if a Provider is a Preferred or Participating Provider:
- Check the Claims Administrator's Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit their website

The Provider directory will give You the following information about the Claims Administrator's Participating Providers:
- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken;
- Whether the Provider is a Preferred Provider; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any In-Network Copayment, Deductible or Coinsurance that would apply to the Covered Services, and You are not responsible for any Non-Participating Provider charges that exceed Your In-Network Copayment, Deductible or Coinsurance, if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:
- The Provider is listed as a Participating Provider in the Claims Administrator's online Provider directory;
- The Claims Administrator's paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- The Claims Administrator gives You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- the Claims Administrator does not provide You with a written notice within one business day of Your telephone request for network status information.

Protection from Surprise Bills.
1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:
   - For services performed by a non-participating Provider at a participating Hospital or Ambulatory Surgical Center, when:
     - A participating Provider is unavailable at the time the health care services are performed;
     - A non-participating Provider performs services without Your knowledge; or
     - Unforeseen medical issues or services arise at the time the health care services are performed.

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

   - You were referred by a participating Physician to a Non-Participating Provider

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

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

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your In-Network Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your In-Network Copayment, Deductible or Coinsurance. You can sign a form to let the Claims Administrator and the Non-Participating Provider know You received a surprise bill.

The form for surprise bills is available at www.dfs.ny.gov or You can visit the Claims Administrator's website for a copy of the form. You need to mail a copy of the form to the Claims Administrator and Your Provider.

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

3. **Access to Care**

When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves the Claims Administrator's network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of the Claims Administrator's relationship with the Provider. The Provider must also provide the Claims Administrator with necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care and obtaining Preauthorization, Referrals; authorizations, and a treatment plan approved by the Claims Administrator. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Copayment, Deductible or Coinsurance. Please note that if the Provider was terminated by the Claims Administrator due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

4. **Ambulance and Pre-Hospital Emergency Medical Services**

Payments for Air Ambulance Services. The Plan will pay a Non-Participating Provider the amount the Claims Administrator has negotiated with the Non-Participating Provider for the air ambulance service or an amount they have determined is reasonable for the air ambulance service or the Non-Participating Provider's charge. However, the negotiated amount or the amount the Plan Claims Administrator determines is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity, the Plan will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any In-Network Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your In-Network Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Copayment, Deductible or Coinsurance, You should contact the Claims Administrator. Visit their website or www.dfs.ny.gov for more information on the independent dispute resolution process for air ambulance bills.

5. **Emergency Services and Urgent Care**

Payments Relating to Emergency Services. The Plan will pay a Non-Participating Provider the amount the Claims Administrator has negotiated with the Non-Participating Provider for the Emergency Service or an amount they have determined is reasonable for the Emergency Service or the Non-Participating Provider's charge. However, the negotiated amount or the amount the Claims Administrator determines is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for Emergency Services is submitted to an independent dispute resolution entity ("IDRE"), the Plan will pay the amount, if any, determined by the IDRE for the services.

You are responsible for any In-Network Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. The Non-Participating Provider may only bill You for Your In-Network Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Copayment, Deductible or Coinsurance, You should contact the Claims Administrator.

6. **Controlling Plan**

All of the terms, conditions, limitations, and exclusions of Your Plan to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUG EXPENSE BENEFITS

THIRD PARTY ADMINISTRATIVE SERVICES PROVIDED BY NAVITUS

If you are covered under the Plan's Medicare Part D Prescription Drug Plan, there may be slight variations from the Plan provisions noted below. Please consult your Evidence of Coverage (EOC) document provided by the Claims Administrator for specific information about that Plan's benefits and coverage.

The Prescription Drug Expense Benefits portion of the Plan is a separate coverage from the Medical Expense Benefits. However, in addition to the exclusions indicated below, all provisions and limitations of the Plan shall apply to this coverage. The Plan shall not exclude coverage of any drug approved by the FDA for the treatment of certain types of cancer on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the food and drug administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

i. the American Medical Association Drug Evaluations;
ii. the American Hospital Formulary Service Drug Information; or
iii. the United States Pharmacopeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal.

Coverage shall not be provided for any experimental or investigational drugs or any drug which the food and drug administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed unless directed to pursuant to an external appeal. Covered expenses paid under this portion of the Plan shall not be a benefit under any other portion or coverage of the Plan.

Co-Payment

The co-payment amount shall be the amount per prescription specified in the Schedule of Benefits which shall not be considered a covered expense. Payment of the co-payment amount per prescription shall be the responsibility of the Covered Person.

Note: Once your aggregate maximum co-payment per individual or family (please refer to the Schedule of Benefits) is met, further co-payments will be waived.

Covered Drugs

Covered Drugs include only the following:

1. Legend drugs,
2. Insulin on prescription.
3. Tretinoin, all dosage forms (e.g., Retin-A). For individuals over age 25, documentation verifying medical necessity must be submitted to the Claims Administrator before reimbursement will be made.
4. Compounded medication of which at least one ingredient is a prescription legend drug; subject to Prior Authorization.
5. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

6. Nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenyl Ketonuria, branched-chain Ketonuria, galactosemia and momocystinuria as administered under the direction of a physician.
7. Syringes and needles for diabetic use.
8. Enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated cause chronic disability, mental retardation, or death. Specific diseases for which enteral formulas have proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohns'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 malnourishment, chronic physical disability, mental retardation, or death.
9. Prescription drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility, except that coverage shall not include prescription drugs in connection with in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, the reversal of sterilization, sex change procedures, cloning or procedures or services that are experimental. Coverage is limited to individuals whose ages range from twenty-one (21) through forty-four (44) years.
10. Drugs for bone density as approved by the federal Food and Drug Administration (FDA).
11. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein, or which contain modified protein which are medically necessary, and such coverage for such modified solid food products shall not exceed $2,500 per person per calendar year.
12. Drugs or devices for the treatment of erectile disfunction; subject to a maximum of 6 pills per month.

Please refer to the section titled List of Prescription Drugs Requiring Precertification for additional information.

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 Expense Benefits portion of the Plan for the following:

1. Non-legend drugs;
2. Charges for the administration or injection of any drug.
3. Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use, unless otherwise covered under this Plan or required by law.
4. Prescriptions if benefits are provided under any state or federal workers' compensation, employers' liability, or occupational disease law;
5. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual unless directed pursuant to an External Appeal;
6. Immunization agents, unless specifically included, biological sera, blood, or blood plasma;
7. Medication which is to be taken by or administered to an individual while in an acute inpatient medical facility;

8. Any prescription refilled in excess of the number specified by the Physician or allowed by the Plan, or any refill dispensed after one year from the Physician's original order;
9. Drugs that are available without a prescription, unless otherwise specifically included;
10. For Medicare primary eligible members only: Drugs that are covered under Medicare Part B must first be processed by Medicare. Secondary claims may then be submitted to Aetna under the medical portion of the Plan.

Please refer to the section titled List of Prescription Drugs Requiring Precertification for additional information.

Dispensing Limitations
The amount normally prescribed by Physician, but not to exceed a 31 day supply, except when a maintenance drug is ordered from a retail pharmacy or the Plan's mail order pharmacy vendor. Maintenance medications dispensed through a retail pharmacy or the mail order vendor are limited to a maximum of a 90-day supply.

Non-Participating (Pharmacy) Providers
There is no out-of-network pharmacy coverage. If you obtain covered prescription drugs from a pharmacy which does not participate in the Plan's Prescription Drug Expense Benefits program through the Claims Administrator, claims will not be covered.

Retail Network (Up To 31 or 90 Day Supply)
The Claims Administrator’s retail pharmacy network includes local brick-and-mortars, such as Yorktown Pharmacy, in addition to such large retailers as Rite Aid, Shoprite and CVS. The pharmacy network is subject to change. For a complete list for your area, please see the pharmacy listing available on the Claims Administrator’s member portal or call their Customer Care team at the number on the back of your ID card for assistance. You can obtain up to a 31-day supply or 90-day supply for Maintenance Medications at retail pharmacies.

You can request that your new pharmacy work with your previous pharmacy to have your prescription refills transferred, if necessary.

90-Day Retail Network
The Claims Administrator has designed a limited 90-day retail network that provides additional discounts to the Plan and membership. This new 90-day retail network will not include Walgreens Pharmacy, but includes such pharmacies as CVS, Rite Aid, ShopRite, and Stop & Shop. The pharmacy network is subject to change. For a complete list for your area, please see the pharmacy listing available on their member portal or call their Customer Care team at the number on the back of your ID card for assistance in selecting a low-cost pharmacy.

Mail Order Pharmacy
The Plan utilizes a Claims Administrator to administer a Home Delivery Prescription Drug Program for maintenance or long term use drugs. The mail order program is completely optional. The Claims Administrator’s Home Delivery mail order kits can be obtained by logging into the Claims Administrator’s website or by phone.

Prescription Drug Coordination of Benefits
If the Plan is not the primary payer, the claim may still be adjudicated at the pharmacy. Show your primary prescription drug card and your Claims Administrator's card to the pharmacy and ask that both primary and secondary claims be processed. If the pharmacy does not process your secondary claim, you may submit a secondary claim, including itemized receipt and evidence of the primary payers explanation of benefits to the Claims Administrator.

Certification for Certain Prescription Drugs
Certification of the necessity of certain prescription drugs is required before the drug may be dispensed by a pharmacy.

Certification Procedures
It is your responsibility to arrange for the prescriber of the drug to call the Claims Administrator to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

The Claims Administrator will notify you and your healthcare provider of the decision, in writing, within three (3) business days of receipt of the necessary information. If the certification request is denied, this notice will provide the procedure to follow if you choose to appeal the decision.

If the drug is to be dispensed after the certification period ends, certification must again be requested, as described above.

Examples of Prescription Drugs Requiring Certification*
The following prescription drugs require certification before the drug is dispensed:
- Appetite suppressants/ weight loss medications
- Specialty drugs (e.g., growth hormones, Multiple Sclerosis agents, Hepatitis C agents, Rheumatoid Arthritis agents)
- Retin-A (over age 25)
- Non-formulary drugs

*Please contact the Claims Administrator for the complete list.

Cost Sharing - Generic Limit
The Plan encourages employees to use the lowest-cost option available. This typically means choosing a generic drug over a brand drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. Generics are taken and work the same way in the body as brands. Quality, performance and intended use are also the same for generics and their brand-name counterparts. The Food and Drug Administration reviews all generic drugs and uses the same strict criteria used for approval of brand-name medications.

- The Plan formulary is a list of preferred drugs covered by the Plan. It indicates the tiers at which specific drugs will be covered. In order to provide more affordable options, the pharmacy Claims Administrator places lower cost generics on preferred tiers that deliver savings to you and the Plan.

If the prescription is marked “Dispensed as Written” (DAW) or if you or your physician specify that a brand name drug must be used when there is a preferred generic available, there will be an additional cost. You will pay the appropriate brand copay plus the difference in cost between the brand and generic drugs. This additional cost can be overridden with an approved authorization. These amounts do not count toward your annual out-of-pocket limit.

Please contact the Claims Administrator’s Customer Care for more information on how your prescriber can initiate the authorization process. They are available 24/7, except on Thanksgiving and Christmas.

Compound Medications
Certain ingredients commonly used in prescription compounds will be excluded from coverage. This means the member will be responsible for some or all costs related to compound prescriptions.

A compound medication is one that is made by combining, mixing, or altering ingredients to create a customized medication that is not otherwise commercially available. Compounds can contain substances that have not been rigorously tested for safety or effectiveness. Additionally, not all compounds are approved by the FDA.

Preferred drugs are identified on the Plan’s FORMULARY. The FORMULARY is a listing of drugs which identifies the applicable co-payments. You may obtain a copy of the FORMULARY by calling the Claims Administrator’s customer service number on your identification card or access it on their web site.

The Plan utilizes a network of more than 50,000 preferred pharmacies administered by the Claims Administrator. Prescription purchases at pharmacies within the network are subject to the co-payment. Reimbursements for prescription purchases at non-participating pharmacies are limited to the amount that the Plan would have been responsible for had a participating pharmacy been used.

The Plan utilizes a Claims Administrator to administer a home delivery prescription drug program for maintenance, or long-term use drugs. Special provisions exist for the use of the Mail Order Pharmacy.

Copay Max Plus Program

Effective July 1, 2022, the Plan works with the Copay Max Plus Program to obtain copay assistance on your behalf. This program applies to certain drugs that have manufacturer-funded copay assistance programs available.

Under the Copay Max Plus Program, if the drugs have copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs, whichever is less. To take advantage of this pricing, you will be required to remain enrolled in Navitus’ program for obtaining manufacturer assistance, including co-pay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your annual out-of-pocket maximum or deductible.

Instead, only those payments made directly by you will count toward your out-of-pocket maximum or deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design. Your copay will default to the formulary's current tiered coinsurance/copay if a drug does not qualify or is removed from the program.