

**Bedford Central Schools Health Benefit Plan
Restatement of January 1, 1999
Plan Amendment**

The Bedford Central Schools has adopted and amended the following provisions for the self-funded Bedford Central Schools Health Benefit Plan. Amendment revises Master Plan Document restated as of January 1, 1999.

Amendment Number: R 1999-004
Amendment Effective Date: January 1, 2003

Nature of Amendment: To amend the Plan to increase Deductibles; Out of Pocket Maximum; Network Copayments; Outpatient Hospital Copayment; to increase Prescription Drug Expense Benefit Copayments; to modify Plan to include Certified Psychiatric Social worker for treatment of mental illness as part of a pilot program through 2003; and modify Prescription Drug Expenses to include Mandatory Generic Drug Substitution. Changes apply to Covered Expenses incurred on and after January 1, 2003.

Change name PCS to EHS effective immediately.

Provision Affected

SECTION I - SUMMARY OF BENEFITS; C. Hospital Expense Benefits (HEB)

Under **General Hospital; Hospital Outpatient Care;** increase Copayment from **\$25.00** to **\$35.00**; increase Copayment for **Outpatient Alcohol Rehabilitation** from **\$10.00** to **\$15.00** as follows:

Hospital Expense Benefits Covered Services	Network and Out-of-Network Benefits/Limits
General Hospital	
<i>Hospital Outpatient Care</i>	
Surgery	<i>\$35.00 per visit Copayment</i> then balance of Allowable Fees paid in full.
Preadmission Testing	<i>\$35.00 per visit Copayment</i> then balance of Allowable Fees paid in full.
Kidney Dialysis	Full Benefits
Diagnostic X-ray Lab and Machine Tests	<i>\$35.00 per visit Copayment</i> then balance of Allowable Fees paid in full. See separate benefit for preventive mammography.
Radiation Therapy	Full Benefits
Physical Therapy	<i>\$35.00 per visit Copayment</i> then balance of Allowable Fees paid in full for physical therapy that starts within six months after inpatient Hospital stay for related Surgery or Illness and when rendered within 365 days after the Surgery or in the case of Illness after Hospital discharge. Major Medical Expense Benefits available for other Covered physical therapy.

Outpatient Alcohol Rehabilitation	<i>\$15.00 Copayment</i> , then Plan pays balance of Allowable Fees for an Approved Plan of Care up to 60 visits per Calendar Year. (20 of these visits may be used for enrolled Family Member counseling. Five of the 20 may be used even if the affected Family Member is not receiving care.) Additional Coverage <i>is not</i> available under Major Medical Expense Benefits.
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Provision Affected

SECTION I –SUMMARY OF BENEFITS; D. Major Medical Expense Benefits; Deductibles, Copayments and Benefit Maximums.

Change Calendar Year Deductible -Individual Deductible from **\$250.00 to \$400.00** and Family Limit from **\$750.00 to \$1050.00** and Common Accident Deductible from \$250.00 to \$400.00; Change Family Percentage Copayment Limit from **\$3750.00 to \$7000.00**; Enrollee pays 20% from **\$750.00 to \$1400.00**; Change Network Copayment from **\$10.00 to \$15.00** and maximum per each event from **\$30.00 to \$45.00** as follows:

Major Medical Expenses	Network	Out-of-Network
Calendar Year Deductible	Does not apply.	Individual: \$400.00 per Covered Person. Family Limit: \$1050.00 maximum Calendar Year Deductible for three or more Family Members.
Common Accident Deductible	Does not apply.	Limit per family: \$400.00 per accident. Cumulative for two or more Covered Family Members injured in the same accident. Only expenses due to that accident and applied against the Plan Deductible count toward this limit.
Percentage Copayment Family Percentage Copayment Limit	Does not apply. Does not apply.	After Calendar Year Deductible, Plan pays 80% of Allowable Fees (UCR charges). After Calendar Year Deductible, Plan pays 80% of the first \$7000.00 of Allowable Fees Incurred by one or more Family Members, then 100% of Allowable Fees Incurred during the remainder of the Calendar Year. Enrollee pays 20% or \$1400.00
Network Copayment <i>Does not apply when Medicare or another health plan is primary payer.</i>	\$15.00 per Provider per type service. Copayment Limit: \$45.00 per Covered Person each event (all services by same Provider same day) <i>After Network Copayments, the Plan usually pays balance of Network allowances in full. If the Plan limits Network benefits to a number of visits, per visit maximum or other benefit maximum, the Provider can balance bill up to the Network allowance.</i>	Does not apply.

Provision Affected

SECTION 1 – SUMMARY OF BENEFITS; E. Prescription Drug Expense Benefits

Insert disclaimer for Mandatory Drug Substitution; Change name “PCS” to EHS; For Pharmacy, change Specified Drugs Copayment from **\$7.00 to \$10.00**; generic from **\$3.00 to \$5.00**; brand name from **\$10.00 to \$15.00**; for Mail Order Pharmacy (no change for Specified Drugs), change Generic Copayment from \$1.00 to \$4.00 and Brand Name from \$5.00 to \$9.00 as follows:

E. Prescription Drug Expense Benefits

Mandatory Drug Substitution: Plan has mandatory brand name drug substitution. If the brand name drug is not substituted by the generic drug, then the Plan allowance is limited to the Generic Drug costs. You will be responsible for the applicable copayment and charges more than the generic drug allowance. Exception: Plan will allow the cost of a brand name drug when the generic substitute is harmful to your health. See **Section IV-Covered Services; F. Prescription Drug Expense Benefits** under **Mandatory Generic Drug Substitution Program** for details on how to obtain benefits for this exception.

Covered Services	Participating Pharmacy	Nonparticipating Pharmacy
Pharmacy	<p>Allowable Fees are limited to the EHS network drug allowance even if a Nonparticipating Pharmacy is used. If you use a Participating Pharmacy, you are responsible only for the Copayment. If you use a Nonparticipating Pharmacy or do not show your Plan identification card, you are responsible for payment of the Copayment and the charges more than the drug allowance and you must submit your claim to EHS to receive Plan benefits.</p> <p>Limited to 34 days supply or 100-dosage unit, whichever is greater.</p> <p>Drug Copayments: <i>Specified Drugs:</i> \$10.00 Copayment for each prescription or refill for the following drugs: Coumadin, Dilantin, Lanoxin, Levothroid, Synthroid, Premarin, Slo-bid, Tegretol, and Theo-Dur. <i>All other Covered drugs:</i> <i>Generic:</i> \$ 5.00 for each prescription or refill. <i>Brand Name:</i> \$ 15.00 for each prescription or refill.</p>	
Mail Order Pharmacy	<p>Mail order up to 90 day supply Mail Order Copayment: <i>Specified Drugs:</i> \$3.00 Copayment for each prescription or refill for the following drugs: Coumadin, Dilantin, Lanoxin, Levothroid, Synthroid, Premarin, Slo-bid, Tegretol, and Theo-Dur. <i>All other Covered drugs:</i> <i>Generic:</i> \$4.00 for each prescription or refill. <i>Brand Name:</i> \$9.00 for each prescription or refill.</p>	Not a Benefit

Provision Affected

SECTION IV - COVERED SERVICES; D. Major Medical Expense Benefits

Modify Paragraphs under “**7. Outpatient Mental Health Care**” to show Certified Psychiatric Social worker as a covered provider under a Pilot Program

7. Outpatient Mental Health Care

Alcohol or Substance Abuse treatment is not Covered under this benefit. Refer to alcohol Outpatient services under *Hospital Expense Benefits* shown previously in this section and Substance Abuse Care shown previously in this section.

Benefits are available for Outpatient mental Illness care given for you or your Dependents. Coverage is limited to once per day unless additional visits are found Medically Necessary according to Plan provisions. Exception: Coverage will be provided separately for an individual and a group therapy visit given on the same day. Refer to **Section I - Summary of Benefits** for benefit limits. Services must be given and billed by a psychiatrist or licensed clinical psychologist or billed by a Hospital, mental health facility, Physician’s corporation or clinic for the services of a psychiatrist or licensed clinical psychologist. *Coverage also includes Certified Social Workers as part of the District pilot program for one year through 2003. The District has the sole right to determine whether coverage for this provider will be extended beyond 2003. **No other Providers are Covered.*** Treatment must be directed at a diagnosed mental Illness. Benefits are not payable for care that is primarily directed at raising the level of consciousness, social enhancement, retraining, professional training or counseling limited to everyday problems of living, marriage counseling, family counseling, sex therapy, or support groups. Under no circumstances are benefits provided for therapy that includes the satisfaction of requirements for professional training. Alcohol or drug addiction treatment is not covered under this benefit. See alcohol and/or substance rehabilitation benefits shown previously in this section.

Provision Affected:

SECTION IV - COVERED SERVICES; F. Prescription Drug Expense Benefits.

Change Name PCS to EHS; Delete “**2. Voluntary Generic Drug Substitution Program**” and related paragraphs insert new heading “**2. Mandatory Generic Drug Substitution**” and related paragraph; Change copayments to match changes made for the Summary of Benefits as follows:

Secondary Coverage. The EHS retail pharmacy or mail service benefit does not apply if this Plan is secondary according to the COB order of benefit determination. See **Section VI - Coordination of Benefits**. If you or your Dependent obtain drugs through the Participating Pharmacy or the mail service when another plan is primary, you will be responsible for reimbursement of any Plan overpayments.

2. Mandatory Generic Drug Substitution Program. As part of a continuing effort to control costs and preserve the quality of the Plan, Covered Persons are encouraged to use Generic Drugs whenever appropriate for your condition. A Generic Drug is a drug that is chemically equivalent to the original brand name drug. The only difference is that the patent on the brand name medication has expired allowing other manufacturers to sell the drug. As a result, the generic manufacturer does not incur research costs and can charge significantly less for the drug. Since Generic Drugs cost less than brand name drugs, cost savings may result for you and the Plan when you substitute the lower priced drug. If you have any questions about Generic Drugs, ask for advice from your Physician or your pharmacist.

Noncompliance Benefit Reduction. Under the EHS program, if you or your eligible dependent receives a brand-name drug when a generic substitution is available, you are responsible for paying the difference between the cost of the brand name drug and the generic drug and the applicable Copayment for the brand name drug. Drug costs will be based on the participating pharmacy prices as established by EHS. This can result in substantial payment by you as there may be a significant difference in costs between the expensive brand name drug and the lower priced generic drug.

Medical Exception. If the attending physician considers the generic substitute to be harmful to the Covered Person’s health, then the Plan will allow coverage for the costs of the brand name drug. To qualify for this exception, the physician must provide written specific reasons why the generic drug is harmful to you or your Dependent’s health. This exception will not apply if the physician just wants to prescribe that particular brand name drug. *Your physician may fax his/her written statement to POMCO at 1-607-786-3470. It will be promptly reviewed and if approved, you will be able to obtain the brand name drug each time it is purchased. If you have any questions concerning this procedure, you may contact the clinical co-coordinator for the POMCO pharmacy program at 1-800-836-0709.*

Benefits will continue to be paid for brand-name drugs, which have no generic equivalent.

3. When Another Plan is Primary. do not obtain benefits through EHS. Do not obtain drugs.....
..... from using EHS retail pharmacy or the mail service Pharmacy.

4. Participating Pharmacy. A Participating Pharmacy has an agreement with the prescription drug Claims Administrator, EHS to accept the Plan benefit, after any applicable Copayment, as payment in full. If this Plan is the primary Coverage, you or your Dependents may purchase Covered drugs at EHS Participating Pharmacies. If an EHS Pharmacy is used, you will be required to pay only the following Copayments:

a. Copayments:

For Specific Drugs Listed:

\$10.00 Copayment for each prescription or refill for the following drugs: Coumadin, Dilantin, Lanoxin, Levothroid, Synthroid, Premarin, Slo-bid, Tegretol, and Theo-Dur.

All other Covered drugs:

Generic: \$ 5.00 for each prescription or refill.

Brand Name: \$ 15.00 for each prescription or refill.

- b. **Plan Identification Card.** You can use your Plan identification card at any EHS Participating Pharmacy. The Pharmacy may display the EHS participation logo or you may ask the Pharmacy if it participates as an EHS Participating Pharmacy.
- c. **Obtaining Benefits.** To obtain your Covered drug or supply at Participating Provider costs, you need only present your Plan identification card and the written prescription to the EHS Participating pharmacist, then pay the applicable Copayment amount. The Pharmacy will bill EHS directly.....
.....during normal operating hours or send a written inquiry.

5. **Nonparticipating Pharmacy.** If this Plan is primary for benefits to EHS. Benefits will be based on the EHS Participating Pharmacy allowance..... than the EHS allowance.and the completed drug claim form should be mailed to:

**Eckerd Health Services
P.O. Box 2860
Pittsburgh, PA 15230-2860**

6. **Mail Service for Maintenance Drugs.** If this Plan is primary, you or your Dependents may obtain maintenance drugs from the EHS mail service pharmacy, Express Pharmacy Services. After applicable Copayment, the mail service bills the Plan for the balance of their fees.

a. Mail Service Copayments:

For Specific Drugs Listed: \$3.00 Copayment for each prescription or refill for the following drugs: Coumadin, Dilantin, Lanoxin, Levothroid, Synthroid, Premarin, Slo-bid, Tegretol, and Theo-Dur.

All other Covered drugs:

Generic: \$ 4.00 Copayment for each prescription or refill.
Brand Name: \$ 9.00 for each prescription or refill.

b. How to Use the Mail Service Pharmacy Program

- 1) When the Physician writes a prescription
..... a retail Pharmacy while mail order is being processed.

**Express Pharmacy Services
PO Box 270
Pittsburgh, PA 15230-9949
For Refill Orders Phone Toll-free: 1-888-645-9303**

Provision Affected:

SECTION X –DEFINITIONS

Insert **Certified Social Worker** and related paragraph between definitions for **Calendar Year and Claims Administrator** as follows:

CERTIFIED SOCIAL WORKER - A licensed social worker who has a license/certificate No. which begins with an "R" issued by the New York State Education Department or similar qualifications outside New York.

Authorized Signature of the Plan Administrator		
	(Signature)	
	(Title)	
		(Date)