NY44 HEALTH BENEFITS PLAN
East Central New York Area, MVP
The Core Plan

FOR

PARTICIPATING SCHOOL DISTRICTS
located outside the Counties within the East Central Region of the State of New York
AND THEIR EMPLOYEES AND RETIREES

PLAN AND SUMMARY PLAN DESCRIPTION

Effective January 1, 2008

As amended, effective January 1, 2025

Established and maintained by:
Board of Trustees of the
NY44 Health Benefits Plan Trust

Administered by MVP Select Care, Inc. (for Medical Benefits) and Capital Rx, Inc. (for Prescription Drug Benefits).

THIS ORGANIZATION OPERATES UNDER THE SUPERVISION OF THE NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES PURSUANT TO REGISTRATION UNDER ARTICLE 44 OF THE NEW YORK STATE INSURANCE LAW.

The NY44 Health Benefits Plan Trust ("Trust") does not and cannot make treatment decisions for Enrollees. The Trust, pursuant to the terms of the Medical Benefits Plan ("Plan") makes only payment decisions. Treatment decisions are independent from payment decisions. It is the responsibility of the patient and his/her physician to determine whether treatment should be rendered, regardless of whether the charges are totally or partially Covered or excluded from Coverage under this Plan. The Plan is only the payer of Covered benefits, and it does not select, nor take any responsibility for the proper or improper performance of any hospital, physician, clinic, laboratory or other Service Provider.

Certain facts are needed by the Plan's Claims Administrator to make payment determinations and to process claims. The Claims Administrator has the right to decide which facts they need and may obtain medical records and other needed facts from any Service Provider, organization or person. The Claims Administrator need not notify or obtain the consent of, any person to do this. Any such information given will be kept confidential and will be used only as deemed necessary for proper Plan administration purposes.

Participating Districts and/or the Enrollee are required to notify the Claims Administrator immediately if there is any change in Employee or Dependent status. Proof of eligibility may be required for processing of any claims. The Trust and/or the Claims Administrator will notify Participating Districts, Employees, Retirees and/or Dependents of the documentation necessary to verify eligibility under the Plan.

TABLE OF CONTENTS

SECTION 1 – INTRODUCTION

The Trust and your Participating District are pleased to provide you with a copy of the NY44 HEALTH BENEFITS PLAN TRUST MEDICAL BENEFITS PLAN AND SUMMARY OF PLAN DESCRIPTION. This document sets forth the terms and conditions of the Plan offered to you by the Trust and your Participating District. You should read this booklet carefully to acquaint yourself with its provisions for eligibility, benefits, filing a claim and other important information.

THE COVERED BENEFITS UNDER THIS PLAN ARE SELF-FUNDED. THIS MEANS THAT THE TRUST ASSUMES TOTAL RESPONSIBILITY FOR COVERED CLAIMS THAT ARE INCURRED, SUBJECT TO ANY STOP-LOSS ARRANGEMENTS THE TRUST MAKES WITH AN INSURANCE COMPANY.

The Trust ("us" or "we" or "our") hereby agrees to provide benefits for the Health Care Services set forth herein to enrollees (or "you" or "your"), subject to the exclusions, limitations, conditions, and other terms of this Plan.

For claims incurred on and after January 1, 2025, this restated Plan document supersedes any and all predecessor Plan and Summary Plan Description documents.

You will find terms starting with capital letters throughout the Plan. To help you understand the benefits payable under this Plan, see the definitions of those terms in Section 2 of the Plan.

Important Information

Listed below is information that will be helpful to you if you have any questions about the administration of the Plan.

A. **Plan Name**. The Plan is the NY44 HEALTH BENEFITS PLAN TRUST MEDICAL BENEFITS PLAN (hereinafter referred to as the "Plan").

B. **Effective Date**. This Plan was first effective as of January 1, 2008. This current version of the Plan and Summary Plan Description, administered by MVP Select Care, Inc. (for medical benefits) and Capital, Rx, Inc. (for prescription drug benefits) is effective as of January 1, 2025.

C. **Establishment of Plan**. The Plan is established and maintained by the Board of Trustees of the NY44 Health Benefits Plan Trust, 355 Harlem Road, West Seneca, NY 14224.

D. **Plan Year**. The Plan Year begins at 12:00 a.m. on each July 1 and ends at 11:59:59 p.m. on the following June 30. Each succeeding like period will be considered a new Plan Year.

E. **Fiscal Year**. The Plan's Fiscal Year begins at 12:00 a.m. on each July 1 and ends at 11:59:59 p.m. on the following June 30. Each succeeding like period will be considered a new Fiscal Year.

F. **Claims Administrators**. The Plan's Claims Administrator are MVP Select Care, Inc. ("MVP"), located at 625 State Street, Schenectady, NY 12305 (1-800-229-5851), for medical benefits and Capital Rx, Inc. ("Capital Rx"), located at 228 Park Avenue S., Suite 87234, New York, NY 10003 (1-833-772-2779) for prescription drug benefits, or such other entity or entities as designated by the Trust. The Claims Administrators are the entities providing administrative services to the Plan in connection with the operation of the Plan and performing such functions, including processing and payment of claims, as may be delegated to it.

G. **Plan Administrator**. The Plan Administrator is the Board of trustees of the Trust, located at 355 Harlem Road, West Seneca, NY 14224. The Board of trustees, as established pursuant to the Trust Agreement, is comprised of five (5) managerial and five (5) bargaining unit representatives from Erie 1 BOCES.

H. **Agent of Legal Process**. Service of legal process may be made upon the Chair of the Board of Trustees of the Trust.

I. **Type of Plan**. This is a governmental employees' employee welfare fund providing payment and/or reimbursement for certain hospital, surgical, medical and prescription drug expenses. Contributions for funding benefits are provided by the Participating Districts and, in some cases, also by payroll deduction contributions of the Employee or contributions paid by Retirees or COBRA-eligible Enrollees. Benefits under the Plan are self-funded by the Trust's Plan assets and may be reinsured with stop loss coverage.

J. **Eligibility**. The persons eligible for participation in this Plan as Enrollees are as defined by the Participating Districts, with their eligible Dependents, and COBRA-eligible covered Enrollees.

K. **Authority for the Plan**. The Trust is not a licensed insurer. The Trust and Plan is a governmental employee welfare fund that operates pursuant to registration under Article 44 of the Insurance Law of the State of New York.

L. **Number and Gender**. All singular terms used herein shall be deemed to include the plural thereof and vice versa, and terms of the masculine gender shall be deemed to include the feminine and neutral gender and vice versa, unless the context of usage clearly requires that only the specific terminology used shall apply.

M. **Amendment or Termination of the Plan**. The Trustees intend to continue the Plan described herein as a permanent program. However, the Trustees specifically reserve the right to amend, suspend or terminate the Plan described herein at any time and for any reason, except that: (1) no amendment, suspension or termination of the Plan shall affect any claim for any expense incurred as of the effective date of the amendment, suspension or termination; (2) this paragraph shall not affect the rights and liabilities of any of the parties under any applicable collective bargaining agreements; and (3) no amendment of the Plan may be made which would permit any part of the Trust Fund to be used for, or diverted to, purposes other than for the exclusive benefit of the Covered Persons, or the payment of expenses of the Trust or Plan. Any amendment, suspension or termination of the Plan shall be by a motion duly made, seconded and passed by the Board of Trustees, and evidenced by an instrument in writing signed by the Trustees.

N. **Construction and Determination by Trustees**. The Trustees shall have full and exclusive discretionary authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They shall have full and exclusive discretionary authority to construe the provisions this Plan, and the terms used herein. They shall be the sole judges of the standard of proof required in any case. Any such determination, construction or judgment adopted by the Trustees in good faith shall be final and binding upon all of the parties hereto and any Enrollees and beneficiaries hereof. No decision of the Board of Trustees shall be reversed or overturned unless determined to be arbitrary and capricious. No matter respecting the foregoing or any difference arising thereunder, or any matter involved in or arising under this Plan shall be subject to the grievance or arbitration procedure established in any collective bargaining agreement between an Employer and Union, provided, however, that this paragraph shall not affect the rights and liabilities of any of the parties under any such collective bargaining agreements.

Covered Persons' Rights

Those who operate and/or administer this Plan are known as Plan "fiduciaries" and have a duty to act prudently and in the interest of all Plan Enrollees and beneficiaries. No one, including and Employer, union, or any other person, may

fire or otherwise discriminate against a person in any way to prevent him from obtaining a benefit or from exercising his rights under this Plan. If a fiduciary misuses the Plan's money, or if a person is discriminated against for asserting his rights, he may file a suit in court.

Any Questions about the Plan should be addressed to the Plan Administrator, c/o the Board of Trustees, whose address can be found in Section 1.C. of this Plan or the Claims Administrator as appropriate.

Entire Agreement

This Plan document and Summary Plan Description, together with its amendments and any applicable endorsements, constitutes the entire Plan.

SECTION 2 – DEFINITIONS

Accidental Injury: an unforeseen and unintended injury.

Adoptive Child: a child or infant as described in Section 3 of the Plan.

Ambulance: see Pre-Hospital Emergency Medical Services.

Application: the form completed by an applicant requesting Coverage from us and listing all Family Dependents to be Covered on the date such Coverage takes effect; the information from the completed application form is entered into the NY44 Trust's enrollment system by the Participating District's benefit staff.

Assistant Surgeon: a surgeon who assists another surgeon during the course of a surgical procedure.

Attending Physician: a Participating Physician or Designated Physician who is primarily responsible for attending to the care of a Covered Person with respect to any particular injury or illness.

Calendar Year: a twelve-month period beginning January 1 and ending at midnight of December 31 of each year.

Claim Form: the form provided by the Claims Administrator for incurred Eligible Expenses for treatment by Service Providers.

Coinsurance: your share of the costs of a Covered service, calculated as a percent of the allowed amount for the service. The use of the term coinsurance is not intended to mean or imply that the Plan is insured. The Plan is a self-funded plan.

Contribution for Coverage: the periodic amount of money we currently charge for benefits and services Covered under this Plan.

Copayment: a fixed amount, in addition to the Contribution for Coverage, which you are required to pay per visit for certain Covered services provided under the Plan. It is usually expressed as a fixed dollar amount payable each time a service is provided regardless of the number of times it is provided. You are responsible for the payment of any Copayment directly to the provider when In-Network Services are provided.

Coverage or Covered: the Health Care Services reimbursed under the Plan.

Covered Person or "you" or "your": a person who meets all relevant eligibility requirements under Section 3 of the Plan, who applies and is accepted for

Coverage from us, for whom the monthly Contribution for Coverage has been received by us and is Covered for benefits under this Plan.

Deductible: the amount you owe for Out-of-Network health care services in a Calendar Year before the Plan begins to pay. The Deductible may not apply to all services. Any amounts paid for Copayments or Coinsurance shall not count toward the Deductible. The Deductible is determined as of the date(s) the claims are processed by the Claims Administrator, not the date(s) on which the services occurred.

Designated Physician: a Non-Participating Physician who provides a service with respect to a particular injury or illness when the service is not available from a Participating Physician. The Referral to a Designated Physician must be authorized in advance in writing by: The Covered Person's Primary Physician and the office of the Medical Director. Authorization in advance is not required in a Medical Emergency.

Diagnosis: the act or process of identifying or determining the nature of an illness, injury or disease through examination.

Effective Date: the date from which you are entitled to receive Health Care benefits from us. Coverage begins at 12:01 a.m. Eastern Standard Time on the Effective Date in accordance with the following:

a. When a person makes application for enrollment within thirty (30) days after the date he/she was first eligible, Coverage will be effective on the Eligibility Date;
b. When a person fails to enroll within thirty (30) days of his/her Eligibility Date, he/she must wait until the next Open Enrollment Period to enroll in this Plan unless he/she is eligible for a Special Enrollment;
c. When a person is eligible for a Special Enrollment and
d. When Contributions for Coverage for all persons under this Plan have been received by us.

Eligibility Date: the date(s) when a person is eligible through a Participating District to participate in this Plan, provided that the Contribution for Coverage for Coverage under this Plan has been received by us. An eligible person must elect Coverage within the thirty (30) day period following the date he/she could first obtain Coverage (including eligible dependents) or when a person is eligible under Special Enrollment. If a Covered Person terminates Coverage for any reason other than termination of employment or eligibility with the Participating District, Coverage may be added only during the Open Enrollment Period except where the Covered Person qualifies for a Special Enrollment.

Eligible Expenses: the reasonable fees for Medically Necessary Health Care Services Covered under this Plan. Eligible Expenses include only fees for services actually provided to you. For services and items provided by Participating Providers, Eligible Expenses are the fee schedule amounts. For services and items provided by Non-Participating Providers, Eligible Expenses are the lesser of the Non-Participating Provider's charges, the rate negotiated by us, or the 90th percentile of the Usual, Customary and Reasonable (UCR) rate for the Health Care Services rendered in the applicable geographic area for Non-Participating Providers.

Enrollee: an employee of a Participating District or other individual (including but not limited to COBRA enrollees, Trust employees, retirees, etc.) who is eligible for coverage under the Plan.

Essential Health Benefits: The Affordable Care Act ensures certain health plans offer a comprehensive package of items and services, known as "essential health benefits." Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Any payments you make for Essential Health Benefits provided under the Plan count toward your Out-of-Pocket" Maximums. Payments you may make for benefits that are considered non-Essential Health Benefits do not count toward your Out-of-Pocket Maximums.

Experimental and/or investigational: any medical treatment, procedure, drug, substance or device:

a. that is the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

b. for which a written protocol or protocols or written informed consent, used by the treating facility or provider (or the protocol or written informed consent of another facility or provider studying substantially the same medical treatment, procedure, drug, substance or device), identify the medical treatment, procedure, drug, substance or device as a research or investigational or experimental or a clinical trial or study, unless the proposed medical treatment, procedure, drug, substance or device (1) is so identified solely for purposes of clinical data collection and statistical survival analysis and (2) is generally recognized by the medical community, as reflected in the published peer review medical journals, as

the standard of care for the treatment of the Covered Person's specific Illness or Injury; or

c. that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration ("USFDA") and approval for marketing has not been given at the time the drug or substance or device is furnished; or

d. that is a drug or substance or device which is not, at the time it is furnished, approved by the USFDA for the specific Illness or Injury for which the patient is being treated; or

e. that is a drug or substance or device which is labeled: "Caution -- limited by federal law to investigational use" or a substantially similar label or warning.

f. notwithstanding any provision of the Summary Plan Description to the contrary, the Claims Administrator shall have the authority to determine issues of Coverage raised under Section 7, Paragraph 15 in accordance with the Claims Administrator's applicable policies in effect at the time the claim arises.

Family Dependent(s): a person meeting all the eligibility requirements set forth in Section 3.

Group Benefit Plan(s): health benefit plans such as: HMO; health insurance; employer self-insurance or other group health plan that covers Enrollee or Family Dependents.

Habilitation Services Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Provider: a person who is licensed, certified or otherwise qualified under a state's laws to provide the Covered benefits authorized pursuant to such license, certification or other qualification. All Health Care Providers are independent contractors and are not our employees or agents.

Health Care Services: Medically Necessary services to treat your illness, injury or disease. Health Care Services do not include services which are not actually provided to you.

Home Health Agency: a public or private agency that specializes in giving skilled nursing services in the home and possesses a valid certificate of approval or a license issued pursuant to Article 36 of the Public Health Law of New York State.

Home Health Care: health care services a person receives at home which are provided by a licensed or certified agency engaged in providing Health Care Services including, but not limited to, skilled nursing services from an agency having a valid certificate of approval or a license issued pursuant to Article 36 of the Public Health Law of New York State. This Plan does not Cover private duty nursing or custodial care.

Hospital: an acute general care facility operated pursuant to law which (1) is primarily engaged in providing diagnostic therapeutic services for surgical or medical Diagnosis, treatment, and care for persons having illness, injury or disease by or under the supervision of a staff of duly licensed physicians; (2) has 24-hour nursing services by registered professional nurses; (3) is not (other than incidentally) a place for rest, custodial care; for the aged; or a nursing home; convalescent home; or similar institution; and (4) is duly licensed to operate as an acute general hospital under applicable state or local laws.

Hospice Care: the care and treatment of an enrolled Covered Person who has been certified by his Health Care Provider as having a life expectancy of six (6) months or less which is provided by a hospice organization certified under the New York Public Health Law or under a similar certificate process required by the state in which the Hospice is located.

Identification Cards: the cards that we issue to you showing that you are entitled to Covered Health Care Services. You will receive separate cords for the medical and prescription drug benefits.

Independent Review Organization (IRO): an organization, independent of all affected parties, which determines whether a health care item or service is medically necessary and medically appropriate or experimental/investigational.

Infertility: the inability to conceive after twelve (12) consecutive months of reasonably frequent contraceptive free, unprotected sexual intercourse with an intent to conceive. A Covered Person who has the ability and/or history of conception but has a history of inability to carry the pregnancy to term does not meet the criteria of Infertility.

Infertility Services: medical or surgical procedures which are Medically Necessary to diagnose or correct a malformation, disease or dysfunction resulting in Infertility, and diagnostic tests and procedures that are necessary to determine Infertility, including, but not limited to, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound.

In-Network Services/Benefits: Covered Health Care Services which are provided by a Participating Provider or authorized by us.

Maternity Care: Coverage for Hospital, surgical or medical services and treatment relating to pregnancy, delivery, and postnatal care including:

a. the services of a certified nurse-midwife under qualified medical direction affiliated or practicing in conjunction with a duly licensed facility, provided such services are not duplicative of services already provided by a physician.
b. parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

Medical Director: the licensed physician or pharmacist designated by the Claims Administrator, to exercise general supervision over the provision of medical care rendered under this Plan.

Medical Emergency: the sudden onset or behavioral condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, or (2) serious impairment to such person's bodily functions, or (3) serious dysfunction of any bodily organ or part of such person, or (4) serious disfigurement of such person.

Medically Necessary: any Health Care Services required to preserve and maintain your health as determined by acceptable standards of medical practice. The Medical Director shall have authority to determine whether any health care rendered to you is Medically Necessary. Such determination is final as long as it is neither arbitrary nor capricious. The Medical Director's determination is subject to Section 15 - Appeal Procedures. The Plan Covers only Medically Necessary services.

Medicare: the Health Insurance for Aged and Disabled Program established pursuant to Title XVIII of the Federal Social Security Act, as it is in effect at the Effective Date of the Plan or as that Act may be subsequently amended.

Mental Health Condition: acute mental, nervous, or emotional disorder, which is susceptible to short-term treatment and poses a serious threat to the mental or physical well-being of a Covered Person.

Non-Covered Service(s): the Health Care Services not Covered by the Plan.

Non-Participating Provider: a licensed physician or other licensed or certified Health Care Provider who does not currently have a Participating Provider agreement with either MVP or Capital Rx.

Open Enrollment Period: a period of time (generally the month of May) which we establish when the Participating District or unit can add new Enrollees. The Open Enrollment Period shall occur not more frequently than once a year and usually coincides with the Plan Year.

Out-of-Network Services/Benefits: Covered Health Care Services that are provided or referred by a Non-Participating Provider which the Covered Person elects to have rendered without the necessary prior authorization from the Claims Administrator.

Out-of-Pocket Maximum (for In-Network Services and Drugs): the most you pay out-of-pocket each Calendar Year before the Plan starts to pay 100% for In-Network Covered Essential Health Benefits. This limit includes Deductibles, Coinsurance, Copayments, or similar charges and any other expenditure required of you for Covered Essential Health Benefits. This limit does *not* include, for example, your Contribution for Coverage, penalties for failing to obtain Precertification, or spending for non-Essential Health Benefits. **Your total Out-of-Pocket maximum for In-Network Services and Drugs is $5,000 per person; $10,000 per family per calendar year.**

Your Out-of-Pocket Maximum is calculated separately for (1) <u>In</u>-Network Services/ Drugs and (2) <u>Out</u>-of-Network Services/ Drugs.

Out-of-Pocket Maximum (for Out-of-Network Services and Drugs): The most you pay out of pocket each Calendar Year before the Plan starts to pay 100% for Out-of-Network Covered Essential Health Benefits. This limit includes Deductibles, Coinsurance, Copayments, or similar charges and any other expenditure required of you for Covered Essential Health Benefits. This limit does not include, for example, your Contribution for Coverage, balance billing amounts for Non-Participating Providers and other Out-of-Network cost-sharing, or spending for non-Essential Health Benefits. **Your total Out-of-Pocket maximum for Out-of-Network Services and Drugs is $9,500per person; $19,000per family per calendar year.**

Your Out-of-Pocket Maximum is calculated separately for (1) <u>In</u>-Network Services/ Drugs and (2) <u>Out</u>-of-Network Services/ Drugs.

(Note: when you obtain services Out-of-Network, the Plan pays the Non-Participating Provider at one hundred percent (100%) of the lesser of (1) the Non-Participating Provider's billed charges; or, as applicable, (2) the negotiated rate which the Non-Participating Provider has agreed to accept; (3) the Usual, Customary and Reasonable Rate (UCR) for services rendered outside our Service Area. UCR is determined at the 90th percentile of the Fair Health Scheduled Rates. If there is no Fair Health scheduled rate, claims will be processed with a straight 50% of billed charges.)

Partial Hospitalization Program: a structured program of outpatient active psychiatric treatment that is more intense that the care you get in a doctor's or therapist's office. This type of treatment is provided during the day and doesn't require an overnight stay.

Participating District: the school or school district employer, or unit which contracts with us to Cover Health Care Services for you.

Participating Physician(s): any physician who has agreed to provide Health Care Services to you as a Participating Provider.

Participating Provider(s): a participating Physician or pharmacy; Hospital; Skilled Nursing Facility; Home Health Agency; ambulance service; laboratory; or other duly licensed Health Care Provider that has a Participating Provider agreement with either MVP or Capital Rx. All Health Care Providers are independent contractors and are not employees or agents of ours.

Participating After Hours Care Center: an alternative site of service which:

a. is for the purpose of managing acute, urgent, non-life-threatening conditions other than in an Emergency Room of a Hospital during non-traditional physician office hours;
b. is not a substitute for routine care provided in the Primary Physician's office or as a substitute for care for a Medical Emergency at the Emergency Room of a Hospital;
c. is equipped to accommodate minor outpatient procedures;
d. provides ancillary services such as laboratory and radiology;
e. directs the Covered Person to receive any necessary follow-up care from the Covered Person's Primary Physician; and
f. has entered into an agreement with MVP to provide care to Covered Persons.

Physical Therapy: Medically Necessary short-term therapy, which can result in significant clinical improvement in your condition, as determined in our sole discretion.

Preauthorization: a decision by the Plan that a Health Care Service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. Sometimes called prior authorization, prior approval or Precertification. The Plan may require Preauthorization for certain Health Care Services before you receive them, except in a Medical Emergency. Preauthorization is not a promise that he Plan will cover the cost.

Precertification: a decision by the Plan that a Health Care Service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. The Plan may require Precertification for certain Health Care Services before you receive them, except in a Medical Emergency. Precertification is not a promise that the Plan will cover the cost.

Pre-Hospital Emergency Medical Services (Ambulance): the prompt evaluation and treatment of a Medical Emergency, and/or non-air-borne transportation of the Covered Person to a Hospital; provided however, where the Covered Person utilizes non-air-borne emergency transportation pursuant to this subsection, Coverage will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

Primary Physician or Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who:

a. is selected by a Covered Person with the approval of the physician; and,

b. directly provides or coordinates a range of health care services for the Covered Person. The primary care physician is responsible for providing all primary care services including periodic examinations; immunizations; Diagnosis and treatment of illness and injury; coordinating the Covered Person's overall medical care and record maintenance, providing twenty-four (24) hour physician coverage; and authorizing all Referrals to Specialty, Attending and Designated Physicians.

Qualified Ob/Gyn Provider: a Health Care Practitioner who:

a. Is selected by a Covered Person with the approval of the Qualified Ob/Gyn Provider;

b. Is duly licensed to provide obstetric and gynecological services, working within the scope of his/her practice; and

c. Practices as a Physician specializing as an obstetrician/gynecologist; Physician specializing as a family practitioner; Professional midwife as authorized by Title VIII, Article 140 of the New York State Education Law and Regulations of the Commissioner of Education; or Nurse practitioner with a specialty in obstetrics/gynecology or women's health, as authorized by Title VIII, Article 139 of the New York State Education Law and Regulations of the Commissioner of Education.

A Covered Person may select her Qualified Ob/Gyn Provider at any time and may change her Qualified Ob/Gyn Provider at any time to any other Qualified Ob/Gyn Provider.

Referral: a written/electronic authorization for services written by a Participating Physician or by the Medical Director.

a. Covered Persons are required to have a Referral for all services from a Designated Physician
b. Written authorization must be received from the Medical Director for any Out-of-Network Services to be Covered as In-Network.
c. When determined by the Medical Director in accordance with an approved treatment plan, a Referral may remain valid for the same Diagnosis for care by the same Health Care Provider for a period of time as authorized by the approved treatment plan.

Semi-Private Room: a room with two (2) or more beds in a Hospital, Skilled Nursing Facility, or other participating health care facility.

Service Area: the United States of America, including the District of Columbia.

Service Provider: a provider of services or supplies which are Covered under the Plan.

Skilled Nursing Facility (SNF): a facility providing therapeutic services to inpatients requiring medical and skilled nursing care as defined under Section 2801 of the New York Public Health Law or otherwise duly licensed or certified outside New York State and which is qualified to participate as an extended care facility under Title XVIII of the Social Security Act.

Special Enrollment: the ability of an eligible person or dependent to participate in the health benefits plan under this Plan as described in Section 3.B. of this Plan.

Specialty Physician: 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.

Total Disability: an injury, illness or disease, which renders a working Enrollee incapable of performing each and every task of any employment for which he has or can be trained. In the case of a non-working Enrollee when, by reason of illness, injury or disease, he is wholly unable to engage in the normal activities of a person of the same sex and age. The inability to perform some, but not all, of many tasks will not be deemed to a Total Disability.

UCR (Usual, Customary and Reasonable): the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. By Usual we mean the fee regularly charged and received for a given service or supply by a provider. By Customary and Reasonable we mean the fee for a service or supply that we determine is the most standard and reasonable amount charged by providers in the locality where the charge for such services or supply is incurred. Locality means an area whose size is large enough, in our judgment, to give an accurate representation of standard charges for that type of service or supply.

Urgent Care: 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 room care. The Medical Director shall have the authority to determine whether any health care rendered to the Covered Person is Urgent Care. Such determination is final as long as it is neither arbitrary nor capricious.

Utilization Review: the process of making medical management decisions and is provided by the Claims Administrator.

SECTION 3 - ELIGIBILITY, ENROLLMENT, AND CONDITIONS OF COVERAGE

A. Eligibility

Individuals are accepted for enrollment when they meet the requirements outlined below:

1. Employees: To be eligible to enroll as an Employee, an individual (including any retiree) must be entitled to participate through the Participating District, or through employment with the Trust, and meet such eligibility requirements (such as length of service, active employment, etc.) as may be imposed by the Participating District or the Trust.

   Enrollees on Approved Leaves of Absence. If an Enrollee goes on an approved leave of absence (without pay) for other than medical reasons, coverage for the Enrollee and his/er Covered Family Dependent(s) may be continued for the duration of the approved leave, provided all required Contributions for Coverage are made when due, and the leave is approved by the specific Participating District. (Policies on unpaid leaves vary by Participating District, and continued eligibility during an unpaid leave is determined by the Participating District.) If an Enrollee goes on an approved leave of absence (without pay) due to Total Disability for more than three months, coverage for the Enrollee and his/er Covered Family Dependent(s) will be continued for the duration of the approved leave of absence, not to exceed one year. All required Contributions for Coverage must be made when due.

2. Family Dependents: To be eligible to be Covered as a Family Dependent, an individual must qualify under one of the following paragraphs:

   a. Married to the Enrollee;

   b. For an Enrollee who is participating through a Participating District that has authorized domestic partner coverage by formal board resolution or by specific language in a collective bargaining agreement, coverage shall be available to the Enrollee's domestic partner who meets all of the following:

      1. Of the same or opposite sex as the Enrollee; and
      2. At least eighteen (18) years of age; and
      3. Not related by marriage or by blood in a way that would bar marriage; and
      4. Not married to anyone else nor have had another domestic partner for a period of not less than one (1) year; and
      5. Registered/verification/application or other requirements as established by your employer (please contact your employer) and

6. Provides proof of cohabitation with the Enrollee (e.g., a driver's license, tax return or other sufficient proof); and
7. Provides evidence of two or more of the following with the Enrollee:
   A. a joint bank account;
   B. a joint credit or charge card;
   C. joint obligation on a loan;
   D. status as authorized signatory on the Enrollee's bank account, credit card or charge card;
   E. joint ownership of residence;
   F. joint ownership of real estate other than residence;
   G. listing of both partners as tenants on a lease of the shared residence;
   H. shared rental payments of residence (need not be shared 50/50);
   I. listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
   J. a common household and shared household expenses, (e.g., grocery bills, utility bills, telephone bills, etc.);
   K. shared household budget for purposes of receiving government benefits;
   L. status of one as representative payee for the other's government benefits;
   M. joint ownership of major items of personal property (e.g., appliances, furniture);
   N. joint ownership of a motor vehicle;
   O. joint responsibility for child- care;
   P. shared child-care expenses;
   Q. execution of wills naming each other as executor and/or beneficiary;
   R. designation as beneficiary under the other's life insurance policy;
   S. mutual grant of durable power of attorney;
   T. mutual grant of authority to make health care decisions (e.g., health care power of attorney);
   U. affidavit by creditor or other individual able to testify to partners' financial interdependence;
   V. other items of proof to establish economic interdependency under the circumstances of the particular case.

In order to enroll the Enrollee's domestic partner, the Enrollee must execute a Domestic Partner Affidavit, which may include any additional requirements established by a Participating District, and/or any documentation required to prove Family Dependent eligibility and pay us the additional Contribution for Coverage, if any, within thirty (30) days of the domestic partner's Eligibility Date, during the Participating District's Open Enrollment Period or during a Special Enrollment

period. In addition, the Enrollee must complete an annual Domestic Partner Checklist and return it to the Trust by July 1.

c. A child of the Enrollee including any stepchild (or child of a domestic partner who meets any additional requirements of the Trust); legally adopted child; grandchild, foster child, proposed adoptive child or child for whom the Enrollee is the legal guardian, who is less than twenty-six (26) years of age and is not on active duty in the armed forces of any country.

   Adoptive non-infant children less than age twenty-six (26) are Covered from the date we receive notification and payment for additional Contribution for Coverage, if any, provided that the following steps resulting in final adoption are completed:

   1. We are notified of the Coverage for the Adoptive Child within thirty (30) days of taking physical custody;
   2. the Enrollee files a petition for adoption pursuant to applicable law within thirty (30) days of taking physical custody;
   3. no notice of revocation of the adoption is filed pursuant to applicable law; and
   4. consent to the adoption has not been revoked and the Enrollee retains a legal obligation for the total or partial support of the child in anticipation of adoption.

   Adoptive infants are Covered from the moment of birth when the following steps resulting in final adoptions are completed:

   1. we are notified of the Coverage for the adoptive infant and receive payment of additional Contribution for Coverage, if any, within thirty (30) days of the date of birth;
   2. the Enrollee takes physical custody of the adoptive infant upon release from the Hospital;
   3. the Enrollee files a petition for adoption pursuant to applicable law within thirty (30) days of birth;
   4. no notice of revocation of the adoption is filed pursuant to applicable law and
   5. consent to the adoption has not been revoked and the Enrollee retains a legal obligation for the total or partial support of the infant in anticipation of adoption.

   If we do not receive notification and payment of additional Contribution for Coverage, if any, on or before the thirtieth (30th) day from the date of birth or the date upon which the child is physically in the household of the

Enrollee, then Coverage will begin on the Participating District's Open Enrollment Period or during a Special Enrollment event if notification and payment is received by us on or before the thirtieth (30th) day from that date. Coverage of the initial Hospital stay for a newborn adoptive infant is not provided by us if a natural parent has insurance or other coverage available for the adoptive infant's care.

Upon request, the Enrollee must provide us with proof of eligibility for a Family Dependent. This may include a birth certificate, divorce decree, domestic partner documentation, adoption certificate, legal guardianship papers, and/or a copy of the Enrollee's income tax form to demonstrate that a child is claimed as a dependent, if applicable.

d. An unmarried child of the Enrollee including any stepchild, legally adopted child, or proposed adoptive child who is the age of twenty-six (26) or over and is:

    1. Incapable of self-sustaining employment because of mental illness, mental retardation or developmental disability, as defined by the N.Y.S. Mental Hygiene Law, or because of physical handicap, and
    2. Dependent upon the Enrollee for support and maintenance. The child must have been Covered by this Plan and must have become incapable prior to age twenty-six (26) for purposes of this provision. The dependent child, to remain eligible, must continue to be subject to the conditions set out above. The Enrollee may be required by us to provide evidence of the handicapping conditions claimed to be existing for the child. The Enrollee may be required by us on an annual basis to provide evidence that the child is dependent upon the Enrollee for support and maintenance.

A new Family Dependent, because of marriage or adoption of a child, may be enrolled during an eligibility period extending for a period of thirty (30) days after the Family Dependent first becomes eligible for Coverage from us. If we do not receive notification and payment of additional Contribution for Coverage, if any, on or before the thirtieth (30th) day from the date the Family Dependent first becomes eligible, then Coverage will begin on the Participating District's Open Enrollment Period or a Special Enrollment event if notification and payment is received by us on or before the thirtieth (30th) day from that date. Newborn natural children of the Enrollee shall be Covered from birth if notification is received and additional Contribution for Coverage paid, if any, within thirty (30) days of the date of such child's birth; otherwise, Coverage begins on the date we receive notification and payment, provided such notification and payment is received by us reasonably and close to the child's birth.

3. Persons not entitled to Coverage include:

    a. Persons who are in the armed forces of any government other than for duty of thirty (30) days or less.

    b. Persons who are eligible for Medicare and for whom Medicare would be primary payer but who have not enrolled in both Medicare Part A and Medicare Part B (in accordance with the Trust's Policy on "Medicare Eligibility, Enrollment and Conditions of Coverage/Contributions for Coverage Provisions").

    c. Any child born to an Enrollee's child, except as provided in III.A.2.c.

    d. Persons with a medical condition which is covered under another Plan's extension of benefits coverage until that other Plan's coverage for that condition has terminated.

    e. Family dependents who are Enrollees of the Plan through their own employment.

    f. Family Dependents who are Family Dependents of another Enrollee of this plan and enrolled for coverage by that other Enrollee.

4. We reserve the right to examine a Participating District's records including payroll records and an individual's employment or enrollment records in determining eligibility status for enrollment or under certain benefit exclusions such as, but not limited to, Workers' Compensation, unpaid leaves of absence, etc.

5. We reserve the right to require and be furnished with such proof as may be needed to determine eligibility status of an Enrollee or Family Dependent.

B. Enrollment

The Trust recommends an Enrollee complete updated Open Enrollment documentation annually. Each Participating District should provide eligible employees with the necessary documentation regarding the Trust to allow for enrollment including, but not limit to, annual required notifications.

1. Enrollees may be enrolled with us only within thirty (30) days of their first day of eligibility for enrollment, during the Open Enrollment period, or within thirty (30) days of a Special Enrollment Event and upon meeting the eligibility requirements imposed by the Participating District.
2. A potential Enrollee may enroll other than during the Open Enrollment Period when one of the following occurs ("Special Enrollment Events") and when proof of such situation is presented to us:

    a. a person becomes a Family Dependent of the potential Enrollee through marriage, birth, adoption or placement for adoption;

b. exhaustion of COBRA continuation Coverage;

c. an involuntary loss of health insurance coverage resulting from a loss of eligibility or the employer's contributions towards coverage were terminated, provided that such person had such coverage at the time coverage hereunder was previously offered.

In addition to the Special Enrollment Events, you may change your election during a Plan Year (including any election change to disenroll from the Plan) only if another event as allowable under Code Section 125 of the IRC occurs, consistent with the Participating District's Section 125 plan.

3. An Enrollee's spouse or Family Dependent may enroll other than during the Open Enrollment Period when the person becomes a dependent of the Enrollee through:

   a. marriage or assumption of a domestic partnership;

   b. birth, adoption or placement for adoption, and the case of the birth or adoption of a child, the spouse of the Enrollee may enroll as a dependent if otherwise eligible.

4. Enrollees may enroll themselves and their Family Dependents during an eligibility period by completing an Application Form and submitting it to the Participating District's benefit staff; the Participating District's benefit staff will enter the enrollments into the Trust's enrollment system provided and used by the Trust. The Participating District agrees to give all newly hired employees our descriptive literature as soon as they become eligible for Coverage. Such Enrollees may apply for Coverage from us within thirty (30) days of the date they become eligible for Coverage. If Enrollees do not apply within thirty (30) days of the date they become eligible they must wait until the next Open Enrollment Period or Special Enrollment event to become Covered.

5. Changes to the original Application Form must be made by completing a new Application Form and submitting it to the Participating District's benefits staff; the Participating District's benefit staff will make the changes through the Trust's enrollment system. The Participating District agrees to promptly notify us if there is any change in the Enrollee's eligibility for Coverage.

6. Coverage of Enrollees and Family Dependents shall take effect on the Effective Date.

SECTION 4 - PRECERTIFICATION REQUIREMENTS for Out-of-Network Services AND REVIEW of In-Network and Out-of-Network Hospital and Skilled Nursing Facility Services

A. PRECERTIFICATION REQUIREMENTS

This Plan provides for a Precertification process in connection with all your Out-of-Network inpatient hospitalization benefits and certain Out-of-Network outpatient services.

In-Network inpatient hospitalization benefits and certain outpatient services require Pre-authorization, for which the Participating Provider is responsible. Pre-authorization for certain outpatient services, surgical procedures, and durable medical equipment may be waived by MVP in accordance with current policies in place for the MVP Provider Network.

1. **Except in the case of a Medical Emergency, all Out-of-Network inpatient hospital services and certain Out-of-Network outpatient services must be Precertified.**

2. **Precertification is the process by which it is determined if Health Care Services are Medically Necessary**. In order for the Covered Person to receive Out-of-Network Coverage or benefits under this Plan, the Claims Administrator must determine that your care is Medically Necessary. In order for the Claims Administrator to make the determination, you must follow the rules set forth below.

3. **Precertification of all inpatient Hospital services received from Out-of-Network Providers and certain outpatient services received Out-of-Network.** Before you receive non-emergent Out-of-Network inpatient Hospital or SNF Services or certain Out-of-Network outpatient services, you or your physician must call the Claims Administrator so that the Medical Director or designee can review the reason for your Hospital care, SNF care, or requested outpatient service. The Medical Director or designee will ascertain if the requested services are Medically Necessary. This requirement applies only to non-Medical Emergency admissions to a Hospital or SNF or requested outpatient service. Outpatient services requiring Precertification are identified in Section 5. Precertification does not apply to admissions for Medical Emergency care or admissions for the delivery of a baby.

4. **Notification of admissions for Out-of-Network inpatient hospital admissions.** All Out-of-Network emergency inpatient admissions must be reviewed and approved by the Medical Director or designee immediately following the admission. You must comply with the following procedure:

You, a family member, your physician, or the Hospital should call the telephone number shown on your Identification Card within seventy-two (72) hours following your hospital admission.

5. **It is your responsibility to make sure that the Precertification or Notification and review process is followed.** After the Medical Director or designee reviews the Hospital, SNF, or outpatient service, he will notify you, your physician, and the Hospital, SNF, or provider of the requested service. If the Medical Director determines that it is not Medically Necessary for you to have the requested service, a representative of the Claims Administrator will notify your physician. If the physician provides the Claims Administrator with additional information, the Medical Director or designee may reconsider the Medical Necessity of the requested service. The Medical Director or designee will make the determination as to whether the requested services are Medically Necessary. This notification will generally be made within three (3) business days, provided that all reasonably necessary information has been supplied. Notification concerning non-urgent pre-service requests will be made within 15 calendar days.

6. **If the Medical Director does not give approval for Coverage of your Out-of-Network admission prior to your admission to the Hospital or SNF or receipt of Out-of-Network outpatient services, you will be notified.** You may appeal the decision. See Section 15 for guidelines on how to file an appeal.

7. **Failure to participate in the Precertification/Notification process will result in a reduction of Coverage or benefits.**

    a. If your admission is without prior approval or approval of Coverage by the Claims Administrator, you will be responsible for the payment of the first $1,200.00 of charges for the service for each admission otherwise Covered under this Plan, in addition to any applicable Deductible and Coinsurance in section 5 below and any additional payments.

    b. If your receipt of outpatient services is without approval of Coverage by the Claims Administrator, you will be responsible for the payment of 50% of the eligible expenses for the service for each outpatient service otherwise Covered under this Plan, in addition to any applicable Deductible and Coinsurance in section 5 below and any additional payments.

    c. Failure to call for prior approval for an Emergency Department visit will result in an increase in the Copayment to $350 or 50% of the cost,

whichever is less. The Copayment will be waived if the individual is admitted to the hospital as an inpatient.

8. **Transplant Services.** The protocol, policies and procedures of the Claims Administrator shall apply for Preauthorization of all transplant services. Please note that Out-of-Network transplant services are excluded from Coverage under this Plan, unless the Claims Administrator determines no In-Network transplant services are available.

B. REVIEW OF YOUR INPATIENT HOSPITAL AND SNF SERVICES (both In-Network and Out-of-Network)

Whenever you are admitted to a Hospital or SNF for inpatient care, the Medical Director or designee will review your condition and your medical records at regular intervals to determine whether it is Medically Necessary for you to continue to receive inpatient care. If the Medical Director or designee determines it is not Medically Necessary for you to continue to have inpatient Hospital or SNF care, the Claims Administrator's representative will consult your physician. If your physician provides additional information, which, in the Medical Director's or designee's opinion, justifies continued inpatient Hospital or SNF care, the Claims Administrator will approve Coverage of the care.

1. The Claims Administrator will notify you or your physician at least one day before the day payment of benefits for the stay will cease. You may appeal the decision. See Section 15 for guidelines on how to appeal a decision.

2. **If the Claims Administrator has notified you that your continued stay is no longer Medically Necessary, and you elect to remain in the Hospital or SNF, then you will be responsible for payment of all charges for the continued stay.**

SECTION 5 - COVERAGE OF HEALTH CARE SERVICES

A. Health Care Services which are Medically Necessary will be Covered or reimbursed in accordance with this Section 5 as follows:

1. Participating Providers: Health Care Services received from Participating Providers will be Covered in conformance with Section 5, Schedule of Benefits under the In-Network benefits.

2. Capital Rx Participating Provider (Pharmacy): Prescription drugs received from a Capital Rx Participating Pharmacy will be Covered in conformance with Section 5, Schedule of Benefits under the In-Network benefits.

3. Non-Participating Providers. Subject to Precertification requirements, Health Care Services rendered by Non-Participating Providers will be Covered in conformance with Section 5, Schedule of Benefits under Out-of-Network benefits.

4. There may be situations where you receive services from a Participating Provider and a Non-Participating Provider renders a portion of those services. In those cases where the use of a Non-Participating Provider is beyond your control, the services will be Covered in conformance with Section 5, Schedule of Benefits under the In-Network benefits, based on the Usual, Customary, and Reasonable (UCR) charges. The Claims Administrator has the discretionary authority to determine whether the circumstances are beyond your control. Examples of circumstances beyond your control include but are not limited to:

    a. services provided by a Non-Participating anesthesiologist when the operating surgeon is a Participating Provider;

    b. diagnostic laboratory and pathology tests referred to a Non-Participating laboratory or pathologist by a Participating Provider; or

    c. consultation services by a Non-Participating Provider which are provided to you while you are confined as an inpatient at a Participating Hospital or other facility and the physician who requested the consultation is a Participating Provider.

B. Fee Schedule.

1. We have approved a Fee Schedule for the Health Care Services described in this Plan. Upon request, a fee will be set for any Health Care Service not listed in the Fee Schedule. The Fee Schedule determines the maximum amount we will pay for Health Care Services from a Participating Provider.

2. You may request Fee Schedule information regarding a specific Health Care Service at the MVP offices during regular business hours. The Fee Schedule is also on file in the Office of the Superintendent of Insurance of the State of New York. The Fee Schedule may be changed by MVP from time to time without notification to you.

C. Payments, copayments, Deductibles, coinsurance, Additional Payments and Out-of-Pocket Maximums.

1. Coverage for Medically Necessary In-Network Health Care Services is subject to applicable copayments.

2. Coverage for Medically Necessary Out-of-Network Services are subject to the following Deductibles and coinsurance payments unless otherwise stated:

a. Coverage is subject to a $2,000 Deductible per person per Calendar Year. However, once Covered Persons in a family have met a total of $5,000 towards their individual Deductibles, all Covered Persons in the family will be considered to have met their Deductible for that Calendar Year.

b. In addition to Deductibles, you must pay coinsurance equal to 30% (50% coinsurance for DME) of the lesser of the Non-Participating Provider's charges, the rate negotiated by the Claims Administrator, or the 90th percentile of the Usual, Customary and Reasonable (UCR) rate for the Health Care Service rendered in the applicable geographic area for Non-Participating Providers. After you have met the annual Deductible, we will pay 70% (50% for DME) of the lesser of Non-Participating Provider's Charges, the rate negotiated by the Claims Administrator, or the 90th percentile of UCR Fair Health scheduled rate for the Health Care Service rendered in the applicable geographic area for Non-Participating Providers. If there is no Fair Health scheduled rate, claims will be processed with a straight 50% of billed charges.

3. Additional payments The charges of Non-Participating Providers may exceed the amount of reimbursement we pay. Therefore, in addition to Deductibles and coinsurance, you must pay the difference between our reimbursement and the balance due the Non-Participating Provider.

4. Out-of-Pocket Maximum In-Network Services and Drugs, and Out-of-Network Services and Drugs are found in Section 2, Definitions.

D. SCHEDULE OF COVERAGE

Coverage is subject to the exclusions in Sections 7 and 8 and to the limitations of this plan.

Certain services may require Preauthorization or Precertification as described in Section 4 in order for you to receive Coverage. These services can be identified with the telephone icon shown below:

Medically Necessary In-Network Services will be Covered as set forth below, subject to applicable copayments. Medically Necessary Out-of-Network Services will be Covered as set forth below, subject to applicable Deductibles, Coinsurance, and additional payments.

PROFESSIONAL SERVICES IN AN OFFICE SETTING

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Services	$10 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Home Visits	$10 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Diagnostic X-Ray, such as Organ Scans, Sonogram and Ultrasound	$15 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Advanced imaging procedures (e.g., MRI, MRA, PET)	These services require preauthorization.  If preauthorized, $15 copayment	These services require Precertification.  If Precertified, subject

		to Deductibles, coinsurance and additional payments set forth in Section 5C.
Laboratory Services	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Mammography Screening for occult breast cancer, subject to the following schedule: a. Upon recommendation of a physician, a mammogram at any age; b. A single baseline mammogram for women aged 35 through 39, inclusive; c. An annual mammogram for women aged 40 and older.	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Well-child visits (including a medical history; physical exam; developmental assessment; anticipatory guidance; necessary and appropriate immunizations; and laboratory tests ordered at the time of the visit) for dependent children from birth through the attainment of the age of 19, provided further that the visits are scheduled in accordance with the prevailing clinical standards of the American Academy of Pediatrics.	Covered in full	Not Covered
Periodic Routine Health Examinations	Covered in full	Not Covered
Immunizations for Covered Persons over age nineteen (19)	Covered in full	Not Covered
Voluntary Family Planning	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Medical Supplies	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Obstetrical Services, including, but not limited to, Prenatal Care, Prenatal Case Management, Delivery and Post-Partum Care. Payments for Prenatal Care, Delivery and Post-Partum Care	$10 copayment Copayment is limited to first visit.	Subject to Deductibles, coinsurance and additional payments

will normally be made after delivery; when necessary payments will be made at reasonable intervals for services rendered for Prenatal Care and a separate payment for the Delivery and Post-Partum Care provided.		set forth in Section 5C
Allergy Tests and Allergy Injections	$10 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Hearing Examinations ordered by a Physician	$15 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Surgical Procedures when performed in the office	$75 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Surgical Care and Anesthesia Multiple surgical procedures performed during the same operative session and through the same incision shall be reimbursed in an amount not less than the amount we would pay for the most expensive procedure then being performed. Multiple surgical procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the amount we would pay for the most expensive procedures then being performed, and with regard to the less expensive procedures, in an amount at least equal to 50% of the amount we would pay for these procedures (In-network providers accept this payment as payment in full).	Covered in full when performed in an Inpatient Hospital or Inpatient Skilled Nursing Facility Setting; for surgery performed in an Outpatient Hospital or Ambulatory Surgery Center setting, the professional services will be covered in full and the $75 copayment will be applied to the facility charges.	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Second Surgical Opinions	$10 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.

Infertility Services In order to be eligible for Infertility Services, the Covered Person must: a. be at least twenty-one (21) years of age and no older than forty-four (44) except for Diagnosis and treatment for a correctable medical condition which incidentally results in Infertility; b. have a treatment plan submitted in advance to the Claims Administrator by a physician who meets the applicable training, experience and other standards for the Diagnosis and treatment of Infertility as promulgated by New York State or the applicable state where services are rendered; and c. have a treatment plan that is in accordance with standards and guidelines established and adopted by the American Society for Reproductive Medicine. THIS BENEFIT DOES NOT COVER TREATMENT FOR THE COVERED PERSON'S PARTNER, IF THE PARTNER IS NOT COVERED UNDER THIS PLAN. This benefit does not include prescription drugs.	Covered in full or with copayment, as appropriate for the specific services provided	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Annual Cervical Cytology Screening including: a. pelvic exam; b. Pap smear collection and preparation; c. laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Chemotherapy	$15 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Radiation Therapy	$15 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Bone Mineral Density Measurements or tests, drugs and devices pursuant to the criteria of the Federal Medicare program and the criteria of the National Institutes of Health (NIH) for the detection of osteoporosis. This benefit provides Coverage for Covered Persons meeting the criteria under the Federal Medicare program or the NIH who, at a minimum: a. have been previously diagnosed as having osteoporosis or have a family history	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C

of osteoporosis; or b. have symptoms or conditions indicative of the presence or the significant risk of osteoporosis; or c. are currently on a prescribed drug regimen that poses a significant risk of osteoporosis; or d. have lifestyle factors to such a degree as posing a significant risk of osteoporosis; or e. are of such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis		

PROFESSIONAL SERVICES WHEN THE COVERED PERSON IS IN A HOSPITAL, SKILLED NURSING FACILITY, OR AN OUTPATIENT FACILITY

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Surgical Procedures including Assistant Surgeon. This includes breast reconstruction surgery on one or both breasts after a mastectomy as deemed appropriate by the Attending Physician in consultation with the Covered Person to produce a symmetrical appearance. There is also Coverage for physical complications associated with all stages of mastectomy including lymphedemas and prostheses required because of a mastectomy. Multiple surgical procedures performed during the same operative session and through the same incision shall be reimbursed in an amount not less than the amount we would pay for the most expensive procedure then being performed. Multiple surgical procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the amount we would pay for the most expensive procedures then being performed, and with regard to the less expensive procedures, in an amount at least equal to 50% of the amount we would pay for these procedures (In-network providers accept this payment as payment in full).	These services require Preauthorization.  If Preauthorized, Covered in full when performed in an Inpatient Hospital or Inpatient Skilled Nursing Facility Setting; for surgery performed in an Outpatient Hospital or Ambulatory Surgery Center setting, the professional services will be covered in full and the $75 copayment will be applied to the facility charges.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Second Surgical Opinions	$10 copayment	Subject to Deductibles, coinsurance and additional payments

		set forth in Section 5C.
General and Local Anesthesia Services	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Radiotherapy Treatment	$15 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Burn Treatment	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Surgical Pathology	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Obstetrical Services, including, but not limited to, Prenatal Care, Prenatal Case Management, Delivery and Post-Partum Care. Payments for Prenatal Care, Delivery and Post-Partum Care will normally be made after delivery; when necessary payments will be made at reasonable intervals for services rendered for Prenatal Care and a separate payment for the Delivery and Post-Partum Care provided.	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Initial Newborn Care	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Inpatient Professional Care while the Covered Person is a bed patient in a Hospital or SNF during a covered **Non-emergent stay**	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section

		5C
Inpatient Professional Care while the Covered Person is a bed patient in a Hospital during a covered **Emergency hospitalization**	Covered in full	Covered in full
Dialysis Services	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C

INPATIENT HOSPITAL SERVICES

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Non-emergent hospitalization, Semi-Private Room	These services require Preauthorization.  If Preauthorized, Covered in full	The Hospital services require Notification of Admission.  If approved, subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Emergency hospitalization, Semi-Private Room	These services require Notification of Admission.  If approved, Covered in full	These services require Notification of Admission.  If approved, Covered in full
Inpatient care for lymph node dissection, lumpectomy or mastectomy	These services require Preauthorization.  If Preauthorized, Covered in full with length of stay to be determined by Covered Person's Attending Physician in consultation with Covered Person.	These services require Notification of Admission.  If approved, subject to Deductibles, coinsurance and additional payments set forth in Section 5C

Maternity Care Maternity Care, other than care for prenatal complications, such shall include Hospital care for mother and newborn for at least forty-eight (48) hours after childbirth for any delivery other than a Caesarian section, and for at least ninety-six (96) hours after a Caesarian section. The mother shall have the option to be discharged earlier than provided above, in which case the inpatient Hospital care shall include at least one Home Care visit.	Covered in full. Early discharge Home Care visit is Covered in full.	Subject to Deductibles and, coinsurance and additional payments set forth in Section 5C. Early discharge Home Care visit is Covered subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Newborn and Infant Nursery Care	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Intensive/Cardiac Care during a covered **non-emergent hospitalization**	The Hospital or SNF stay requires Preauthorization.  If Preauthorized, Covered in full	The Hospital or SNF stay requires Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Intensive/Cardiac Care during a covered **emergency hospitalization**	The Hospital services require Notification of Admission.  If approved, Covered in full	The Hospital services require Notification of Admission.  If approved, Covered in full
Transplants - Recipient	These services require Preauthorization.  If Preauthorized, Covered in full - costs and/or services related to searches and/or screenings for donors of organs to be	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section

	transplanted are not covered.	5C. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.
Transplants - Donor	These services require Preauthorization.  If Preauthorized, Covered in full if the donor is an Enrollee; if the donor is not covered by the Plan, charges not covered by the donor's plan will be covered in full - costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C - costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.

OUTPATIENT HOSPITAL SERVICES OR AMBULATORY SURGERY

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Use of Operating and Recovery Room for Ambulatory Surgery	$75 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Diagnostic X-Ray, such as Organ Scans, Sonogram and Ultrasound	$15 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Advanced imaging procedures (e.g., MRI, MRA, PET)	These services require Preauthorization.  If Preauthorized, $15	These services require Precertification. 

	copayment	If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Chemotherapy	$15 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Radiation Therapy	$15 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Preadmission Testing if performed in Hospital facilities prior to a scheduled admission. The tests must be Medically Necessary and consistent with the Diagnosis and treatment of the condition for which surgery is to be performed; reservation for a Hospital bed and operating room are made prior to the tests; surgery takes place within seven (7) days of the pre-surgical tests; and the Patient is physically present at the Hospital for the test.	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Pulmonary Rehabilitation – limited to twenty-four (24) visits per Calendar Year. In-Network Services plus Out-of-Network Services combined equals the total benefit.	These services require Preauthorization.  If Preauthorized, $20 copayment	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Dialysis Services	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Laboratory Services	Covered in full	Subject to Deductibles, coinsurance and additional payments

		set forth in Section 5C

MEDICAL EMERGENCY SERVICES

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Hospital Emergency Department Copayment is waived if admitted or you receive services in the Emergency Department for certain long-term observation holds. **Please Note:** A maximum copay of two times the applicable copay in the event a common accident or injury occurs that causes a Family Unit to seek treatment in an emergency room at the same time.	$400 co-payment,	$400 co-payment,
PreHospital Emergency Medical Services (Ambulance) Ambulance services must be provided by a licensed ambulance, Medically Necessary, and required as a result of a Medical Emergency. Services include Medically Necessary ambulance services between Hospitals, and between a Hospital and SNF. Use of ambulance services other than PreHospital Emergency Medical Services will be reviewed retrospectively for Medical Necessity.	$50 copayment	$50 copayment
Urgent Care Services	Covered in full	A Covered Person is entitled to Urgent Care Services outside the Service Area provided that the Covered Person is unable to obtain care within the Service Area.

DIABETES SERVICES

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Insulin and oral agents Subject to the Capital Rx Formulary, up to a thirty (30) day supply of insulin and Tier 1 and Tier 2 oral agents for controlling blood sugar	**Insulin and oral agents must be obtained from a Capital Rx Participating Pharmacy to be covered.** Covered in full	Not covered
Supplies up to a thirty (30) day supply of test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets, and cartridges for the visually impaired.	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Equipment Medically Necessary durable medical equipment for the management of diabetes. This equipment includes items such as: injection aids, insulin pumps and appurtenances thereto, insulin infusion devices, data management systems, blood glucose monitors and blood glucose monitors for the visually impaired.	Preauthorization is required for Medically Necessary durable medical equipment for the management of diabetes.  If Preauthorized, Covered in full.	Precertification is required for Medically Necessary durable medical equipment for the management of diabetes.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C
Education Medically Necessary self management education and education relating to diet for persons Diagnosed with diabetes provided by the physician or other licensed Health Care Provider legally authorized to prescribe under Title Eight of the Education Law, or their staff, as part of an office visit for diabetes Diagnosis or treatment or by a certified nutritionist, certified dietician or registered dietician when recommended by a physician or other licensed Health Care Provider legally authorized to prescribe under Title Eight of the Education Law.	Covered in full	Subject to Deductibles, coinsurances, and additional payments set forth in Section 5C.

ACUTE MENTAL HEALTH CARE SERVICES

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Services –	These services require Preauthorization.  If Preauthorized, Covered in full.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Partial Hospitalization Program	These services require Preauthorization.  If Preauthorized, Covered in full.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Outpatient Services On a family policy, visits may be used for family therapy related to a Mental Health Condition of a Covered Family Member.	$10 copayment	Subject to Deductibles, Coinsurance and additional payments set forth in Section 5C.
Autism Spectrum Disorder Services The Plan covers services and equipment for the screening, diagnosis, and treatment of autism spectrum disorders. Covered treatment includes behavioral health treatment, psychiatric and psychological care, medical care, therapeutic care including facilitative/non-restorative care, and pharmacy care.	Behavioral health treatment, psychiatric and psychological care - $10 copayment *** Medical, therapeutic, and pharmacy care are covered subject to any applicable preauthorization, copayments and limitations for the type of service provided.	Not covered, except in an emergency *** Medical, therapeutic, and pharmacy care are covered subject to any applicable preauthorization, Deductibles, Coinsurance and additional payments set forth in Section 5C and limitations for the type of service provided.
Assisted Communication Device for the treatment of Autism Spectrum Disorder Services	Subject to 50% Coinsurance.	Subject to Deductible and 50% Coinsurance and

		additional payments set forth in Section 5C.
Applied Behavioral Analysis for Autism Spectrum Disorder Services	Covered in full to a maximum benefit of $45,000 per Calendar Year.	Subject to Deductibles, Coinsurance and additional payments set forth in Section 5C, to a maximum benefit of $45,000 per Calendar Year.

ALCOHOLISM, ALCOHOL ABUSE, AND SUBSTANCE ABUSE TREATMENT

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Detoxification – Medically Necessary detoxification for alcoholism, alcohol abuse and substance abuse or addiction.	These services require Preauthorization.  If Preauthorized, Covered in full.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Inpatient Rehabilitation - for diagnosis and treatment of chemical dependency, which for purposes of this benefit shall mean alcoholism; alcohol abuse; and substance abuse. a. Services must be provided in: Facilities in New York State which are certified by the Division of Alcoholism and Alcohol Abuse or the Division of Substance Abuse Services and in other states, to those accredited by the J.C.A.H.O. as alcoholism or substance abuse treatment programs. b. The services must be provided pursuant to a treatment plan, which has been submitted by the facility to the Claims Administrator within ten (10) days of the first treatment and approved in writing by the Medical Director. Services rendered after the initial ten (10) day period will not be Covered without Medical Director approval of the treatment plan. c. Persons whose primary Diagnosis is alcohol abuse or alcoholism may be treated only in a facility certified to treat such Diagnoses.	These services require Preauthorization.  If Preauthorized, Covered in full.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.

d. Persons whose primary Diagnosis is substance abuse or substance dependence may be treated only in a program approved to treat such Diagnoses. e. Care must be as a result of alcohol dependence or substance dependence f. Treatment of associated health conditions will be Covered under basic Health Care Services of the Plan.		
Outpatient services. visits for Diagnosis and treatment of alcoholism; alcohol abuse; and substance abuse. On a family policy, visits may be used for family therapy related to alcoholism; alcohol abuse; or substance abuse by a Covered Family Member. Limitations: a. Services must be provided in: Facilities in New York State which are certified by the Division of Alcoholism and Alcohol Abuse or the Division of Substance Abuse Services, and in other states, to those accredited by the J.C.A.H.O. as alcoholism or substance abuse treatment facilities/programs. b. The services must be provided pursuant to a treatment plan, which has been submitted by the facility to the Claims Administrator within ten (10) days of the first treatment and approved in writing by the Medical Director. Services rendered after the initial ten (10) day period will not be Covered without Medical Director approval of the treatment plan. c. Persons whose primary Diagnosis is alcohol abuse or alcoholism may be treated only in a facility certified to treat such Diagnoses. d. Persons whose primary Diagnosis is substance abuse or substance dependence may be treated only in a program approved to treat such Diagnoses. e. Care must be as a result of alcohol dependence or substance dependence. f. Treatment of associated health conditions will be Covered under basic Health Care Services of the Plan.	$10 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.

HOSPICE

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Services – Care in a hospice or in a Hospital including Medically Necessary supplies and drugs.	Covered in full.	Subject to Deductibles, coinsurance and additional payments

		set forth in Section 5C.
Outpatient Services – Home care and outpatient services provided by hospice including Medically Necessary supplies and drugs.	Covered in full.	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Family visits – Five (5) visits for bereavement counseling, either before or after the terminally ill Covered Person's death. In-Network visits plus Out-of-Network visits equals the total benefit.	Covered in full.	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.

OTHER SERVICES

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Acute Inpatient Medical Rehabilitation Therapy Inpatient treatment in an approved rehabilitation unit or facility which can result in a significant clinical improvement in a Covered Person's condition. Must be prior approved by the Medical Director after a Hospital stay for the same injury or illness. Admission must be within one (1) day of Hospital discharge.	These services require Preauthorization.  If Preauthorized, Covered in full.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Inpatient Skilled Nursing Facility (SNF) - in a Semi-Private Room; must be ordered by a Covered Person's physician as an alternative to Hospitalization. Central supply items, drugs, medications, biological and vaccines are Covered when provided by a Skilled Nursing Facility. Benefits limited to 45 days per calendar year.	These services require Preauthorization.  If Preauthorized, Covered in full.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Home Health Care When ordered by a physician and approved in writing by the Medical Director as an alternative to Hospitalization or treatment in a Skilled Nursing Facility (as defined in 42 USC Sec. 1935 et seq.).	These services require Preauthorization.  If Preauthorized,	These services require Precertification. 

The Covered services include part-time or intermittent home nursing care by or under the supervision of a registered professional nurse; part-time or intermittent home health aide which consists primarily of caring for the patient; physical, occupational or speech therapy if provided by the home health service or agency, and medical supplies. Up to four (4) continuous hours of home health aide services are counted as one home care visit. The Medical Director has the right to determine if home care is Medically Necessary. This determination can be made at any time during an episode of care. Drugs and medications, including Home Infusion therapy prescribed by a physician, and laboratory services by or on behalf of the home health agency are Covered to the extent such items would have been Covered or provided if the Covered Person were hospitalized or confined in a Skilled Nursing Facility. Medically Necessary home infusion is covered. Long-term physical therapy, long-term rehabilitation, private duty nursing, respite care and custodial care are excluded.	Covered in full. Limit of 40 visits in each Calendar Year	If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Durable Medical Equipment (DME) DME is equipment which: a. Is able to withstand use by more than one person; b. Is primarily and customarily used to serve a medical purpose; c. Is not useful in the absence of illness or injury; and d. Is for use in the home. We may determine to rent, purchase, and repair or replace DME, at our sole discretion. Replacement, repair, and maintenance are Covered when functionally necessary if it is not Covered under a manufacturer's warranty or purchase agreement. We will determine what is considered DME that is safe and sufficient for a Covered Person.	These services require Preauthorization.  If Preauthorized, subject to 50% coinsurance.	These services require Precertification.  If Precertified, subject to Deductible and 50% coinsurance and additional payments set forth in Section 5C.
Prosthetic Devices Prosthetics are devices which replace all or part of a body organ (e.g., artificial eyes, artificial limbs)	These services require Preauthorization.  If Preauthorized,	Not Covered

	subject to 50% coinsurance.	
Medical Appliances Medical Appliances are devices which are used to support a weak or deformed part of a body (e.g. trusses, rigid and semi-rigid devices which support the orthopedic system. Medical appliances include ostomy supplies.	These services require Preauthorization.  If Preauthorized, subject to 50% coinsurance.	Not Covered
Physical Therapy, Speech Therapy and Occupational Therapy Services We will pay for 30 visits for each therapy (physical, occupational and speech therapy) in each Calendar Year. Services must be Medically Necessary and expected to result in the significant improvement of your condition. Additional medically necessary visits may be covered only when Preauthorized. Long-term therapy is not Covered and payment for long-term therapy is your responsibility.	Covered in full, up to 30 visits for each therapy (physical, occupational and speech therapy) in each Calendar Year. Additional medically necessary visits may be covered only if Preauthorized. $15 Copayment	Covered in full, up to 30 visits for each therapy (physical, occupational and speech therapy) in each Calendar Year. Additional medically necessary visits may be covered only if Preauthorized; subject to Deductibles, $15 Copayment, Coinsurance and additional payments set forth in Section 5C.
Chiropractic Services Medically Necessary Chiropractic Care: Coverage will be provided for care by a licensed chiropractor for the purpose of removing nerve interference and the effects thereof which are the result of or related to distortion, misalignment, or subluxation of or in the vertebral column, when determined to be a Medically Necessary service by the Medical Director. This care must be provided in connection with the detection or correction by manual or mechanical means, of any structural imbalance, distortion or subluxation in the human body. Benefits are limited to 20 visits per calendar year.	Benefits are limited to 20 visits per calendar year. $15 Copayment	Subject to Deductibles, $15 Copayment, coinsurance and additional payments set forth in Section 5C. Benefits are limited to 20 visits per calendar year.

Cardiac Rehabilitation - Cardiac rehab after a heart transplant, bypass surgery or a heart attack. Long-term therapy is not Covered and payment for long-term therapy is your responsibility.	These services require Preauthorization.  If Preauthorized, $20 copayment Limit of 36 visits per calendar year.	These services require Precertification.  If Precertified, subject to Deductibles, coinsurance and additional payments set forth in Section 5C. Limit of 36 visits per calendar year.
Second Medical Opinion Regarding Cancer - A Covered Person who receives a positive or negative Diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer is entitled to a second medical opinion by an appropriate Specialty Physician, including but not limited to a Specialty Physician affiliated with a specialty care center for the treatment of cancer.	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Diagnostic Screening for Prostate Cancer Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate specific antigen (PSA) test; annual standard diagnostic examination including, but not limited to, a digital rectal examination and PSA test.	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Blood plasma and packed blood cells, except when participation in a volunteer blood replacement program is available to the Covered Person.	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Medically Necessary autologous blood	Covered in full	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.
Planned Ambulance Transport Ambulance services must be provided by a licensed ambulance and Medically Necessary. Services include Medically Necessary ambulance services between Hospitals, and between a Hospital and SNF.	$50 copayment These services require Preauthorization. 	$50 copayment These services require Precertification. 

Accidental Dental Medically Necessary dental care and treatment due to Accidental Injury to sound natural teeth which is provided within twelve (12) months from the date of the Accidental Injury. An accidental injury is caused by an external force or element such as a blow or fall. Injury to the teeth while eating is not considered an accidental injury. A sound natural tooth is defined as one that has not been weakened by existing dental pathology such as decay or periodontal disease, or has not been previously restored by a crown, inlay, onlay, porcelain restoration or treatment by endodontics or orthodontia. Covered dental services are limited to procedures that will restore an injured tooth to a usual condition. Examples include, but are not limited to, emergency root canal, extraction if the tooth cannot be saved, and re-implantation of the injured tooth. The use of dental implants is not covered.	$10 copayment	Subject to Deductibles, coinsurance and additional payments set forth in Section 5C.

VISION SERVICES

SERVICES	IN-NETWORK (Davis Vision)	OUT-OF-NETWORK
	Vision services must be obtained from Davis Vision, the Participating Provider, to be covered.	Not covered
Refractive (Routine) Eye Exam Limited to (one exam every 12 months)	$10 copayment	Not covered
Frames **(one set every 12 months)**	Member copay $40 10% discount on balance of all frames over $70	Not covered

Standard Plastic Lenses (one set every 12 months)	Single Vision - $35 Copay Bifocal - $55 Copay Trifocal - $65 Copay Photosensitive - $65 Copay Polarized Lenses - $75 Copay Progressive - $125 Copay	Not covered
Lens Options	UV Coating - $15 Copay Solid Tint Coating - $10 Copay Gradient Tint Coating - $12 Copay Standard Anti-Reflective Coating - $45 Copay Standard Polycarbonate - $30 Copay Standard Scratch Resistant - $20 Copay	Not covered
Contact Lenses (one set every 12 months)	20% discount off provider U&C schedule of allowance for conventional contact lenses (applies to materials only). Fitting and follow up are not covered benefits.	Not covered
Laser Vision Correction	U.S. Laser Network for LASIK or PRK. Member receives up to a 25% discount off provider U&C schedule of allowance or 5% off promotional pricing.	Not covered

PRESCRIPTION DRUGS

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs - Up to a thirty (30) day supply at each fill, in most instances, of Medically Necessary prescription drugs including enteral formulas for home use. Enteral formulas are only Covered if the Covered Person has an order from a duly licensed physician or other Health Care Provider. The order must state that the enteral formula is Medically Necessary and proven effective as a disease specific treatment for any of the following diseases: Phenylketonuria (PKU); Inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; Gastrointestinal disorders such as chronic intestinal pseudo-obstruction; multiple, severe food allergies; or any other disease which, without the specified enteral formula, would cause malnourishment, chronic physical disability, mental retardation or death. Enteral formulas include modified solid food products that are low protein or which contain modified protein. This Plan Covers modified solid food products, prescription drugs approved by the Federal Food and Drug Administration for the diagnosis and treatment of Infertility ("Infertility Drugs"), which are prescribed to an eligible Covered Person who meets the definition of Infertility as set forth under the Plan and is at least twenty-one (21) years old and no older than forty-four (44). All prescriptions for Infertility Drugs must be specifically Preauthorized and must be prescribed pursuant to a treatment plan which has been submitted in advance to us. Infertility Drugs (self-injectable or otherwise) related to the following procedures are NOT Covered: Reversal of Elective Sterilization; Reversal of tubal ligation; Reversal of vasectomy; In vitro fertilization (IVF); Gamete intrafallopian tube transfer (GIFT); Zygote intrafallopian tube transfer (ZIFT); Cloning or any services incident to cloning; Infertility Services that are deemed to be experimental in accordance with clinical guidelines promulgated by New York State; Sex change procedures.	**Prescription drugs must be obtained from a Capital Rx Participating Pharmacy to be covered.** Except as provided below, when dispensed in accordance with Capital Rx's Drug Formulary, the Covered Person is responsible for: $5 copayment for Formulary Tier 1 drugs, insulin, and Tier 1 and Tier 2 oral agents to control blood sugar; $25 copayment for each 30-day supply of Formulary Tier 2 drugs; $60 copayment for each 30-day supply of Tier 3 drugs; 7% coinsurance for Tier 4 drugs, injectables, and specialty drugs, to a maximum copayment of $120 per 30-day supply. If a member elects to receive a non-preferred brand medication when there is an equivalent generic available, the member will pay the cost difference between the generic	Not covered

All prescriptions must be filled using FDA approved generic equivalents if available. All other prescriptions must be filled using FDA approved brand name pharmaceuticals. Drugs must be prescribed by a duly licensed physician or other Health Care Provider who is licensed to write prescriptions. Enteral formulas must be prescribed by a physician or other licensed Health Care Provider. Drugs must also be obtained at a Participating Pharmacy. Prescription drugs obtained at a Non-Participating Pharmacy are not Covered. Certain injectable and high cost specialty prescriptions must be filled through a specific Participating Pharmacy which specializes in these drugs. These drugs are identified in the Formulary. Coverage of prescribed drugs for certain types of cancer shall not exclude Coverage of any prescribed drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, 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: (i) American Medical Association Drug Evaluations, (ii) American Hospital Formulary Service Drug Information, or (iii) United States Pharmacopeia Drug Information, or recommended by a review article or editorial comment in a major peer-reviewed professional journal. Notwithstanding the above, there is no Coverage for any experimental or investigational drugs unless directed by an external appeal agent or any drug which the FDA has determined to be contra-indicated for treatment of the specific type of cancer for which the drug has been prescribed. Certain drugs must have written pre-approval by the Medical Director. The Plan does Cover smoking cessation prescription drugs. The enrollee's provider will need to obtain prior authorization from Capital Rx prior to use, documenting the enrollee's participation in an approved smoking cessation program. The initial prior authorization will be valid for one month and will be extended based upon documentation of the enrollee's continued participation and compliance in the smoking cessation program. The Plan does Cover nicotine replacement therapy (Nicorette gum or nicotine patches). The Plan does not cover cosmetic medications, or enteral formulas which are not Medically	and the non-preferred brand, plus any applicable copay.	

Necessary and/or taken electively. The amount that the Covered Person will have to pay depends on whether the prescription is filled with a drug that appears on the Formulary. A Formulary is a list of appropriate and cost-effective medications from which physicians prescribe. **The Plan does not cover any weight loss medications and does not cover drugs in the glucagon-like peptide-1 (GLP-1) drug classification unless prescribed for a member diagnosed with type-2 diabetes who also satisfies Capital Rx's prior authorization (PA) criteria for use of such drug.** The Covered Person may access the Plan's Formulary from Capital Rx's website at Freedom. Additional information regarding your prescription drug benefit, including information around prior authorizations (PAs), step therapy (ST) and quantity limitations (QLs), are listed under Capital Rx's member tools portal on Capital Rx's website under formulary and coverage information: https://cap-rx.com/member-tools-judi		
Pharmacy Mandatory Mail Order for All Maintenance Prescriptions You are responsible to end your automatic refills through Mail Order when your prescription end or changes or your Coverage ends.	After the second 30 day prescription refill, all future maintenance refills will be by mail order for 90 days. Co-Payment 2,5 times Tier 1, Tier 2 or Tier 3 Co-Payments.	When outside of NY State, prescriptions should be filled using a Capital Rx nationwide pharmacy network. In-Network benefits apply.
Specialty Drugs Mandatory for Specialty Drugs, contact Payer Matrix at 877-305-6202. Please Note: If your Specialty Drug is eligible for alternative funding under the Payer Matrix Program and you choose to not enroll in the Payer Matrix Program, your Specialty Drug will be excluded from Coverage under the Plan and you will be responsible for the full cost of your Specialty Drug (this expense will not count towards your Out-of-Pocket Maximum). If your Specialty Drug is not eligible for alternative funding under the Payer Matrix Program, your Specialty Drug will be paid according to the	Paid according to applicable Tier unless subject to Payer Matrix Program.	Paid according to applicable Tier unless subject to Payer Matrix Program.

applicable Tier. It is mandatory that all Specialty Drugs be filled through Walmart Specialty Pharmacy, unless otherwise directed by an alternative funding program.		

SECTION 6 - LIMITATIONS OF COVERAGE

A. Non-Participating Providers

1. You must obtain Covered Health Care Services from Participating Providers to receive the Coverages stated in Section 5 In-Network provisions.

2. You may obtain Health Care Services from Non-Participating Providers subject to the Out-of-Network provisions of Section 5 of this Plan. If services are obtained from Non-Participating Providers, you may have to submit your own claim forms to the Claims Administrator and you will be responsible for payment to the Non-Participating Provider.

B. Medical Emergency Health Care Services

You are responsible for the applicable Copayment for Emergency Department Health Care Services unless you are admitted to the Hospital within twenty-four (24) hours of the Emergency room services for the same illness or injury or you receive services in the Emergency Department for certain long-term observation holds. Covered Persons must contact the Claims Administrator within forty-eight (48) hours of receiving Emergency Department treatment. Whether you seek treatment at a Participating or Non-Participating Hospital, the Emergency room charges will be paid in full, subject to the same applicable Coinsurance or Copayment in the provisions above. Your Emergency Department Copayment capped at two times Copayment in the event a common accident or injury occurs for your family unit at the same time.

SECTION 7 –GENERAL EXCLUSIONS

IN ADDITION TO CERTAIN EXCLUSIONS AND LIMITATIONS SET FORTH ELSEWHERE IN THIS PLAN, THE FOLLOWING ARE NOT COVERED UNDER THIS PLAN, EXCEPT AS REQUIRED BY LAW:

1. Benefits covered by Medicare Parts A and/or B for Covered Persons who are eligible for Medicare, whether or not they are actually enrolled in Parts A or B. This exclusion shall not apply to:

    a. Covered Persons who are eligible for Medicare by reason of age and who are Covered under this Plan by virtue of the Enrollee's or spouse's current employment status with a Participating District with twenty (20) or more full-time employees,

    b. Covered Persons who are eligible for Medicare by reason of disability who are under age sixty-five (65) and are Covered under this Plan by virtue of the Enrollee's or a Family Dependent's current employment status with an employer who has at least one hundred (100) employees, or

    c. Covered Persons who are eligible for or are entitled to Medicare on the basis of end-stage renal disease (ESRD) for the first thirty (30) months of ESRD-based Medicare eligibility to entitlement.

2. Benefits for any medical condition which is covered under any state or federal workers' compensation, employers' liability or occupational disease law; benefits provided for any loss for which mandatory automobile no-fault benefits are recovered or recoverable including but not limited to benefits which would have been recoverable except for the fact that a timely claim was not filed by you or by a Health Care Provider.
3. Benefits for any medical condition which is covered under another plan's extension of benefits coverage until that other plan's coverage for that condition has terminated.
4. Any Health Care Services rendered after the Termination of Coverage (see Section 10), except in the case you are determined to be eligible for benefits under the Continuation of Coverage provision of the Plan (for Continuation of Coverage, see Section 12).
5. Experimental and/or Investigational medical treatments, procedures, drugs, substances or devices (notwithstanding any provision of this Summary Plan Description to the contrary, the Medical Director shall have the authority to determine issues of Coverage raised under Section 7, Paragraph 15 in accordance with the applicable clinical trials and/or experimental procedures policies in effect at the time the claim arises).
6. Orthotic devices and supplies except as explicitly provided in the Schedule of Benefits.

7. In no case is Coverage provided for replacement or repair of Durable Medical Equipment or prosthetics due to loss or misuse; replacement of parts or supplies used in conjunction with prosthetic and orthotic devices except as explicitly provided in the Schedule of Benefits.
8. Any dental care and treatment including procedures involving teeth or areas surrounding the teeth, orthognathic surgery, including shortening of the mandible or maxilla for correction of malocclusion and all professional, hospital and anesthesia services. This exclusion does not apply to Accidental Dental benefits as described in Section 5 or to dental care and treatment Medically Necessary due to congenital disease or anomaly. Covered dental care and treatment is subject to Deductible and Coinsurance and any additional payments. Services for dental care and treatment due to congenital disease or anomaly require Precertification under Section 4.
9. Treatment for temporomandibular disease (TMJ) which is dental in nature.
10. Any cosmetic device, procedure, or operation, including any further procedures which do not require Medically Necessary services, or any Hospital services connected with a cosmetic operation. A cosmetic operation is Covered when it is Medically Necessary. Reconstructive surgery is covered when it is incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved part, including but not limited to, breast reconstruction surgery after a mastectomy or when it is needed because of congenital disease or anomaly of a Covered dependent child which results in a functional impairment. These services require Precertification under Section 4 for Non-Participating Providers and Preauthorization for MVP Participating Providers.
11. Rhinoplasty, unless Medically Necessary. These services require Precertification under Section 4 for Non-Participating Providers and Preauthorization for MVP Participating Providers.
12. Reconstructive surgery shall not include surgery for scar repair/revision only, where no physiological functional defect is present unless it is Medically Necessary.
13. Health Care Services which are not Medically Necessary for the Diagnosis and treatment of an Accidental Injury or sickness or to maintain your health. The Plan Covers only Medically Necessary services.
14. Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies (hereinafter referred to as “Procedures”) not proved to be safe and/or efficacious, or, because of your condition, an efficacious procedure that will have no effect on the outcome of your illness, injury or disease are not Covered. Benefits are limited to scientifically established Procedures that have been evaluated by recognized authorities or governmental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular illness, injury or disease. Procedures that are ineffective or in the stage of being tested or

researched with question(s) as to safety and/or efficacy are not Covered. Investigational or experimental procedures which are proven to be safe and efficacious for a particular illness, injury or disease which have received approval from the Food and Drug Administration and/or the National Institute of Health Technology Assessment are Covered. We reserve the right to determine Coverage on a case-by-case basis. Notwithstanding any provision of this Summary Plan Description to the contrary, the Medical Director shall have the authority to determine issues of Coverage raised under Section 7, Paragraph 15 in accordance with the applicable clinical trials and experimental procedures policies in effect at the time the claim arises. Such determination is final as long as it is neither arbitrary nor capricious. The Medical Director's determination is subject to appeal.

15. The expense of purchasing or fitting hearing aids.
16. Services performed by your immediate family including spouse, brother, sister, parent, or child.
17. Physical and mental examinations and immunizations, and drug testing required by third parties in the absence of Medical Necessity for obtaining or maintaining employment or insurance; medical research; travel; school; or camp.
18. Free care or care where no charge, in the absence of any health plan or insurance plan, would be made to you.
19. Any injury or sickness resulting from war or any act of war (declared or undeclared) or services in the armed forces of any country to the extent Coverage of such injury or sickness is provided through any governmental plan or program.
20. Travel and transportation expenses even though prescribed by a physician, except as provided in Section 5 of the Plan.
21. Benefits otherwise provided in the Plan which we are unable to provide because of any law or regulation of the federal, state, or local government or any action taken by any agency of the federal, state, or local government in reliance on said law or regulation.
22. Long-term Physical Therapy or Long-Term Rehabilitation.
23. Any expense as a result of your failure to vacate a Hospital bed beyond the discharge date established by the Hospital, your physician, and us. All charges in connection with treatments or medications where the Plan participant either is in non-compliance with or is discharged from any facility against medical advice.
24. Medical equipment; appliances; cosmetics; orthotics; computer assisted communication devices or electronic communication devices other than those provided to treat autism spectrum disorders, which are not incorporated into the body such as air conditioners; humidifiers; wigs; cranial prostheses; hair replacements; and athletic equipment even though prescribed by a physician.

Not included here is equipment which would be identified as covered under the Schedule of Benefits.

25. Routine and palliative foot care; including, but not limited to, services or care in connection with any of the following: corns; calluses; flat feet; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; or orthotics/shoe inserts.
26. Custodial care or rest cures and services rendered for the convenience of you or a provider.
27. Court-ordered treatment for Mental Health Conditions and/or Health Care Services.
28. Storage of Blood or Blood Products. This does not apply to autologous (one's own blood) blood donations. Benefits for transfusion services, including storage, for autologous donations of blood and blood components are available when associated with a scheduled, Covered surgical procedure.
29. Devices or equipment used solely for the purpose of athletic activities.
30. Health Care Services prescribed by a physician but not Covered by the Plan.
31. Services or procedures to correct vision.
32. Self-administered injectables. This exclusion does not apply to self-injectable drugs included on the Formulary, to diabetic supplies, or to insulin as provided in the Schedule of Benefits.
33. Any services which were not received in accordance with this Plan, including without limitation, services provided by a Participating or Non-Participating Health Care Provider without appropriate authorization, or when a procedure, treatment, or service is not a Covered health care benefit.
34. Special nurses and attendants or their board, except as allowed under Section 5.D.
35. Care for military service-connected disabilities when you are legally entitled to services and facilities are reasonably available to you.
36. Care for conditions that federal, state or local law requires be treated in a public facility.
37. Services provided for bed rest, custodial care, maintenance care or respite care are not Covered under this Plan and are your responsibility for payment.
38. Any fees for the services of Health Care Providers employed by a Hospital or institution to which a global or case-based payment is made.
39. Care or treatment provided in a governmental hospital.
40. Services required by third parties. Examples of non-Covered services are employment physicals, physicals for camp and school, and court-ordered examinations and hospitalizations except when Medically Necessary.
41. Television or phone charges while an inpatient in a Hospital.

42. The following reproductive health services are not Covered under this Plan:
    a. Infertility Services except as specifically provided in the Schedule of Benefits;
    b. Reversal of Elective Sterilization: reversal of tubal ligation or reversal of vasectomy;
    c. All costs associated with the following assisted reproductive technologies: in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT) and zygote intrafallopian tube transfer (ZIFT), as well as drugs, self-injectable or otherwise, used in conjunction with any of these procedures;
    d. Infertility Services provided to persons who are not our Enrollees or their Family Dependents;
    e. Cloning or any services incident to cloning;
    f. Infertility Services that are deemed to be experimental in accordance with clinical guidelines promulgated by New York State.

    The above does not exclude Coverage for Medically Necessary medical and surgical care for Diagnosis and treatment of a correctable medical condition, solely because the medical condition results in Infertility.
43. Hearing aid evaluation.
44. Wheelchair van transportation.
45. Optifast program or other programs with dietary supplements.
46. Expendable medical supplies.
47. Methadone maintenance.
48. Psychometric services which are primarily the responsibility of the education system, such as developmental psychometric testing, special education classes, etc.
49. Clinical laboratory services, pharmacy services, X-ray or imaging services furnished pursuant to a Referral prohibited by Public Health Law Section 238-a (1).
50. Anything except the items of care listed in the Plan.
51. Services for which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
52. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted; costs related to travel, food or lodging for transplant recipient or donor.
53. Alternative therapies including but not limited to acupuncture, massage therapy, aromatherapy.

54. Marriage and/or family counseling (except family counseling provided related to alcoholism, alcohol abuse, substance abuse or mental health care of a Covered family member).

55. The reproduction and furnishing of X-rays and medical records, or any costs associated with the reproduction or furnishing of X-rays and/or medical records.

56. Benefits for which you are eligible under any governmental program other than Medicare, except Title XIX of the Social Security Act.

57. Out-of-Network transplant services, unless In-Network transplant services are unavailable and such Out-of-Network transplant services are Preauthorized by the Claims Administrator pursuant to Section 4.

58. The full amount charged or otherwise payable for any specialty prescription drug for which another source of payment is available (and for which you are eligible for), including but not limited to manufacturer and copay assistance programs. For clarity, this exclusion applies to the full amount charged or otherwise payable by the Plan for any such drug, not just the amount of alternate assistance potentially available, and applies regardless of whether such alternate assistance is received or pursued (unless you are determined to not be eligible for such alternate assistance through no fault of your own).

59. The Plan does not cover any weight loss medications and does not cover drugs in the glucagon-like peptide-1 (GLP-1) drug classification unless prescribed for a member diagnosed with type-2 diabetes who also satisfies Capital Rx's prior authorization (PA) criteria for use of such drug.

SECTION 8 – ADDITIONAL EXCLUSIONS WHICH APPLY ONLY TO OUT-OF-NETWORK ITEMS AND SERVICES

In addition to certain exclusions and limitations set forth elsewhere in this Plan, the following are not covered Out-of-Network under this Plan:

1. Prosthetic devices and medical appliances; eyeglass corrective lenses and frames, contact lenses, services and procedures to correct vision; cranial prostheses, wigs, hair replacements; orthotics/shoe inserts; cosmetic devices; computer-assisted communication devices or electronic communications devices other than those provided to treat autism spectrum disorders; items such as air conditioners, humidifiers and athletic equipment.

2. Primary and preventive care other than as specifically listed in the Schedule of Benefits as a Covered service.

3. Immunizations for Covered Persons over age nineteen (19).

4. Refractive (Routine) Vision Exams

5. Prescription drugs

SECTION 9 - CLAIM FILING, PAYMENT OF BENEFITS

A. Filing a Claim

In order to process claims, they must be submitted properly and completely. Many claims will be submitted directly by the Service Provider.

For those claims not submitted by the Service Provider, the Covered Person must submit the claim. Submission of a claim for reimbursement shall, to the extent not prohibited by applicable law or regulation, be deemed an authorization to release medical information for Plan administration purposes. A Covered Person should submit a claim even if he isn't certain the expense is covered. In this way benefits can be paid whenever possible. To file a claim, proceed as follows (note, all out-of-network providers must submit a claim within 180 days after service has been provided):

1. **Obtain a Claim Form** Claim forms for all types of benefits covered by the Plan are available through the Participating District or the Claims Administrator. Service Providers may use a standardized claim form to file a claim on behalf of a Covered Person.

2. **Complete the Claim Form** It is important that you carefully follow the instructions included on the claim forms. Failure to properly and completely supply necessary information will probably delay benefit payments. Service Providers filing a claim on behalf of a Covered Person must provide all required information.

    a. Complete the claim form, making certain all questions are answered and that you sign the form. Your address should be your home address, not your work address.

    b. Attach an original itemized statement showing the name of the patient; the date of service, treatment or purchase; a description (using the CPT code if possible) of the treatment or service performed; the amount charged for each item; and the reason for the treatment (diagnosis or nature of Illness or Injury).

    c. Separate claim forms should be submitted for each person for whom a claim is being filed.

    d. The completed claim form (with originals of appropriate bills or statements attached) should then be mailed to the Claims Administrator's Office for processing. The completed claim form should always be signed by the Enrollee.

e. If you are eligible for Medicare, when you receive the Medicare explanation of what was - and was not - paid by Medicare, you must send that explanation and a copy of the itemized bill to the Claims Administrator in order to process your claim for the expenses not paid by Medicare.

f. If another plan is primary to this Plan, you should submit a copy of the other plan's explanation of benefits to this Plan.

3. **Recovery of Overpayments** The Plan may make a payment in error. This might occur because the Covered Person is not covered under this Plan, or the service is not covered, or the payment is more than should have been made. If that happens, the Plan will provide an explanation to the Covered Person who must return the amount of the overpayment to the Plan within sixty (60) days of the Plan's notice to the Covered Person.

4. **Notices** The Plan will mail notices to a person's address as it appears on the Plan's records. Covered Persons must notify the Claims Administrator and their Participating District of any change in their address. All notices to a Covered Person who is a minor or otherwise not legally competent to receive such notices shall be sent to that Covered Person's parent or legal guardian, who is the Covered Employee or covered Retiree.

5. **Medical Records** Covered Persons agree that, to the extent not prohibited by applicable law or regulation, any Physician, Hospital, Skilled Nursing Facility or other Licensed Provider or facility that has rendered services to them are authorized to give the Plan's Claims Administrator and stop-loss carrier all information and records relating to those services for Plan use in determining whether the person is entitled to coverage for those services, in processing that person's claim, and in calculating the amount of Plan coverage. Any further authorization to release information that may be required by applicable law or regulation is part of all Covered Persons' obligations under this Plan.

6. **Questions Regarding a Claim** If a Covered Person has any questions concerning the Plan, the status of a claim or a specific claim payment, the question(s) should be communicated to the Claims Administrator.

B. Proof of Claim

All events which determine the fact that the Plan is liable for a Covered Expense take place on the date the Covered Expense is incurred, which is when the services are performed or the purchases are made. Written proof of claim should be furnished to the Plan at the Claims Administrator's office on the appropriate forms. The filing of a claim by the Service Provider or the Covered Person is not a precondition to the Plan's liability for a Covered Expense. However, the filing of

a claim is a precondition to payment of a claim and the Plan needs written proof of claim as soon as reasonably possible in order to process a claim.

C. Payment of Benefits

Payment of benefits described in the Plan will be made as determined on the basis of the submission of proof that a covered charge, fee or expense has been incurred. Payment of unpaid covered Hospital expenses will be sent directly to the Hospital. Payment of all other covered expenses may be made only to the covered Enrollee or to the Service Provider. Any assignment of benefits to a Hospital or a provider of medical services or supplies will not be accepted by, or binding on, the Plan unless approved by the Plan's Claims Administrator.

D. Legal Action

Subject to exhaustion of the Enrollee Appeal Procedures at Section 15, no action at law or in equity shall be brought to recover under the Plan prior to the expiration of ninety (90) days after submission of the itemized bill or Claim Form and any requested supporting information, nor shall such action be brought after twelve (12) months from the date of completion of a particular course of treatment. Except for voluntary assignments to Service Providers as may be required by law, your right to receive Health Care Services under the Plan may not be assigned, voluntarily or involuntarily, to any other person. A direct payment by the Plan to a person or entity that provides Health Care Services to you or your Family Dependent is not a waiver of this provision. Additionally, a Service Provider may not bring a claim for benefits against the Plan, a Plan fiduciary, the Plan Administrator, the Claims Administrator or a Participating District with respect to the Health Care Services it provides to you or your Family Dependent.

SECTION 10 - TERMINATION OF COVERAGE

Your Coverage shall automatically be terminated on the first of the following to apply (unless otherwise dictated by the Participating District):

1. Upon the Participating District's failure to pay the required Contribution for Coverage to us, in accordance with Section 17 of the Plan or if the Participating District notifies us prior to the expiration of the grace period that it will no longer pay the Contribution for Coverage.

2. The date that the Plan is terminated, or with respect to any specific Health Care Services Covered by the Plan, the date such Coverage terminates.

3. The end of the Plan month in which you cease to be eligible as an Enrollee or Family Dependent.

4. The end of the Plan month which the Enrollee ceases to be eligible with the Participating District.

5. The end of the Plan Month during which the Participating District receives written notice from you requesting Termination of Coverage, or on such later date requested for such termination by the notice.

6. The date on which the Enrollee is retired or pensioned unless Coverage is specifically provided for retired or pensioned individuals by the Participating District.

7. Subject to COBRA, Death of an Enrollee or the divorce from Enrollee or the dissolution of a domestic partnership with the Enrollee:

    a. Upon the death of the Enrollee, coverage of the Enrollee under this Plan shall automatically terminate as of the date of death and coverage of any Family Dependents shall automatically terminate at the end of the month in which the Enrollee's death occurs;

    b. Upon divorce from an Enrollee, or the dissolution of a domestic partnership with the Enrollee, coverage for the spouse or domestic partner under this Plan shall automatically terminate as of the date of divorce decree or dissolution of the domestic partnership.

    For Continuation Rights of Coverage with respect to any surviving Enrollees, see Section 12.

8. Immediately (and possibly retroactively to the date of incident) if you have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Plan. We shall give the Participating District at least one month's prior written notice.

9. Such other reasons as the Board of Trustees and/or the Department of Financial Services may approve consistent with applicable law. We shall give the Participating District at least one month's prior notice.

10. No Benefits after termination of Coverage. Upon termination of Coverage, the Covered Person shall cease to be entitled to any Benefits, including but not limited to, lifetime benefits, unlimited benefits or benefits provided to the Covered Person who is, at the time of termination undergoing a course of treatment. Hospital or SNF Benefits shall be extended for a Covered Person who is hospitalized or in a SNF at the time of termination. Payment will be for the Hospital or SNF charges for that particular confinement unless the Covered Person has obtained other health care Coverage, in which case such other Coverage shall apply. This extension of benefits after termination only applies to Hospital and SNF services; physician and other services are not Covered.

11. Benefits will be provided after termination for persons who have a Total Disability on the date Coverage terminates if service or care was received for the illness, condition or injury which caused the Total Disability while Covered under this Plan, until the person no longer has a Total Disability or twelve (12) months from the date Coverage terminates, whichever occurs first, unless Coverage is afforded for Total Disability under another Group Benefit Plan.

SECTION 11 - CONVERSION PRIVILEGE

There is no conversion privilege associated with the benefits provided under this Plan.

SECTION 12 – CONTINUATION OF COVERAGE

If the Enrollee's Coverage under the Plan ends due to termination of employment or eligibility with a Participating District, he/she may continue Coverage under COBRA at a monthly cost no more than 102% of the Plan Contribution for Coverage. Coverage may be continued for the Enrollee and any of the Enrollee's Covered Family Dependents for periods that can range up to 18, 29 or 36 months depending upon the qualifying event.

An election to take continuation coverage must be made within sixty (60) days of the COBRA Election Notice and persons making this election must pay the full amount of the premiums and may be charged a 2% administration fee. The initial premium is due within forty (45) days of returning a notice electing coverage and must cover the entire premiums due from the date your coverage otherwise would have ceased. An Enrollee or affected Family Dependent must notify the Benefit Administrator at the Participating District within sixty (60) days of divorce, legal separation or a Family Dependent's no longer satisfying the age or other conditions of eligibility in order for the Plan to send out a qualifying event notice and other materials to affected COBRA qualified beneficiaries. More detailed information on COBRA can be found in the COBRA General and Election Notices, if applicable, or by contacting the Claims Administrator. COBRA coverage is subject to the terms of the Plan.

SECTION 13 - COORDINATION OF BENEFITS (COB)

A. If you are eligible for services or benefits under two or more Group Benefit Plans; providing or paying for Health Care Services rendered to you, the Coverage under those Group Benefit Plans will be coordinated so that up to, but no more than, 100% of any of our Eligible Expenses will be paid for; or provided by, all the benefit plans less any Copayments or Deductible and Coinsurance. When we have paid the allowable amount or you have received from other payment sources the rate negotiated by the Claims Administrator or the 90th percentile of the UCR rate, no further payment will be made. We will be responsible, as either a primary or secondary payer, for Health Care Services rendered by Participating Providers; Medical Emergency care; or the services of Non-Participating Providers and as a secondary payer for any item of Allowable Expense up to the rate negotiated by the Claims Administrator or the 90th percentile of the UCR rate as required by the Department of Financial Services' regulations. The term "Allowable Expense" is the necessary, reasonable, and customary item of expense for Covered Health Care Services. Primary responsibility for providing these services or benefits will be determined in the following order:

1. The benefits of a plan that does not have a COB provision or that has a COB provision which does not comply with New York State Department of Financial Services regulations will be primary.

2. The benefits of a plan which covers the person as an employee or Subscriber are determined before those of a plan which covers the person as a dependent.

3. When a plan and another plan cover the child as a dependent of different persons, called "parents":

    a. The benefits of the plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the plan of the parent whose birthday falls later in that Calendar Year; but

    b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

    c. If the other plan does not have the rule described above, but instead, has the rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

    d. The word "birthday" refers only to month and day in a Calendar Year, not the year in which the person was born.

4. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the order shown below. This paragraph shall not apply with respect to any Claim Determination Period of a plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

    a. First, the plan of the parent with custody of the child is primary;

    b. Then, the plan of the spouse of the parent with custody of the child;

    c. Finally, the plan of the parent not having custody of the child;

    d. If the specific terms of a court decree or separation agreement state that one of the parents is responsible for the health care expenses of a child, any entity obligated to pay or to provide the benefits of the plan of such parent that has actual knowledge of those terms, shall have benefits determined first.

5. The benefits of a plan, which covers a person as an employee who is neither laid off nor retired (or as the employee's dependent) are determined before those of a plan, which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee or Subscriber longer are determined before those of the Plan which covered that person for the shorter period of time.

B. We shall be entitled to:

1. Determine whether and to what extent you have indemnity or other Coverage for the Health Care Services provided under the Plan;

2. Establish priorities for primary responsibility among the Health Plans obligated to provide Health Care Services or indemnity benefits;

3. Release to or obtain from any other Health Plan any information needed to implement this provision; and

4. Recover the value of Health Care Services rendered to the Covered Person under the Plan to the extent that such Health Care Services are covered by any other Health Plan with primary responsibility for paying for such Health Care Services.

C. When our Coverage is the primary Coverage, it will pay for all necessary Health Care Services in accordance with the Plan. The secondary health plan may be obligated to pay any Copayment, Deductible, Coinsurance, or other charges not Covered by us if you file a claim with that group health plan. When our Coverage is secondary, we reserve the right to request that you submit claims to the other group health plan; recover any claim payment that you receive from that group health plan to the extent such payment is for services actually received from or paid by that group health plan; or to bill the group health plan for Health Care Services provided or paid for by us.

D. For purposes of this Section, “other plans” include: Group or blanket coverage; Blue Cross Blue Shield, or other prepayment coverage; no fault coverage to the extent required in policies or Plans by a motor vehicle insurance statute or similar legislation; coverage under a labor-management trustee plan, union welfare plan, or an employee welfare benefit plan as defined in the Federal Welfare and Pension Plan Disclosure Act, including any federal or state or other governmental plan or law; or coverage under any plan largely or solely tax supported or otherwise provided by or through action of any government, except Medicaid.

E. If the amount of the payments made by the Plan is more than should have been paid under this COB provision, the Plan, directly or through the Claims Administrator, may recover the excess from one or more of the following:
   1. The persons the Plan has paid or for whom the Plan has paid; or
   2. Insurance companies; or
   3. Other organizations.

F. This Plan may repay to any other health plan the amount that it paid for covered expenses if this Plan decides it should have paid those expenses. These payments are the same as benefits paid to the Covered Person and they satisfy the Plan's obligation to the Covered Person under this Plan.

SECTION 14 – RIGHT OF REIMBURSEMENT AND ASSIGNMENT OF PROCEEDS

A. Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first- and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the participant(s) agrees the Plan shall have an equitable lien on any funds received by the participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a participant(s) settles, recovers, or is reimbursed by any Coverage, the participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the participant(s). If the participant(s) fails to reimburse the Plan out of any judgment or settlement received, the participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

B. Subrogation

As a condition to participating in and receiving benefits under this Plan, the

participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party;

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3. Any policy of insurance from any insurance company or guarantor of a third party;

4. Workers' compensation or other liability insurance company; or

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to

reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness, injury, disease or disability.

D. Excess Insurance.

If at the time of injury, illness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3. Any policy of insurance from any insurance company or guarantor of a third party;

4. Workers' compensation or other liability insurance company; or

5. Any other source, including but not limited to crime victim restitution funds,

any medical, disability or other benefit payments, and school insurance coverage.

E. Separation of Funds.

Benefits paid by the Plan, funds recovered by the participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the participant(s), such that the death of the participant(s) or filing of bankruptcy by the participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

F. Wrongful Death.

In the event that the participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the participant(s) and all others that benefit from such payment.

G. Obligations.

1. It is the participant's/participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

    b. To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;

    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

2. If the participant(s) and/or his/her attorney fails to reimburse the Plan for all

benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the participant's/participants' cooperation or adherence to these terms.

H. Offset.

If timely repayment is not made, or the participant and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the participant(s) in an amount equivalent to any outstanding amounts owed by the participant to the Plan.

I. Minor Status

1. In the event the participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

K. Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be

construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

SECTION 15 - APPEAL PROCEDURES

A. Notification

If your claim for benefits is denied, in whole or in part, you will be notified by the Claims Administrator, in writing, advising you of the specific reason for the denial and explaining the Plan's appeal procedure. If additional information or documentation is required to perfect a claim, you will be notified and told why the additional material is necessary. You, or your authorized representative, may review the pertinent documents upon which the denial is based.

B. Internal Appeal

You, or your authorized representative, may request claim appeal by the Claims Administrator within 180 days of notification of a denial of initial claim. You can file a verbal or written contractual appeal or clinical appeal regarding:

- an urgent/expedited pre-service denial (a denial for concurrent care or urgent care services that have not yet been provided to you),
- a standard pre-service denial (a request to change a denial for other services or care that have not yet been provided to you), or
- a post-service denial (a request to change a denial for care or service already rendered).

You can file the appeal by contacting the Claims Administrator. When filing an appeal, you have the opportunity to submit any written documents or other information relating to the appeal.

Upon receipt of your Claim Appeal and such additional information as supports the appeal, the Claims Administrator will review the appeal, make a determination, and respond in writing to the claimant:

- within 24 hours of receipt of the appeal and such additional information as supports the request for appeal for urgent/expedited pre-service appeals,
- within 15 days of receipt of the appeal and such additional information as supports the request for appeal for standard pre-service appeals, and
- within 30 days of receipt of the appeal and such additional information as supports the request for appeal for post-service appeals.

The response will clearly identify the specific reasons for the decision with appropriate references to the relevant provisions of the Plan.

If your Internal Appeal is denied or if the Plan fails to adhere to the requirements of an Internal Appeal, and your appeal is based upon Medical Necessity, you

may file an External Appeal. The Claims Administrator will provide information regarding the Independent Review Organization (IRO) and the process for making an External Appeal. Please note that the IROs are independent from the Claims Administrator. Neither the Claims Administrator nor the Plan Administrator makes External Appeal determinations. The Plan will maintain contracts with no fewer than 3 IROs for assignments and the assignments will be made in a random and unbiased fashion.

C. External Appeal

If you wish to make an External Appeal, your request must be received by the Independent Review Organization (IRO) within four (4) months after the receipt of a notice of a final adverse benefit determination (the denial of your Internal Appeal).

You or your authorized representative may file your Appeal either orally or in writing as follows:

1. You can call the IRO. You should have your claim denial notice, ID card and any other information you would like to have considered in connection with the Appeal with you when you make your call.
2. You can write a letter to the IRO, stating your position. You should include copies of your claim denial notice, ID card and any other information you would like to have considered in connection with the Appeal.

The address and telephone number of the IRO will be provided to you by the Claims Administrator.

D. Determination of Appeal

Within five (5) business days from the receipt of the External Appeal, the IRO will complete a preliminary review of your request in order to determine your eligibility for an External Appeal.

Within one (1) business day after completion of the preliminary review, the IRO will issue you or your authorized representative and the Plan a written notification of your eligibility for an External Appeal. If your request is complete but not eligible for External Appeal, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to make the request complete and you will have an opportunity to complete the request.

Within five (5) business days after the request has been determined to be eligible for an External Appeal, the Claims Administrator and the Plan Administrator, if

necessary, must provide to the IRO the documents and any information considered in making the adverse benefit determination. If Claims Administrator and/or the Plan Administrator fail to timely provide the information, the IRO may terminate the External Appeal and reverse the adverse benefit determination in your favor.

Upon receipt by the IRO the documents and information, the IRO will review the appeal and make a determination:

- within 24 hours of receipt of the appeal and such additional information as supports the request for appeal for urgent pre-service appeals,
- within 15 days of receipt of the appeal and such additional information as supports the request for appeal for standard pre-service appeals, and
- within 30 days of receipt of the appeal and such additional information as supports the request for appeal for post-service appeals.

The response will clearly identify the specific reasons for the decision with appropriate references to the relevant provisions of the Plan, in a manner calculated to be understood by an average person. The decision shall not be final and binding on you.

SECTION 16 - RELATIONSHIP BETWEEN PARTIES

The relationship between us and Participating Providers is a contractual relationship between independent contractors. Participating Providers are not agents or employees of ours, nor are we or any employee or designee of ours an agent or employee of Participating Providers. The relationship between a Participating or Non-Participating Physician and you is that of a physician and patient. The Participating or Non-Participating Physician is solely responsible for the Health Care Services to you. We are not liable for any act, omission, or other conduct of any provider in furnishing professional, ambulatory, Hospital or any other services to you; nor is any Participating or Non-Participating Provider liable for the acts of any other provider based solely upon his or its association with us.

SECTION 17 - CONTRIBUTION FOR COVERAGE PROVISIONS

A. Contribution for Coverage Payment

All Contributions for Coverage are payable monthly in advance by the Participating District to us at our office indicated in Section 1.C. of the Plan. The Participating District will arrange to collect any applicable Enrollee contributions for the Contribution for Coverage directly from the Enrollee. The Participating District shall pay the total monthly Contribution for Coverage due us on behalf of those Enrollees on or before the fifth day of any month during which Coverage is to be provided to Enrollees. The Participating District shall act as the agent for the group's Enrollees and shall not, under any circumstances, be the agent; employee; or representative of ours in collecting any amounts from such Enrollees and paying it to us. We will provide the Participating District with at least thirty (30) days' notice of the Effective Date of any Contribution for Coverage increase or decrease approved by the Board of Trustees of the Trust.

We shall send the Participating District its invoice for the following month according to the schedule provided by the Trust.

We and the Participating District shall cooperate to complete any retroactive adjustments to the Contribution for Coverage necessary as a result of the addition or termination of Enrollees Covered by us. If an Enrollee is added to the group Covered under the Participating District's Plan during the period from the first (1st) to the fifteenth (15th) day of any month, the Contribution for Coverage will be retroactively adjusted as of the first (1st) day of the month. The Contribution for Coverage will not be adjusted if an Enrollee's Coverage becomes effective between the fifteenth (15th) and the last day of any month. If an Enrollee or Family Dependent is terminated from the Coverage under the Participating District's Plan at any time during any month, the full Contribution for Coverage will be charged for that month (there is no adjustment or proration to the coverage tier level for that month).

The maximum adjustment period for any such retroactive adjustments to the Contribution for Coverage will be limited to sixty (60) days.

B. Grace Period.

A grace period of ten (10) calendar days will be granted for the payment of any Contribution for Coverage during the time the Plan shall continue in force. Late fees of 2% will be assessed after the 15th of any month in which payment was not received.

C. **Default.**

If the Contribution for Coverage is not paid by the end of the month, the Coverage of all Enrollees Covered by the Plan may be deemed to have terminated automatically as of the last date for which Contribution for Coverage payments have been made, without notice from us to the Participating District or to the Enrollees. Any claims submitted by providers or Enrollees that are received by the Plan after such date (regardless of the date of service) or incurred after such date will not be payable by the Plan and will be the responsibility of the Participating District. We shall be entitled to notify Enrollees and Bargaining Units of the non-payment of Contribution for Coverage and the expiration date of the grace period provided by this provision to enable them to make necessary arrangements to pay for their Health Care Services upon termination of their coverage. The termination of Coverage upon expiration of the grace period shall not relieve the Participating District of its obligation to pay for Coverage provided. Upon termination of Coverage, the Participating District shall be liable to us for the payment of any and all Contributions for Coverage and accrued interest, which are due but unpaid at the time of termination, and for any payment of claims as noted above.

D. District Withdrawal from Participation.

In the event a Participating District withdraws from participation in the Plan and does not satisfy the obligations of the Participating District with respect to such withdrawal as set forth in the Trust Agreement and/or Memorandum of Agreement between the parties or does not make any required Contributions during the notice period, the Plan will deem a default to have occurred and the provisions of 17(C) above will apply.

SECTION 18 - PRIVACY PRACTICES

This is a brief summary of some of our key privacy practices. The Plan will protect the privacy of your Protected Health Information (PHI). PHI is health information that includes your name, Social Security Number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI. We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, Enrollee-identifiable medical information is shared with Participating Districts only with your authorization or as otherwise permitted by law. Generally, we will not use or disclose your PHI for any other purpose without written authorization from you (or your representative). Giving us authorization is at your discretion.

This Section, as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows the disclosure of Protected Health Information ("PHI") as defined under HIPAA, to Participating Districts for the purposes specified below.

A. Disclosure of PHI to Trust. The Plan shall disclose PHI to the Trust only to the extent necessary for the Trust to perform the following Plan administrative functions:

    1. To make enrollment, termination and eligibility decisions;
    2. To respond to specific inquiries from an Enrollee concerning his or her medical claim;
    3. To determine disposition of health plan Enrollee appeals;
    4. As required by any applicable law.

B. Use and Disclosure of PHI by Trust. The Trust shall use and/or disclose PHI only to the extent necessary to perform the following Plan Administration functions, which it performs on behalf of the Plan:

    1. To establish and determine eligibility;
    2. To respond to specific Inquiries from an Enrollee concerning his or her medical claims.

C. Trust Certification. The Plan agrees that it will only disclose PHI to the Trust upon receipt of a certification that this Amendment has been adopted and the Trust agrees to abide by such conditions. The Trust is subject to the following:

1. Prohibition on Unauthorized Use or Disclosure of PHI. The Trust will not use or disclose any PHI received from the Plan, except as permitted in these documents or required by law.

2. Subcontractors and Agents. The Trust will require each of its subcontractors or agents to whom the Plan and/or Trust may provide PHI to agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Plan and/or Trust.

3. Permitted Purposes. The Plan and/or Trust will not use or disclose PHI for employment-related actions and decisions or in connection with any other of the Trust's benefits or employee benefit plans.

4. Reporting. The Trust will report to the Plan any impermissible or improper use or disclosure of PHI not authorized by the Plan documents.

5. Access to PHI by Enrollees. The Plan will make PHI available to the Trust to permit Enrollees to inspect and copy their PHI contained in the designated record set.

6. Correction of PHI. The Plan will make an Enrollee's PHI available to the Trust to permit Enrollees to amend or correct PHI contained in the designated record set that is inaccurate or incomplete, and the Trust will incorporate amendments provided by the Plan.

7. Accounting of PHI. The Plan will make an Enrollee's PHI available to permit the Trust to provide an accounting of disclosures.

8. Disclosure to Government Agencies. The Plan will make its internal practices, books and records relating to the use and disclosure of PHI available to the to the DHHS or its designee for the purpose of determining the Plan's compliance with HIPAA.

9. Return or Destruction of Health Information. When the PHI is no longer needed for the purpose for which disclosure was made, the Trust must, if feasible, return to the Plan or destroy all PHI that the Trust received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trust agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

10. Minimum Necessary Requests. The Trust will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

D. Adequate Separation. The Plan and the Trust represents that adequate separation exists between the Plan and the Trust so that PHI will be used only for plan administration. Trust staff and Trustees may have access to limited Enrollees' PHI for the purposes set forth under number 1 above.

E. Adequate Separation Certification. The Plan requires the Trust to certify that the individuals identified above are the only individual that will access and use Enrollees' PHI. The Trust must further certify that such individual will access and use PHI only for the purposes set forth under number 1 above.

F. Reports of Non-Compliance. Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Official at the NY44 Health Benefits Plan Trust, 355 Harlem Road, West Seneca, NY 14224.

SECTION 19 - GENERAL PROVISIONS

A. Entire Plan

The Plan, the application of the Participating District, your individual Application, and our policies and procedures as adopted or amended from time to time, shall constitute the entire Plan between the parties. All statements made by the Participating District or by you shall be deemed representations and not warranties. No such statement shall void or reduce Coverage under the Plan or be used in defense to a claim unless in writing signed by the Participating District and/or you.

B. Alteration

No alteration of the Plan and no waiver of any of its provisions shall be valid unless evidenced by an endorsement or an amendment attached to the Plan, which is signed by the Trustees. No agent has authority to change the Plan or to waive any of its provisions unless delegated authority has been provided by the trustees.

C. Forms

The Participating District shall keep on file copies of all documents, forms, and descriptive literature provided by us for distribution to you. The Participating District agrees to give all new employees our descriptive literature, provided by us, at the time that the employee is hired.

D. Records

1. The Participating District shall furnish us with all information and proofs, which we may reasonably require with regard to any matters pertaining to the Plan. All documents furnished by the Participating District and any other records which may have a bearing on the Coverage under the Plan shall be open for inspection by us at any reasonable time and shall be kept confidential by us in accordance with applicable laws, rules and regulations.

2. You authorize and direct any person or institution that has examined or treated you to furnish us at any and all reasonable time, upon our request; any or all information and records or copies of records relating to the examination or treatment rendered to you. We shall have the right to submit any and all records concerning Health Care Services rendered you to appropriate medical review personnel.

3. In the event of a question or dispute concerning the provision of Health Care Services or payment for such services under the Plan, we may

reasonably require that you be examined, at our expense, by a Participating Physician designated by us.

E. Notice

1. All notices to the parties to the Plan shall be in writing; postage prepaid; first class mail; and shall be deemed given when mailed. The notices shall be mailed to the Plan Administrator or to such other address or person designated, in writing, during the term of the Plan.

2. Notice given by us to an authorized representative of the Participating District shall be deemed notice to all affected Enrollees in the administration of the Plan, including termination of the Plan or the termination of Enrollees' Coverage. The Participating District agrees to provide appropriate notice to all affected Enrollees at its own expense.

F. Covered Benefits

In no event shall you be responsible to pay for Health Care Services Covered by the Plan except as otherwise provided in the Plan.

G. Severability

The unenforceability or invalidity of any provision of the Plan shall not affect the validity and enforceability of the remainder of the Plan.

H. Workers' Compensation Not Affected

The Coverage provided under the Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance or Law.

I. Conformity with Statutes/Venue

The Plan shall be governed by the Laws of the State of New York and venue for any dispute shall be in Erie County, New York.

J. Events Beyond Our Control

In the event of circumstances not reasonably within our control (such as complete or partial destruction of health care facilities; war; riot; civil insurrection; or similar causes), we shall not be responsible for the performance of our obligations under this Plan provided however that we shall resume performance of our obligations under this Plan as soon as reasonably possible.

K. Waiver

Either party's waiver or failure to insist on strict performance of the Plan shall not be considered a waiver or act as a bar to any action for subsequent acts of non-performance.

L. Interpretation

We may adopt and amend from time to time reasonable and uniform policies; procedures; rules; regulations; guidelines; and interpretations in order to promote the orderly and efficient administration of this Plan, all of which shall be binding upon the Participating District and you upon reasonable notification to you.

M. Examinations

The Plan, at its own expense, shall have the right and opportunity through its medical representative to examine any person when and as often as it may reasonably require during the pendency of a claim under the Plan, but only with regard to the condition upon which the claim is based.

N. Legal Incompetence

Payments made to the Covered Person or his beneficiaries, rather than to a Service Provider, are subject to provisions allowing for payment to someone else where either the covered person or his beneficiary is a minor or otherwise not legally competent to give a valid receipt for payment.

When payment is due to a minor, it will be paid to the minor's parent or legal guardian. When payment is due to an incompetent, it will be paid to the incompetent's legal guardian. In the event that a Covered Person dies prior to the date that all benefits are paid hereunder, payment will be made to any of the following living relatives: spouse, child or children, parents, or brothers or sisters, or to the executors or administrators of the Estate. Payment made above will release the Plan from any further liability with regard to those payments.

O. Non-Waiver of Plan Provisions

Failure of the Plan to insist upon compliance with any provision of the Plan at any given time, or under any given set of circumstances, shall not operate to waive or modify such provision, or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are the same or not.

CERTIFICATION

In Witness whereof, the Chair and Vice Chair of the Trust have executed this amendment and restatement of the Plan on the date set forth below.

Jim Fregelette, Trust Chair

Donna Walters, Trust Vice Chair

Dated: January 1, 2025